Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 26 July 2022 at 09:30
Via MS Teams

Enc		Purpose	Page	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* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*			10
A2	Actions from previous meeting *Suzy Brain England OBE, Chair*	*Review*		
B	**PRESENTATION**			**09:40**
B1	The Professional Nurse Advocate *Abigail Trainer, Acting Chief Nurse* *Jenny Hunt, Lead Professional Nurse Advocate*	*Note*		15
C	**True North SA1 - QUALITY AND EFFECTIVENESS**			**09:55**
C1	Board Assurance Framework *Dr Tim Noble, Executive Medical Director – SA1* *Abigail Trainer, Acting Chief Nurse -SA1 Covid*	*Assurance*		10
C2	Chief Nurse Update *Abigail Trainer, Acting Chief Nurse*	*Assurance*		15
C3	Maternity Update *Lois Mellor, Director of Midwifery*	*Assurance*		10
C4	Executive Medical Director Update *Dr Tim Noble, Executive Medical Director*	*Assurance*		15

D	**True North SA2 & 3- PEOPLE AND ORGANISATIONAL DEVELOPMENT**			**10:45**
D1	Board Assurance Framework *Anthony Jones, Deputy Director of People & Organisational Development*	*Assurance*		10
D2	People Update *Anthony Jones, Deputy Director of People & Organisational Development*	*Assurance*		10
	BREAK 11:05 – 11:15			
E	**True North SA4 - FINANCE AND PERFORMANCE**			**11:15**
E1	Board Assurance Framework *Alex Crickmar, Acting Director of Finance*	*Assurance*		10
E2	Finance Update *Alex Crickmar, Acting Director of Finance*	*Note*		10
E3	The Premises Assurance Model Assessment Report 2021/2022 *Alex Crickmar, Acting Director of Finance* *Mathew Gleadhall, Acting Deputy Director of Estates and Facilities*	*Approve*		10
E4	Operational Update – Looking Forward *George Briggs, Interim Chief Operating Officer*	*Assurance*		10
E5	Performance Update *George Briggs, Interim Chief Operating Officer*	*Assurance*		10
E6	Ambulance Handover Delays *George Briggs, Interim Chief Operating Officer*	*Assurance*		10
F	**STRATEGY**			**12:15**
F1	True North, Breakthrough & Corporate Objectives 2022/23 & Q1 Update *Richard Parker OBE, Chief Executive*	*Approve*		10
F2	Research Strategy *Anthony Jones, Deputy Director of People & Organisational Development* *Dr Sam Debbage, Deputy Director of Education & Research* *Jane Fearnside, Research Fellow*	*Assurance*		15
F3	Bassetlaw Emergency Village Outline Business Case *Jon Sargeant, Interim Director of Recovery, Innovation & Transformation* *Kirsty Edmondson-Jones, Director of Innovation & Infrastructure*	*Approve*		15

	BREAK 12:55 – 13:05			
G	**GOVERNANCE AND ASSURANCE**			**13:05**
G1	Corporate Risk Register *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Review*		5
G2	Trust Annual Report 2021/22 including Annual Governance Statement & Annual Accounts 2021/22 Quality Accounts 2021/22 *Richard Parker OBE, Chief Executive*	*Assurance*		10
G3	Standing Financial Instructions, Standing Orders and Scheme of Delegation *Alex Crickmar, Acting Director of Finance*	*Approve*		10
G4	Audit & Risk Committee Annual Report *Kath Smart, Non-Executive Director and Chair of the Audit and Risk Committee*	*Assurance*		5
H	**INFORMATION ITEMS (To be taken as read)**			**13:35**
H1	Chair and NEDs Report *Suzy Brain England OBE, Chair*	*Information*		
H2	Chief Executives Report *Richard Parker OBE, Chief Executive*	*Information*		
H3	Performance Update Appendices *George Briggs, Interim Chief Operating Officer*	*Information*		
H4	Minutes of the Finance and Performance Committee – 25 April 2022 *Neil Rhodes, Non-Executive Director*	*Information*		
H5	Minutes of the People Committee – 3 May 2022 *Mark Day, Non-Executive Director*	*Information*		
H6	Minutes of the Audit & Risk Committee – 19 April, 6 June & 17 June 2022 *Kath Smart, Non-Executive Director*	*Information*		
H7	Minutes of the Trust Executive Group – 14 March, 9 May & 13 June 2022 *Richard Parker OBE, Chief Executive*	*Information*		
H8	South Yorkshire & Bassetlaw Acute Federation –Annual Report for 2021/2022 *Fiona Dunn, Deputy Director Corporate Governance/Company Secretary*	*Information*		
I	**OTHER ITEMS**			**13:35**
I1	Minutes of the meeting held on 28 June 2022 *Suzy Brain England OBE, Chair*	*Approval*		5
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 27 September 2022 **Time:** 9:30 **Venue:** MS Teams	*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**			**13:50**

***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, Lynne Schuller, as Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne directly by 5pm day 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 Lynne Schuller, Lead Governor.
- Questions will be asked by Lynne Schuller, 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: Angela O'Mara
Updated: 28 June 2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting:	Public Board of Directors
Date of latest meeting:	28 June 2022

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

No.	Minute No.	Action	Lead	Target Date	Update
1.	**P22/03/F1**	**<u>Principles for 2022/2023</u>** Corporate objectives to be brought to April's Board of Directors Meeting.	**RP**	**July 2022**	**Update 26.4.2022** – paper received, objectives to be refined based on suggestions, considered by the aligned sub-committees and to return to a future public Board meeting for approval. **Update 28.6.2022** – to be included on July's agenda and include a Q1 update.

PROFESSIONAL NURSE ADVOCATE

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The Vision

DBTH FT and Beyond – Evaluating progress

Jenny Hunt RN(A), BA Professional Practice, MSc Advanced Professional Development, Lead PNA DBTH FT

What is a Professional Nurse Advocate?

The Professional Nurse Advocate (PNA) role is a new, fundamental leadership and advocacy role to deploy the A-EQUIP model

Professional Nurse Advocates (PNA's) have the knowledge and skills to:

1. Provide support to enhance health and wellbeing
2. Develop education and training to progress knowledge and skills
3. Support quality improvement practices to ensure that patients and their families experience safe, enriching care

DBTH Vision

"To be the safest Trust in England, outstanding in all we do"

How does the implementation of the PNA role support and contribute to this vision?

Deployment of the A-Equip model supports continuous improvement and builds personal and professional resilience thereby **enhancing the quality of care delivered**

The four inter-related functions are to designed to **support staff to deliver safe and effective practice**

We care

How the PNA role contributes to the strategic objectives – true north and breakthrough

Strategic: specifically - people, quality improvement

True north: specifically – to provide outstanding care and improve patient experience

Breakthrough: specifically – achieve measurable improvement in our quality standards and patient experience, 90% of staff have an appraisal linked to Trusts Values and feel able to contribute to the delivery of the Trust Vision, Team DBTH feel valued and feedback from staff and learners in top 25%

LEAD NURSE PROFESSIONAL NURSE ADVOCATE PROJECT

The Vision – scoping the role at DBTH

Advocate

Advocating for patients and their families

Communication

Deploy the A-Equip Model

Leadership – developing emotionally intelligent leaders

Promote role to Board/exec team/ward managers

Developing PNAs

Utilise Professional Maternity Advocate (PMA)

Pilot areas

Barriers

Realistic and achievable timeline

How do we measure effectiveness/benefits?

Preceptorship

Changing culture

Education - teaching and promoting professional development

Quantitative data
Provider Workforce Return, sickness/absence rates. Recruitment and retention
Patient Safety

PNA steering group

Quantitative data – feedback from RCS sessions, staff survey feedback

Debriefing

Modules-area specific courses

Training future PNAs

Restorative Clinical Supervision (RCS)

Datix

Quality Improvement

Governance

Focus of approach – staff groups/bands

Appraisal clinics

CQC/NHS Contract

Time

Revalidation clinics

QI clinics

Leading service/quality improvements

Participation in national forums/networks

Supporting PNAs

Continually developing the role

Health and wellbeing

Individual area needs

Empowerment

National and regional guidance

Thematic analysis – key areas of focus

LEADERSHIP AND COLLABORATION

INFORMATION GATHERING

INFORMATION GIVING

PRACTICALITIES

Leadership and collaboration

Link	Coach and support	Learn and inform	Act	Develop	Aim
Link with regional working group Link with PMAs Collaborate with education and QI teams	Coach and support those in training to contribute to meetings and education events to support roll out	Learn and inform other Trusts/PNA network – sharing good practice	Act as role model and mentor to those undertaking or wishing to undertake PNA training	Continually develop the wider roll out, encouraging engagement across the Trust	Aim to publish work – both the roll out and encourage PNAs to publish project work

Information Gathering

- Maintain register of those training and qualifying – identifying number of PNAs in 1 year, 2 year and 3 year timeframe
- Register implementation as QI project – collecting qualitative and quantitative data about benefits
- Use the steering group/committee to establish data collection methods
- Respond to feedback – adapting approach if necessary

Information Giving

Educate board, executive team and ward leaders and wider DBTH nursing team on benefits and the A-Equip model

Begin to embed roll in existing programmes i.e. preceptorship, pre-registration programmes – working with Sheffield University

Feedback results and progress to the regional team, board, executive team, ward leaders and the wider DBTH nursing team

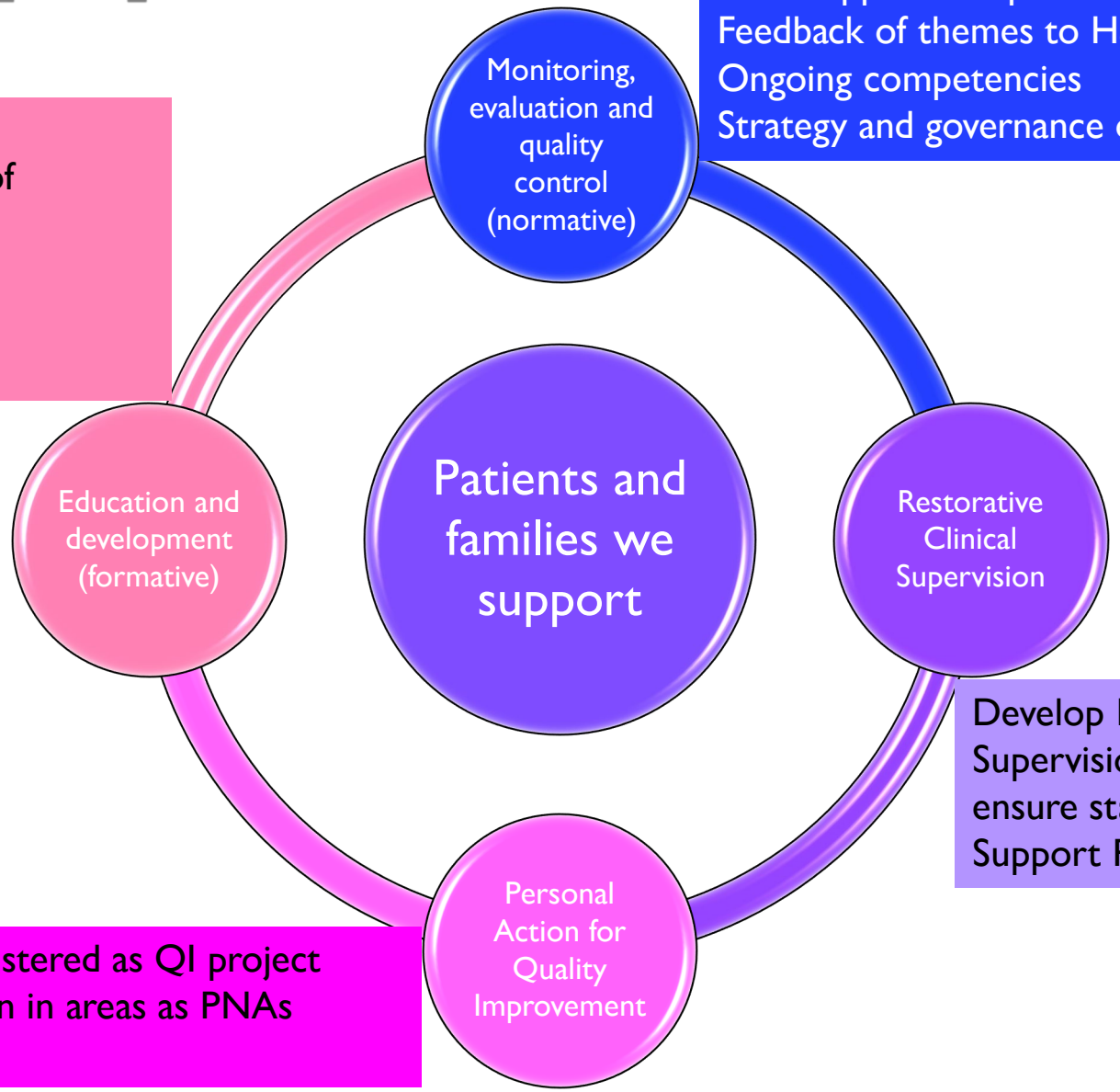
Translating the vision into practice – PDSA (IHI 2021) cycles of implementation

Plan	Do	Study	Act
• Publicise role • Establish recruitment and mentorship strategy • Establish steering group and develop policy governance structure • Identify pilot study areas • Create referral process	• Create information leaflets and presentations • Collate information on current PNAs and activity • Collaborate with Regional Team/ Community of Practice • Plan recruitment and pilot areas • Create Trust network of PNAs • Discuss policy (including securing protected time) and data collection	• Explore feedback – from PNAs, steering group and pilot areas • Explore any further national/regional guidance • Explore PNA activity and protected time arrangements • Review referral process	• Write policy/governance structure and implement – including referral process • Continue PDSA cycles – develop Trust guidelines from pilot sites to continue larger roll out

The A-Equip Model

PNA recruitment and training
Development and mentorship of PNAs/Trainee PNAs
Learning needs analysis
Role development
Service development

Completion of Provider Workforce Return (PWR)
Evaluation of PNA activity
Steering Committee
PNA support – supervision and link meetings
Feedback of themes to H&WB Committee
Ongoing competencies
Strategy and governance development



Develop Restorative Clinical Supervision (RCS) sessions and ensure staff can access if needed
Support PNAs to deliver sessions

Implementation registered as QI project
Pilot implementation in areas as PNAs qualify

Current PNA Team

Myself – Lead Nurse PNA supporting implementation

13 further qualified since my appointment

12 in training

7 awaiting a place

Challenges

- Support for trainee PNAs – particularly year one as limited trained PNAs
- Lack of awareness and understanding of the role – publicising within limits of service
- Ongoing recruitment – year two and three (and succession planning), including managerial support/understanding
- Time and funding for PNAs and supervisee – including exploration of backfill for PNAs and supervisee
- Staff engagement

Progress to date: This is realistically a 3 year project to develop the full service
Key areas of focus:

Recruitment and service development

At least 86 PNAs required to achieve 1:20 ratio

3 PNAs on NHS register

11 awaiting entry to register

12 in training

7 awaiting place

Outline business case – to establish funding

Steering group formed to support development of service and business case

Recruitment strategy devised and disseminated amongst Divisions

Support for PNAs and Trainee PNAs

Mentorship support – establishing mentorship structure

Learning needs analysis for ongoing practice

Regular supervision – Lead PNA providing supervision and regular link meetings and check ins

Additional training opportunities: Awareness courses identified: mental health, drug and alcohol, menopause, financial wellbeing

Raising awareness of the role

Implementation registered with Quality Improvement

Pilot projects are planned in areas where we have trained/trainee PNAs – these will also form part of the service development through ongoing evaluation

Presenting the PNA implementation within induction, preceptorship and international nurse programmes

PNA implementation - Facilitation of Sessions

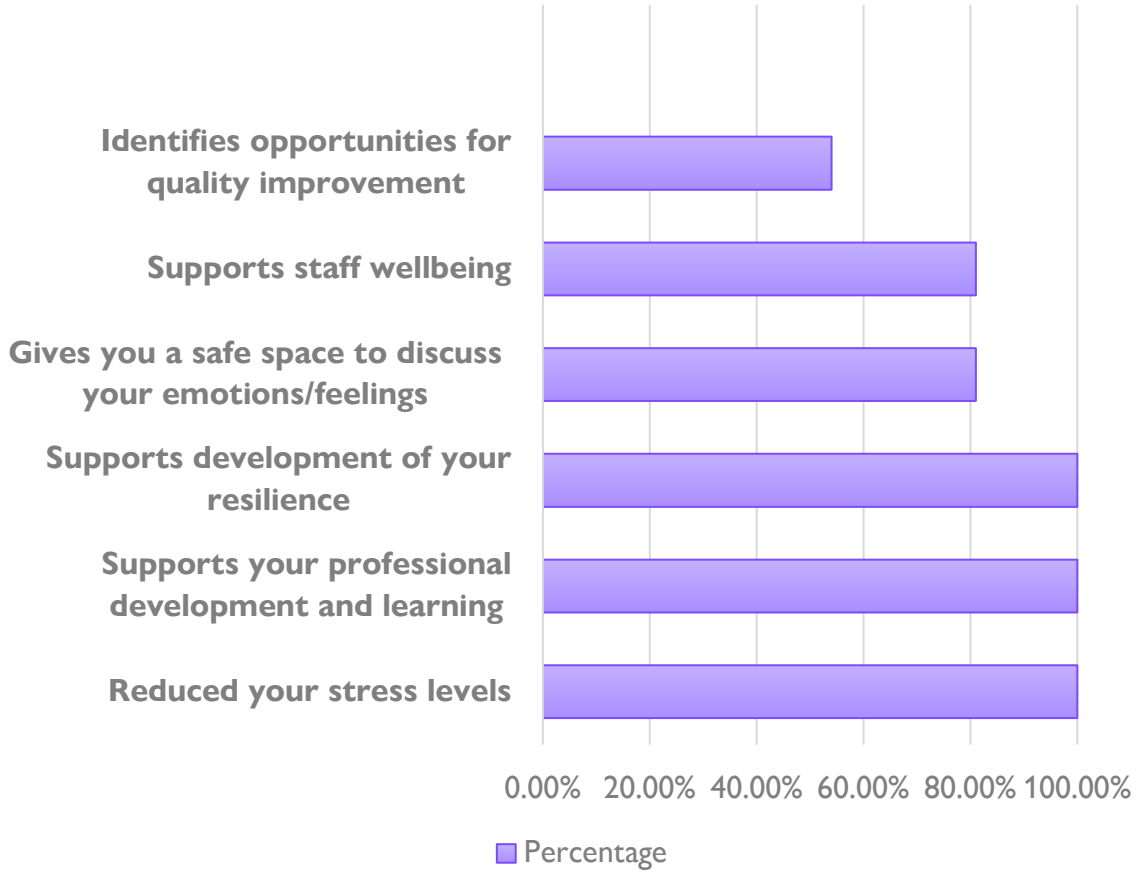
- **3** PNAs currently on NHS England Register

- **11** awaiting entry onto register, **12** in training

- **Pilot areas:** DCC/ITU, ED, CCU, Education Team, End of Life Team, Research Team, Paediatrics, Trauma Theatres, Skin Integrity Team, Surgery (BDGH B5), Orthopaedics, AMU, Endoscopy, Medicine – Gresley, Surgical Practitioner, Surgery (Matron)

- **Sessions facilitated so far**:
  - **26** Restorative sessions – **35** staff supervised
  - **8** Career conversations
  - **1** QI project initiated (main implementation project)

Session evaluation so far – key benefits



Free Text Answers

Yes I felt more relaxed and I was able to identify that it was not personal towards me or my practice – it was to aid other professionals to make an informed decision. **I was able to look at it as a positive experience even after worrying for 2 years**

Massively, I **feel very inspired** and feel like I have more of a plan moving forward

Practical advice received on blocking diaries, handing over and switching off emails on my phone. Also thought of after I finish, having a plan, journaling and **positive thinking**

I did feel like I benefitted from the session because it gave me a **boost of confidence** and actively helped me work on my interview skills

Yes – **direction for QI project**

Yes, to provide peer **support to one another**

I was not sure what to expect but I enjoyed the flow of the session, and it **felt a very safe space** to air my thoughts and concerns

What next?

Develop	Belong	Thrive
The future role – back to the vision and the evaluation of role and implementation	Clinical support – explore advocacy role in clinical setting	Revalidation clinics
QI clinics	Education clinics with education team	Appraisal clinics
Publish academic work to add to the PNA literature base – scarce as new role	Establish and embed Restorative Clinical Supervision	

Recommendations

- Blue sky thinking – PNA core team – Lead, 2 x B7, 2 x B6 supporting sessional PNAs (who have protected time)

- Second option – smaller core team – Lead, 1 x 7, 1 x 6 supporting sessional PNAs (protected time)

- Most realistic option – maintain Lead role to support continued implementation, development, embedding and evaluation with sessional PNAs – evaluating needs as project develops

And Beyond…

Personal objectives:

Be a key driver in the development, launching, embedding and evaluating the delivery of the Professional Nurse Advocate Programme within the Trust and Region

Continue to be an active member of the PNA community – within the Trust, Region and Nationally

Continue to develop myself as an emotionally intelligent leader and lead the PNA team

Support academic programme at Sheffield University and publish academic work related to the project and the PNA role

Report Summary – Lead PNA Project

Professional Nurse Advocate Report/Governance Report	
Directorate	**Corporate Nursing**
Report Author	**Jenny Hunt**
Dates	**March 2022-June 2022**

Brief summary/headlines

- New initiative set out by NHS England which should respond to national initiatives outlined in NHS People Plan 2020/21 by supporting mental health and wellbeing aspect

- Focus on the clinical leadership response to Covid-19 and continuing professional development of the nursing workforce (NHS Confederation 2021)

- From April 2022, the NHS Standard Contract 2022/23 (NHS England 2022) outlines that providers of nursing services are required to implement the PNA role within their organisations. All organisations should ensure the PNA role, and the delivery of Restorative Clinical Supervision (RCS), is embedded in current clinical governance arrangements, including board oversight

- Ruth May set out a vision for 1:20 PNAs by March 2024

- Secondment as Lead PNA in a full time position has been extremely beneficial – allowing the implementation process to become established, enhancing the Trusts reputation by becoming a leading voice both regionally and nationally

- Support structure and ongoing recruitment plan for PNA programme established to support the vision set by Ruth May – currently we will have 26 PNAs on NHS England Register by September with an ambition to recruit a further 31 by March 2023

- Collaborative working and leadership within the Trust and beyond. Involvement in regional strategy development and leading the regional group for annual report template development

- Overall impact difficult to assess in early phase however staff feedback has been positive – on evaluation reduction in anxiety levels, positive experiences which have contributed to supporting career development and continual improvement including QI initiatives

Number of Qualified PNAs	Number of Trainee PNAs	Number of EOIs/awaiting HEi Allocation	Number of RCS sessions	Number of staff supervised
3 on NHS England Register **11 awaiting entry**	**12 – including those awaiting results**	**7**	**26**	**35**
Number of career conversations			**8**	
Number of QI Projects initiated			**List projects:** **Implementation of PNA initiative**	
Number of appointments allocated			**10 – Data collection for June only (evaluation adapted as project progressing)**	
Number of appointments DNA			**0**	
Themes identified			**List themes:** Support for court witness Career development and quality improvement support Support for wellbeing Staff wellbeing – need of urgent support Team dynamics/incivility Workplace relationships Incident debrief Leadership development	

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**	**Team DBTH feel valued and 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:** 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.	**Breakthrough Objective:** Team DBTH feel valued and 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 June 2022 reviewed alongside the corporate risk register.

The entire BAF and CRR were reviewed at Board Sub Committee meetings during June/July 2022 and by the Strategic aim sponsors in June 2022. The individual BAF sheets indicate the assurance detail and the risks have been discussed and captured via the minutes at Board and its sub committees.

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 June/July Sub Committee and Trust Board.

The key risks to achieving 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 May Trust Board and its subcommittees. The risk score for SA1-COVID has increased from 15 to 20 (see BAF for details) and no other changes have been recorded in the overall BAF risk scores for SA1-SA4.

There has been one change in the BAF risk level during quarter 1 2022/2023. (COVID 2472- SA1COVID)

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					
Possible 3				3 , F&P5, Q&E1, ARC01	2 **F&P11**, **COVID 2472**
Likely 4			1 F&P12	6 Q&E9, **F&P1**, F&P3, F&P6, F&P8, , PEO3, PEO2	4 F&P4, F&P20 Q&E12, F&P12,
Certain 5					

Overall change per Strategic Aim (SA)

	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2021/22	No of risks/SA	Change
SA1	⟷			⟷		⟷
SA2	⟷			⟷		⟷
SA3	⟷			⟷		⟷
SA4	⟷			⟷		⟷
COVID	↑			⟷	several	↑

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 – Medical Director/Chief Nurse **Committee: QEC**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : JULY 2022**		
Strategic Objective To provide outstanding care and improve patient experience **Breakthrough Objective** Achieve measurable improvements in our quality standards & patient experience **Measures:** • ~~Ward/department quality assessment scores, recommencement of quality frameworks. Roll out of the Perfect ward assurance tool (now called Tendable) has commenced and the trial wards are testing the question sets~~ . • A quality steering group has now been set up that will be chaired by the Deputy Chief Nurse for Quality, feeding into this steering group will be updates and a progress plan about Tendable, Datix, quality dashboards, quality strategy, PSIRF, Clinical audit dashboard, patient safety, risk management plans, updates from the external quality review and associated recommendations, SafeCare and data quality issues and how we escalate these. This steering group will then send a report to the Chief Nurse who will provide an update to the Transformation board monthly. • Evidence of "closing the loop", through sharing of learning from incidents and follow up from QI processes • Focus on key safety risks – IPC Outbreaks - waits, falls, milestones set through business planning for each division aligned to the division's breakthrough objectives • Clinical effectiveness, processes to include the following of NICE guidance • IQPR measures • Feedback from patients via compliments and complaints. • Patient survey outputs and effectiveness of action plans • Co-production of changes with patients • Insights profiles from CQC • Board Assurance Frameworks • External review of patient safety and clinical governance which will incorporate patient experience	**Risk Appetite:** The Trust has a **low appetite** for risks **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 • Risk to safety and poor patient experience if we do not improve emergency flow in our capacity constrained environment • Current gaps in registered workforce whilst new registrants and international nurse's complete preceptorship with increased reliance on agency staff. • Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures due to uncertain covid pandemic pattern **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 • Review of quality processes within the ICS	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 20 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low	Risk Trend ⟷
		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 women's hospital. • Uncertainty re COVID recovery outcomes • Uncertainty re SYB ICS changes		
		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		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
BIR Data targets & exceptions	Jan 2022	Feb 2022	Med Director (TN)	No unexpected identified
Accountability Framework & Quality framework process ○ Securitization of pt pathways – risk stratification of patient pathways ○ ~~Winter plan implementation~~	Jan 2022	November 2022	Med Director (TN) & COO	Action plans in place, reviews on going
~~Clinical Governance review complete.~~ Awaiting completion of external patient safety and governance review prior to implementation	May 2022	November 2022	Med Director (TN)	~~None identified~~ Awaiting outcome of recommendations to understand gaps In control, not currently mitigated
Urgent and Emergency Care Improvement Programme – ongoing	April 2022	November 2022	Med Director (TN)	Actions & plans in place

Appendix Level1

Action plans to respond to CQC patient surveys	April 2022	September 2022	Chief Nurse & Med Director (TN)	Action plans in place and monitored through PEEC via regular reporting
Patient Experience PPI and Accessible Standards in place which form part of the patient experience pathway	June 2022	September 2022	Chief Nurse	Work plan and strategy to be enhanced to improve patient experience
Risk stratification of patient pathways established. KPMG working with medical director on patient pathways as part of outstanding outpatients forum.	May 2022	June 2022	Med Director (TN)	

	Assurances received (L1 – Operational L2-Board Oversight L3 External) **	**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L3	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.	June21	ARC, Board	Full	None
L1,L2	SNCT undertaken to ensure safe staffing completed in June2022, report outcome will be expected at board in September 2022.	Jan 22	QEC, Board	Full	Awaiting completion of SNCT data collection which is taking place in May 2022
L2,L3	Ockenden feedback received from the LMNS, action plans developed to achieve 7 key actions	Dec 21	Board	Full	Action plan in place
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022	Jan 22	Board	Full	
L2	Nurse Staffing Assurance Framework shared at Board on the 25th of January 2022	Jan 22	Board	Full	

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
CQC (Picker) in patient 2021 survey results received May 2022. Results to be reviewed and actions plans to be developed and submitted to PEEC for August 2022.	**September 2022**	**Survey reports shared with key stakeholders**	**Chief Nurse**	**September 2022**
Commission external review of patient safety and clinical governance which will incorporate patient experience, review recommendations and agree action plan	**July 2022 for report, agree plan November 2022**	**Review underway**	**Medical Director Chief Nurse**	**Dependent on agreed action plan**
Review patient experience strategy and develop work plan for 2022/23	**September 2022**	**Review to commence**	**Chief Nurse**	**Dependent on agreed action plan**

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

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.- COVID19 Major incident

Risk Owner: Trust Board – Medical Director/Chief Nurse/COO **Committee: Q&E, F&P,**	**COVID19 Major incident - Addition to SA1**	**Date last reviewed : July 2022**

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.

Comments: points to consider
- Corridors now reopened but social distancing still in encouraged.
- High risk areas continue to adhere to the 2 metre social distancing rule
- Some reduction in Planned Care – Outpatients & Surgery but risk reducing as Covid numbers decline
- Vulnerable Patients – support still required to support high risk patients
- Minimal impact on critical care currently with no patients requiring this level of care at time of update
- Consolidation of maternity and Delivery of Children's Services
- Trauma Consolidation- Increasing trauma capacity as COVID allows
- Diagnostics and Pharmacy
- Care of Deceased Patient
- People Planning, Education and Research
- Ethical Decision Making
- Infection Control and Prevention Support
- Partnerships, Communication and Engagement
- Visitor restrictions reviewed with a return to 'open visiting' for 2 visitors in areas where there are no active Covid outbreaks
- Visitors encouraged to continue to wear masks at all times and not to attend if they are displaying any Covid symptoms
- To support patient flow all patients continue to be screened on admission, then days 3, 5 and 7 of their hospital stay. If they remain negative no further action is required, however if symptoms are noted patients are then managed in accordance with Covid / IPC guidelines.
- Alternate day screening for contact patients has ceased which has seen an improvement in patient flow and minimal impact on patient safety. This is in accordance with guidance issued in April by NHSE/I.

Comments:
- See evidence of plans in link (Overall Plan)
- Risk log (see link)
- High Level COVID Narrative
- Post implementation review

Risk Appetite:
The Trust has a **high appetite** for risks that impact on patients and staff during a worldwide pandemic.

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 –
  - Changes to rules of the elective incentive fund with increase of thresholds to 95% impacting on funding available to deliver additional activity as per accelerator plans – impact for waiting lists and associated patient care. Potential risk of long waiting patients presenting as emergencies or developing further complications.
- Impact on staff & Inability to provide viable service
- High number of staff absence (due to COVID related reasons) with impact on services across the board – impact on elective services which may affect ability to deliver the elective activity plan and supporting accelerator activity
- Risks on staffing numbers in relation to vaccination awaiting final decision nationally.
- Risks to patient flow due to external availability of care provision, which adversely affects patient experience

Risk references:
link CRR Risk ID2472 on DATIX

Opportunities:
- Change in practices, new ways of working

Initial Risk Rating	5C) x 5(L) = 25 extr	Risk Trend ↑
Current Risk Rating	5(C) x 4(L) = 20 extr	
Target Risk Rating	3(C) x 3(L) = 9 low	

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
- Increase in cases in community prevalence in the last 2 weeks
- Increase in patients requiring hospitalisation in last 2 weeks
- Restarted confirmatory PCR testing on all staff reporting positive lateral flow tests
- Increase in staff absence related to covid

Future risks:
- Impact of COVID on elective restoration
- Potential impact on bank and agency spend to increase due to sickness amongst all staff groups
- Staff engagement post Covid
- Patient expectations following Covid
- Staff working in separate areas following the incident in the women's hospital.
- Uncertainty re COVID recovery outcomes
- Uncertainty re SYB ICS changes

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Pandemic incident management plan implemented. • National reporting & monitoring eg PHE, NHSI/E, WHO etc ○ Level 4 incident stood down & local reviews still in place weekly or as new guidance is issued	2022 June	July 2022	Director of Infection Prevention and Control Chief Nurse	No unexpected identified

Accountability Framework & Quality framework process ○ Scrutinization of patient pathways	June 2022	July 2022	Director of Infection Prevention and Control, Chief Nurse & COO	Action plans in place
Full projections of C19 demand & other emergency flow modelled with partners & supporting bed modelling. This informs week to week operational plans	June 2022	July 2022	Deputy Chief Executive COO	Work plans in place to support flow internally and externally
Urgent and Emergency Care Improvement Programme – underway & reviewed as part of the recovery programme	June 2022	ongoing	Deputy Chief Executive COO	Focused work on ED medical staffing
Ongoing daily operational reviews to allocate or redeploy staff to maintain safe care, or mitigate risks in a particular service as appropriate	June 2022	Ongoing	Chief Nurse COO	Ongoing rota management
Vulnerable Patients- mMAbs service running since Dec21 and request has been made to keep this as an ongoing service which the Trust has agreed to support. COO working with national team on funding stream and clinical team around staffing plan	June 2022	September 2022	Deputy Chief Executive COO	Central funding to be made available. COO working with clinical team to submit a bid so this is funded from central sources

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1,L2,L3	National reporting & monitoring eg PHE, NHSI/E, WHO etc	Nov 21	F&P, Board	ongoing	On going
L1,L2	Enhanced operational meetings currently stepped down due to significant decline in patient numbers. However ongoing incident management arrangements dependent on COVID infection rate at current time and reviewed if further increase in patient and staff numbers which could impact on daily performance	June 2022	F&P,QEC, Board	Full – ongoing review through phases	Action plans in place & continual review
L2	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.	June 2022	F&P, Board	Full – ongoing review through phases	Action plan in place & continual review
L1,L2,L3	BAF completion on specific areas, evaluated by CQC, IPC BAF reviewed at Board of Directors December 2020. BAF reassessed 14th July 2021, to be reassessed with latest guidance. Updated BAF shared with Board on the 25th January 2022. Updated IPC BAF shared with QEC 3/4/2022. New IPC Board Assurance Framework still not been publicised at time of update by national team	June 2022	QEC	Full against current version	None
L2,L3	KPMG Internal Audit reviews on quality outcomes: ○ Covid-19: Business Continuity, Pandemic Response Plan and Remote Working - October 2020 - ○ COVID-19 Financial Governance and Controls - October 2020 -	October 2020	Board	- Significant assurance with minor improvement opportunities	Actions complete

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
~~Discussions required to understand future funding model for Vulnerable Patients- mMAbs service (been running since Dec21 and request to run for further 6 months)~~	~~**30/4/2022**~~	~~**ongoing**~~	~~**Medical Director**~~	~~**30/4/2022**~~
Please see update in appendix 1				

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	C2
Report Title:	**Chief Nurse Report**		
Sponsor:	Abigail Trainer, Acting Chief Nurse		
Author:	Kirsty Clarke, Workforce Lead Stacey Nutt, Head of Patient Experience Marie Hardacre, Head of Corporate Nursing Abigail Trainer, Acting Chief Nurse		
Appendices:			

Report Summary	
Purpose of report:	The Board are asked to approve the ongoing work to improve patient quality against the True North Objectives
Summary of key issues/positive highlights:	The paper outlines May and June outcomes in relation to the key patient safety measures in falls, hospital acquired pressure ulcers, infection prevention and control and serious incidents, highlighting what learning has been undertaken and how this is shared across the Trust. The paper highlights patient experiences in May and June. Focused on the effectiveness of the complaints procedures, themes of complaints and how we evidence learning. The paper also gives an insight into the current position on safe staffing, highlighting the mitigations in place and the future developments to support safety.
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:	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, Quality and Effectiveness Committee	
Date:	May 2022	**Decision:**	Regular updates required to QEC
Next Steps:		Update progress to QEC	
Previously circulated reports to supplement this paper:		None	

BIR July 2022 (May and June 2022 data)

The national patient safety strategy defines 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 Just Culture approach has got to be our key priority to enable DBTH to fully embrace and implement the patient safety strategy.

Safer Culture, Safer Systems

Safety culture indicators can be measured by reviewing the safety questions on the NHS staff survey. DBTH results are in line with national results and demonstrate a reduction in the positivity percentage. To allow a temperature check of staff feedback, the new TENDABLE application has a weekly staff questionnaire relating to safety culture embedded in the question sets, allowing the divisional teams to specifically focus work on wards / departments with lower scores.

The patient safety specialists have liaised with the people and organisational development team and plan to create an overarching improvement plan linking with divisions to address our intention to improve the psychological safety of teams at DBTH to raise concerns.

Insight

Serious Incidents

There were five serious Incidents logged in May, and there were also five logged in June, see the details below:-

- A Patient attended for removal of a PEG, medication advice not followed by nursing home and anticoagulant not stopped prior to procedure as intended.
- Miscommunication issue, failure to follow process
- Failure to escalation to specialist centre
- Failure of a preventative surgical pathway following first admission and treatment for pancreatitis
- Shoulder dystocia (HSIB case)
- Delayed diagnosis of a slipped upper femoral epiphysis (SUFE) in a 14 year old patient
- Inpatient fall resulting in a subdural bleed
- Issue with patient follow-up and surveillance programme
- Intra-partum still-birth
- Delayed diagnosis of testicular torsion
- Sub-optimal care, pathway from the Emergency Department to Orthopaedics for a patient admitted with an infected knee and sepsis.

This is a total of 13 serious incidents reported, year to date for 2022-2023.

HSIB Investigations

Two HSIB investigations, year to date, which are:-

- Shoulder dystocia. Baby required prolonged resuscitation and therapeutic cooling
- Intra-partum still-birth at 40+5/40.

Patient Safety Incident Response Framework (PSIRF)

NHSE have not as yet sent any information to Trusts with guidance on the implementation and transition to PSIRF. The patient safety specialists have already commenced work with the quality improvement team to develop a plan and map current processes. Each of the five patient safety priorities below will have a work stream supported by the Qi team. Until guidance is available no further work can progress:-

- Skin integrity
- Falls
- Discharge
- Recognition of deteriorating patient
- Medication safety officer

DBTH is also involved in collaboration with the Nottinghamshire ICB who have organised a steering group to ensure learning across the system that aligns our patient safety improvement priorities.

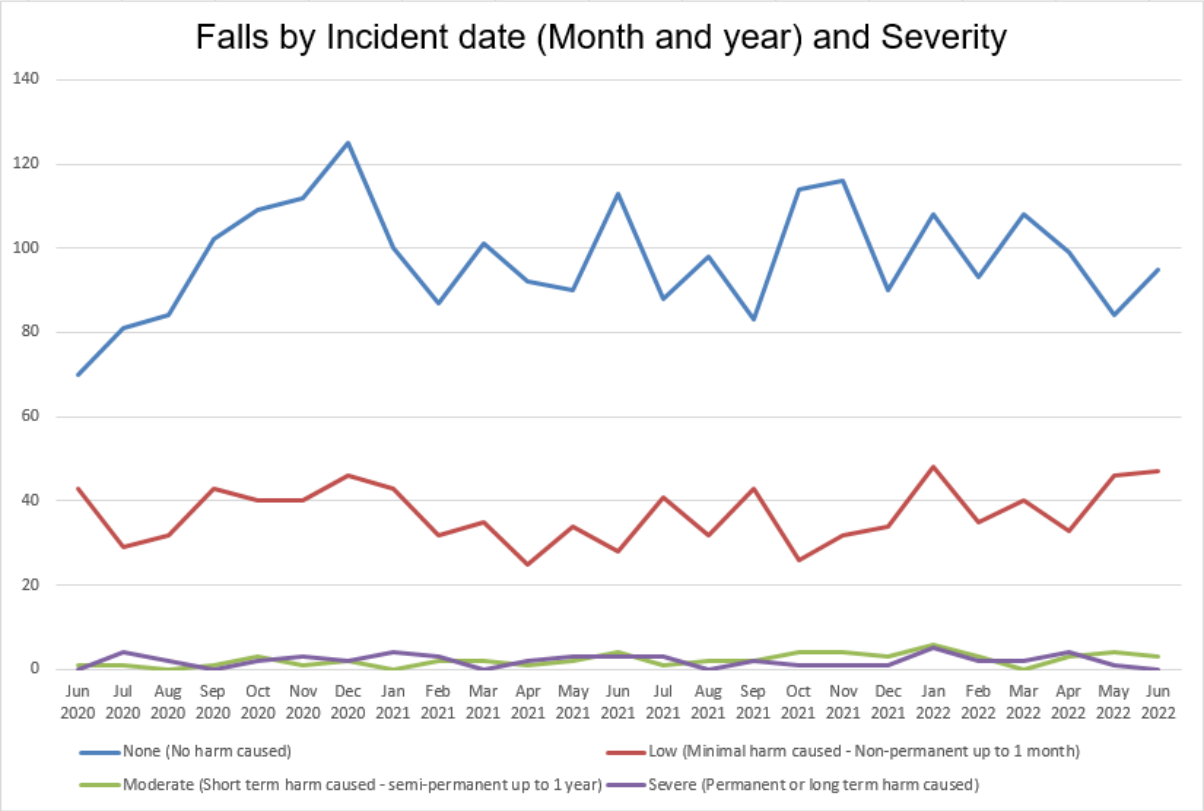
Patient Safety Specialists

The Trust patient safety specialists are Dr Juan Ballesteros (Associate Medical Director for Clinical Safety), Ms Marie Hardacre (Head of Nursing for patient safety and corporate services) and Ms Nicola Severein-Kirk (Lead Nurse for patient safety and quality). There is significant change surrounding how we investigate, learn and develop a safety just culture. The transition to PSIRF will need a system wide change and will need to incorporate the just culture approach.

Falls

There have been 117 falls in May and 130 falls in June a total of 247 falls in the past two months. 163 falls resulted in no harm, and 16 were non-inpatient falls. 76 falls have resulted in low harm.

There have been seven moderate harms, and one severe harm in the past two months. See graph below with 12 months data.



The falls safety improvement panel meet monthly and analyse all moderate and severe harm from falls and any themes identified for learning. The themes are communicated to the wider DBTH team and shared in a monthly newsletter, the themes this month include:-

- Clear MDT communication and collaborative working
- The transfer of a patients care from one department to another involves complex communication and handover. Risks of poor communication impacting on care delivery.

In July 2022 Mallard ward celebrated two years with no serious harm caused following an inpatient fall. This was achievable following a quality improvement project that was first introduced in February 2019. The project focused on using a tool as part of a safety huddle to update staff on the patient's required level of supervision. This required a change in culture during staff handover and highlighted those most at risk. The project also supported the promotion of low beds, and the prompt cohorting of high-risk patients. This supports the theory of patient safety and the value of learning from what goes well. The whole team approach demonstrated on Mallard ward is a huge achievement and clearly focuses on the themes identified above, surrounding handover and the transfer of care.

Hospital Acquired Pressure Ulcers (HAPU)

There were 52 HAPU's in May and 47 in June this is a total of 163 year to date. This has affected 77 patients. Of these patients, zero were classified as category four HAPU's; five were category three HAPU; eight were unstageable HAPU's; two Mucosal Pressure Ulcer and zero were uncategorisable Pressure Ulcers.

Learning from the skin integrity improvement panel continues monthly with the use of a Trust social media page, Trust Intranet page (Hive), bespoke ward training and Trust wide training via eLearning and Face to Face.

Infection Prevention and Control

Clostridium difficile (C. diff) there were three in May and three in June 2022. Four of these cases were hospital onset, hospital associated (HOHA) infections. This is a total of nine cases of Clostridioidies difficile for the financial year, against a trajectory of 48.

E-Coli bacteraemia In May, ten cases were reported, in June seven were reported. Ten were classed as HOHA and seven as community onset hospital associated (COHA). This is a total of 24 cases with a current trajectory of 87 for the year.

MRSA bacteraemia there were no MRSA bacteraemia reported in May or June 2022. This is against a trajectory of zero. The Trust has not had an MRSA bacteraemia since 26 February 2021 which is a fantastic achievement.

MRSA colonisation there were two reported colonisations reported in May, and two in June. This is a total of six cases and will be closely monitored by the divisional teams and IPC.

Involvement

The framework for involving patients in patient safety

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

The patient safety specialists have identified our first patient safety partner and initial meetings have taken place. The overall aim is to link in with patients who have been involved in patient safety incidents to seek support and recruit more patient safety partners.

Patient Safety Syllabus

The patient safety syllabus (level one) is on the ESR system and available for all staff to use. This is a national eLearning package to improve safety culture. The patient safety specialists are working with the education team to launch the safety syllabus to coincide with the world patient safety day in September 2022. The plan is for a week long program of activities to engage the teams with patient safety pledges and visit wards and departments across DBTH. The main focus of the world patient safety day is medicine safety. WHO have released information via our medicines safety officers that the aim is to light buildings up in orange across the world to signify the risks to patient safety with medication safety.

Improvement

Shared Learning

Following investigation, recommendations and learning from patient safety incidents, the monthly patient safety review group hear presentations on the agenda each month. These

presentations share learning across all divisions. This allows operational discussion surrounding learning surrounding an incident and to share and cascade through governance processes.

The patient safety specialists are working with the education team to relaunch a patient safety newsletter, to coincide with the world patient safety day in September 2022.

Digital Transformation

The **TENDABLE** accreditation application has gone live with the first two audits on 1 July. Wards and departments can now undertake electronic audits on the Trust hand-held devices. The first two audits launched are the ward / department weekly audits and the matron's assurance monthly audit. Staff engagement sessions are planned across all 3 sites at the end of July to ensure feedback and evaluation takes place.

The quality dashboards (currently named the hard truths data) are being redesigned alongside the clinical audit and effectiveness team to pull data from our electronic system i.e. nerve centre and relevant quality indicators to assess performance in relation to bed days per month data to make the dashboards more representative of activity and percentage of harm.

The digital transformation programme continues and has introduced risk assessment documentation electronically Trust wide and is trialling care planning on ward C2 at BDGH. Clinical photography is planned for roll out at the end of July. This move towards electronic patient records is welcome and builds on the success of the electronic observations. Learning is shared at the digital clinical governance meeting.

The children's divisions' transition to electronic observations has not been progressed due to difficulties in recruiting administrative support on the Children's assessment ward. This issue is being addressed by the divisional director of nursing.

DATIX upgrade is scheduled for July / August. A QPIA is being presented at TEG on 11 July for a decision on deletion of data from the test system. A project plan is being created and liaison with DATIX compact is ongoing, to ensure a smooth transition to the new server technology and to progress the planned DATIX system upgrade.

<u>Complaints</u>

May

In May the number of complaints received was 55, consisting of 49 40 working days, 4 60 Working days and 2 MP complaints. This was a slight increase compared to the 50 received in April.

When split by Division Medicine had 21 complaints, Surgery and Cancer 18, Children's and Families 13, Clinical Specialties 2 and Other (corporate areas) 1.

The number of concerns registered were 71 which was an increase compared to April (58).

The number of complaints closed in May was 22.

Of those complaints that were closed 5 were upheld, 11 partly upheld, and 6 not upheld, all closed complaints had an outcome recorded. Each Division now present a highlight report to PEIC every month which particularly focuses on what they are learning from complaints and what actions they have taken to address them.

In May we have had 1 contact from the PHSO - This was a request for information which was provided in the requested timeframe.

June
In June the number of complaints received was 61, consisting of 57 40 working days, 4 MP complaints. This was a slight increase compared to the 55 received in May.

When split by Division Medicine had 24 complaints, Surgery and Cancer 24, Children's and Families 7, Clinical Specialties 4 and Other (corporate areas) 2.

The number of concerns registered were 61 which was a slight decrease compared to May (71). The number of complaints closed in June was 16.

Of those complaints that were closed 3 were upheld, 6 partly upheld, and 7 not upheld, all closed complaints had an outcome recorded. Each Division now present a highlight report to PEIC every month which particularly focuses on what they are learning from complaints and what actions they have taken to address them.

In June we have had 0 contacts from the PHSO.

May saw a slight reduction in the inpatient Friends and Family Test response rates compared to April, DRI 7.5%, BDGH 6.4% and Montagu 18.4%.

A meeting with the Deaf Society took place in June. They are keen to work with the Trust on providing some free training and a 10 week course on BSL. They are also going to provide some video clips of raising awareness of deaf patients' needs/requirements.

Meeting set up in July with DMBC and DCCG to look at Carers Charter and Carers Passport.

PLACE Assessments will commence in September, we are currently looking at recruiting patient representatives and looking to Divisions to support this.

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 with the on-going Covid 19 pandemic has created additional

workforce challenges across the breath of the organisation, with particular pressure in areas across medicine, surgery and critical care areas.

May 2022
There were 39 inpatient wards were open throughout May 2022.

22 (56.4%) were on green for planned v actual staffing, 5 (12.8%) wards were on amber for being 5% under planned v actual staffing (ITU, 32, 24, 17, C1). The Heamatology ward was the only ward which was rated as amber for being 5% over planned v actual staffing during May.

8 (20.5%) wards were red for being 10% under planned v actual staffing (S10, S11, A5, 21, 20, REHAB 2, CDS, M1). There were 3 (7.69%) wards (B5, ST LEGER, REHAB 1) rated red for being over 10% of their planned v actual staffing during May.

Ward distribution of planned versus actual rate	**May**	
	No.	%
Within 5%	**22**	**56.4%**
5% under planned versus actual	**5**	**12.8%**
5% over planned versus actual	**1**	**7.5%**
10% under planned versus actual	**8**	**20.5%**
Surplus over 10%	**3**	**7.9%**
Total IP wards	**39**	
Number of wards closed	**0**	

June 2022
There were 39 inpatient wards were open throughout June 2022.

22 (56.4%) were on green for planned v actual staffing, 3 (7.69%) wards were on amber for being 5% under planned v actual staffing (A5, C1, Rehab 2). Ward 25 and Ward G5 (5.12%) were the only wards which were rated as amber for being 5% over planned v actual staffing during June.

9 (23%) wards were red for being 10% under planned v actual staffing (S10, 24, 21, 20, 32, DCC, CDS, M1, B6/ESSU). There were 3 (7.69%) wards (B5, ST LEGER, REHAB 1) rated red for being over 10% of their planned v actual staffing during June.

Ward distribution of planned versus actual rate	**June**	
	No.	%
Within 5%	**22**	**56.4%**
5% under planned versus actual	**3**	**7.69%**
5% over planned versus actual	**2**	**5.12%**
10% under planned versus actual	**9**	**23%**
Surplus over 10%	**3**	**7.69%**
Total IP wards	**39**	
Number of wards closed	**0**	

Update on Registered Nurse Band 5 Vacancy Position

The Band 5 Staff Nurse position is currently a significant area for concern and is driving the utilisation of temporary workforce solutions including agency. Below demonstrates the current registered nurse vacancy position, taking into account expected newly qualified nurses starters and international nurses (following OSCE pass and transition):

Medicine Division *(Excludes OPD areas)

RN Current Ward based RN Vacancy June 2022	NQ Sept/Oct 2022	IR arrive August and not in RN numbers before Oct 2022	NA / Aps due to qualify Oct 2022	Approx. vacancy following NQ IR and NA (Excluding ward 22)
86.21	36 wte	7 wte	6 wte	37.21 wte

Surgery Division *(excludes OPD & Endoscopy)

RN Current Ward based RN Vacancy June 2022	NQ Sept/Oct 2022	IR arrive August and not in RN numbers before Oct 2022	NA / Aps due to qualify Oct 2022	Approx. vacancy following NQ IR and NA (Excluding Modular Ward)
35.76	18 wte	2 wte	2 wte	13.76 wte

CSS (*excludes theatres & OPD)

RN Current Ward based RN Vacancy June 2022	NQ Sept/Oct 2022	IR arrive August and not in RN numbers before Oct 2022	NA / Aps due to qualify Oct 2022	Approx. vacancy following NQ IR and NA (Excluding ward Modular)
7.14	2 wte	2 wte	0	Approx. 3.14 wte

Trust wide ward-based vacancy June 2022 **129.11 wte - 4,841 hours per week.**
Trust wide ward-based vacancy end of October 2022 **54.11 wte - 2,029 hours per week.**

The vacancy position excludes the Orthopaedic Modular ward and Ward 22 which are part of winter planning / elective restoration proposals planned to open approximately October 2022 onwards.

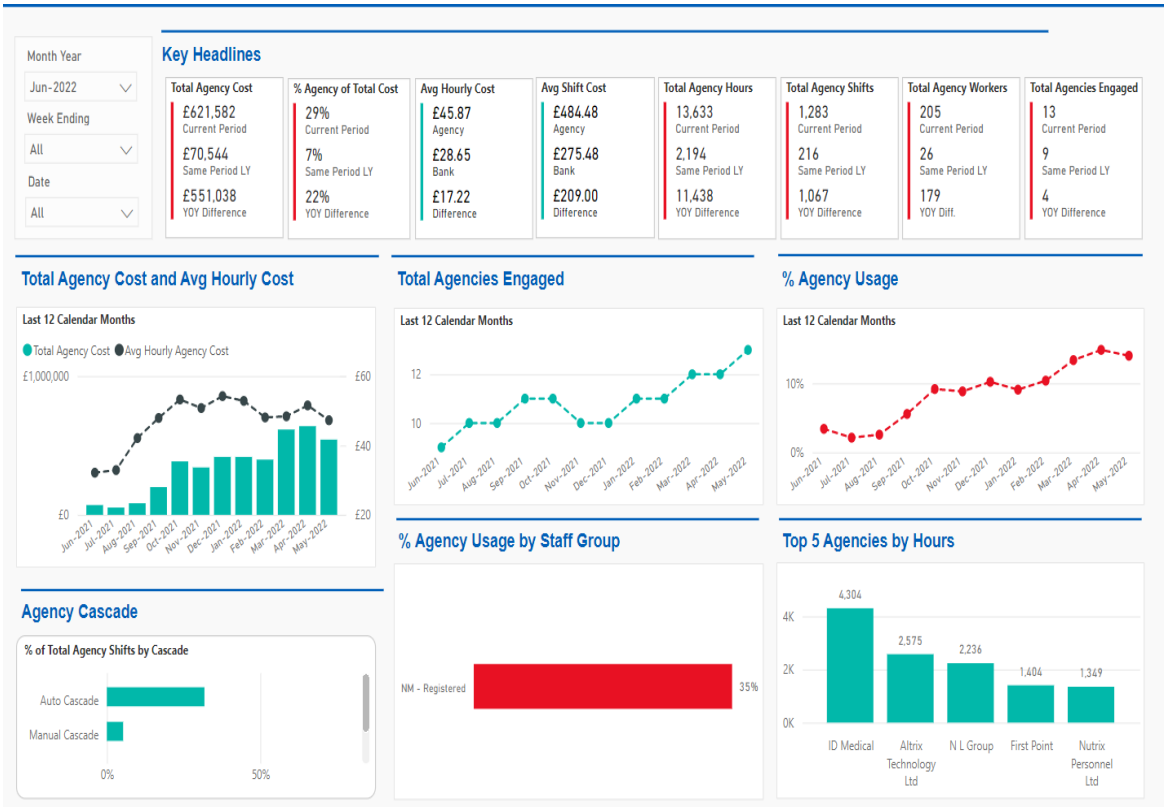
Midwifery
Further detail relating to Midwifery vacancies are provided via the Ockenden updates to board, however there are significant vacancy within Registered Midwife roles of approximately 36 posts and 15 Midwifery Support worker post vacancies.

Maternity leave, short term and long term sickness is also contributing for the reliance on temporary staffing solutions.

May 2022 Agency usage summary

Data for May demonstrates that a reduction in utilisation of the Tier 3 agency provider.

Agency position up to 26 June 2022



With changes to the agency cascade and increased pick up from the newly engaged agencies the utilisation of Tier 3 agencies is seen to be reducing further. There has been an increased utilisation of ID medical as they provide pre booked agency support for midwifery services and to support the opening of Ward 19 - this approach provides continuity of workers and reduces risk associated with adhoc infrequent workers.

Current Governance Process for temporary workforce solutions

Monthly review of agency cascade through monthly N&M meeting between Trust and NHSP.

Attendance at this meeting includes trust representatives from Corporate Nurse team, Senior Nurse Divisional reps, Procurement, Trust ERoster Lead and now includes a finance representative.

Quarterly strategic meeting with NHSP includes Trust representatives from Corporate Nursing, Procurement, Trust E Roster lead and facilities however representatives are required from finance and other staff group leads including administration.

Monthly ICS meetings to discuss Temporary workforce issues with NHSP take place - this includes a pre meet between providers and then a meeting with NHSP present in the meeting. However, a review of membership of representatives from DBTH is required to ensure all interested parties are engaged. This is being worked through currently.

International Recruitment

International workforce recruitment is key to reducing vacancy gaps across a variety of roles within the NHS and has been a key workforce solution for a long period of time. At DBTH part funded through NHSEi funding bids, 55 adult nurses were recruited 2021 to 2022 and following a further successful bid another 50 adult nurses and 5 paediatric will have been recruited and arrive at the Trust by 31 December 2022.

A further funding stream has also been offered by NHSE/I and the executive team supported a bid for an additional 20 adult nurses which was submitted on 7 July 2022 to NHSE/I. The NHSE/I funding offer provides up to £4,000 per candidate (covers only part of the recruitment associated costs) and up to £40K to support with infrastructure costs. Nurses must have arrived by 31 December 2022. This would mean that DBTH would have recruited 70 international nurses (65 adult 5 paediatric) throughout 2022 and would be contributing to reducing the Registered Nurse vacancy gap by end of March 2023.

The education team have reviewed the current process for supporting international nurses and it is hoped this will maintain OSCE pass rates but also shorten the transition into practice for international nurses on obtaining their NMC pin number. This was undertaken following a review of DBTH processes in conjunction with the NHSE/I regional workforce lead for North East, Yorkshire and Humber. The new process front loads the focused OSCE support and on completion of the OSCE exam they then transition into practice.

Midwifery international recruitment is progressing but at a slower pace. The Director of Midwifery and Midwifery workforce lead will provide an update on this to the executive team in terms of initial bid, pipeline, challenges to recruitment and financial implications.

Additional international recruitment support from NHSE/I includes focus on three Allied Healthcare Professional roles - Diagnostic Radiographer, Occupational Therapist and Podiatrist. DBTH are preparing a bid for funding for 5 Diagnostic Radiographers with successful recruits commencing in a supported induction / supervision / transition programme by 31 March 2023.

Future developments

Safe Care

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

The Trust has undertaken the first nursing workforce data collection set for 2022 using the Safer Nursing Care Tool across the adult and paediatric inpatient wards, including assessment areas. This data collection took place during May 2022 and will be shared with the Chief Nurse and Divisional Directors of Nursing to inform ongoing discussions relating to optimal nurse staffing levels and workforce planning. This is a 4-week data collection process which concluded at the end of May 2022 and will then go through the analysis process before being shared with the Chief Nurse. A full report will come to September's Board.

The interim deputy chief nurse (safe staffing) has completed a two day introductory session with NHSE/I and the Shelford group and arrangements are underway for a group of up to 20 ward managers / matrons (plus 4 or 5 Paediatric nurses) to also complete training to undertake effective SNCT data collection. This will provide greater reassurance that the data collected is robust and provide a wider opportunity for peer review of the data. Those trained will then provide a cascade of training to other colleagues.

As part of the future developments for 2022/23 the senior nursing leadership team are progressing the utilisation of the Allocate Safe Care model to support effective utilisation of nurse staffing resource. Safe Care is x3 times a day staffing software that supports review or staffing levels against 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. This is utilised alongside real time data that can be streamed from varying digital solutions used at DBTH including Well Sky Pharmacy solution and Nerve centre (E observations, risk assessments) which also provide red flag data utilised in support safe staffing allocation.

Rota review in terms of hands per shift templates and correlating budgets are key to success and all adult areas rotas are now signed off (with the exception of DCC & G5 - underway). Paediatric services are currently being reviewed by the new DDoN and the Finance BP with a plan for all to be signed off by end of July 2022 at the latest.

Safe Care will be piloted at Bassetlaw Hospital and due to the support required from allocate, administration vacancy in E Roster team and summer break this is planned for September 2022.

Healthcare Assistant recruitment
Health care assistant recruitment remains a focus for the nursing teams and the Trust are continue to engage with NHSE/I in relation to the national zero HCSW programme. The Trust has moved to a monthly centralised recruitment process and a large local community open event for HCA roles is being planned to take place during August / September now that face to face processes are being reintroduced.

A paper has been submitted to Chief Nurse and Director of P&OD with a proposal for a change in recruitment processes for HCAs in the aim to move in line with other acute providers across the SYB footprint, whilst still offering apprentice opportunities and career development processes from the outset. Salary remains a key issue for HCA recruitment.

Although the Trust cannot influence change on salary, as this is set nationally via agenda for change, it can place focus on flexible working, job satisfaction, employee benefits and career progression as methods to recruit and retain staff. Development of recruitment resources to support healthcare recruitment continues including production of a HCA recruitment video which promotes the role and career opportunities at DBTH for staff working within health care assistant roles. Utilisation of other promotional materials including a radio campaign and banners for use across the community setting promoting the Trust and the role.

Further work with Doncaster College, RNN and local post 16 providers has resulted in a number of planned recruitment events taking across July to provide a feeder stream of HCA's who have recently completed Level 2 / 3 health & social care award. This will provide an additional recruitment stream into the Trust in preparation for winter 2022.

The vocational team are also exploring expanding the support provided to HCA in training within the clinical setting with a new Assistant practitioner post, which as well as being beneficial to learners is also an example of career progression for HCA into training and development roles.

Professional Nurse Advocate
Update from previous paper - a further 9 DBTH staff have successfully completed their PNA programme and are awaiting certification of the award. A short presentation event to 9 PNA's will be undertaken with support from the executive team recognising the hard work to complete the award and the value PNA roles bring to the organisation.

The PNA lead is currently drafting a business case with the Senior Nursing team to gain support to fund a permanent PNA lead post and provide PNA's with protected time to undertake the role. Presentation at a national PNA conference has also raised the profile of the way in which DBTH is investing and supporting the PNA initiative.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	C3		
Report Title:	**Maternity Update**				
Sponsor:	Abigail Trainer, Acting Chief Nurse / Board level Safety Champion				
Author:	Lois Mellor, Director of Midwifery				
Appendices:	Perinatal Surveillance Dashboard (June 2022)				

Report Summary					
Purpose of report:	To update the Board on the progress in the Maternity Service				
Summary of key issues/positive highlights:	• Update on current PMRT reviews for the month and quarter 4 findings • Current HSIB cases in progress and reports received. • Education and training compliance below the 90% target due to the pausing of training during the recent wave of covid 19 • Trajectories / plans in place to recover the training position • Ongoing work with the maternity voices partnership (MVP) and improved collaborative working • Year 4 CNST standards recommenced 7 May 2022				
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:	
Corporate risk register:	
Regulation:	
Legal:	
Resources:	

Assurance Route			
Previously considered by:	All parts of this report have been discussed at all levels in the C & F Division.		
Date:		**Decision:**	
Next Steps:	Support to continue with improvements in maternity service, and achieve full compliance with CNST Year 4 standards and the Ockenden immediate actions		
Previously circulated reports to supplement this paper:			

Monthly Board Report

June 2022

Please read this report in conjunction with the Board Surveillance PowerPoint Presentation

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

1.1 Stillbirths and late fetal loss > 22 weeks

Quarter 1 findings

There were 7 stillbirths and fetal losses.

- 39 weeks AN loss, 3rd baby – Extensive mental health issues and known smoker. Admitted with decreased fetal movements and intrauterine fetal death was confirmed. Care graded as A (in line with guidance)
- 23 weeks 3rd baby, admitted with decreased fetal movements intrauterine death identified. Care graded B (some learning)
- 32 week 2nd baby, admitted with decreased fetal movements intrauterine death identified. Massive obstetric haemorrhage, admitted to intensive care - case under review
- 36 weeks 4th baby, heavy smoker. Unable to locate fetal heart rate, scanned and intrauterine death identified. Known Covid 19 infection in pregnancy
- 24 weeks 6th baby, heavy smoker intrauterine death identified on scan – awaiting review
- 40 weeks 2nd baby intrapartum stillbirth, decreased growth on scan. – Will be investigated by HSIB.
- 34 weeks 1st baby, known covid 19 infection, admitted decreased fetal movements – awaiting review

Neonatal Deaths

There were 3 in quarter 1

- 26 weeks gestation , twin pregnancy with prolonged rupture of membranes. Known covid 19 infection had an emergency caesarean section. (1 twin died – RIP)
- 21 weeks gestation, medical termination of pregnancy, known cardia abnormality – referred to the coroner
- 18 weeks gestation, missing bladder medical termination of pregnancy – referred to coroners

1.2 Actions/ Learning from PMRT

Actions and learning from PMRT is ongoing in accordance with current practice.

Creation of suitable environment for families that have lost a baby. This is an ongoing action, funding has been established and work will commence soon on creating a bereavement suite on level 3.

2. Findings of review of all cases eligible for referral HSIB

Cases to date	
Total referrals	22 ↑ 1
Referrals / cases rejected	4
Total investigations to date	18
Total investigations completed	14
Current active cases	4 ↑ 1
Exception reporting	0

2.1 Reports Received since last report

None

2.2 Current investigations

HSIB case number: MI-006029
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 13.01.22
Referral date: 18.01.22

Draft report to the Trust for factual accuracy – completed
Draft report sent to the family – response awaited

HSIB case number: MI-006325
HSIB criteria: HIE/ Cooling
Trust site: Doncaster
Incident date: 25.01.22
Referral date: 28.01.22

Second neonatal review taken place
Second anaesthetic review taken place
An additional staff interview has been requested

HSIB case number: MI-009360
HSIB criteria: HIE/ Cooling

Trust site: Doncaster
Incident date: 11.05.22
Referral date: 18.05.22

Scoping of records taking place
Meeting with family being arranged

HSIB case number: MI-010419 (new)
HSIB criteria: Stillbirth
Trust site: Doncaster
Incident date: 10.06.22
Referral date: 21.06.22

Contact made with the Trust and family

3. Serious Incident Investigations (Internal)

None

4. Training Compliance

The service has set trajectories to meet 90 % compliance with training by December 2022. Progression is being made in all areas of training and the current figures are;

CTG Study Day

A trajectory to achieve 90% by December 2022 has been set and staff have been allocated the study day on their rosters, and allocated dates to attend training.

90% of all staff must have attend the fetal monitoring study day by the 5th January 2023. Including the numbers that have attended and booked to attend, the trajectory up to the end of September 2022 will be :

Consultants	100%
Doctors	34%
Midwives	56.5%

In mitigation the K2 CTG compliance (on line) training compliance is good.

The current training position is:

MDT Role	Number	Number Compliant	K2 CTG Compliance	Number of Staff Undertaken Fetal Monitoring Study Day	Study Day Compliance
Consultants	13	13	**100.0%**	10	**76.9%**
Doctors	23	21	**91.3%**	8	**34.8%**
Midwives	193	173	**89.6%**	58	**30.1%**
NHSP Midwives	17	15	**88.2%**	0	**0.0%**
Divisional	**246**	**222**	**90.2%**	**76**	**30.9%**

PROMPT Training (Obstetric Emergencies)

A trajectory has been set to achieve 90% compliance by December, and there has been an overall improvement from 43.3% (Divisional) to 46.7% this month.

MDT Role	Number	Number Compliant	Prompt Compliance
Consultants	13	5	**38.5%**
Doctors	20	12	**60.0%**
Midwives	194	123	**63.4%**
NHSP Midwives	18	4	**22.2%**
Support Workers	76	17	**22.4%**
Theatre Staff	82	34	**41.5%**
Anaesthetists	32	8	**25.0%**
Divisional	**435**	**203**	**46.7%**

5. Service User Feedback

The new maternity voices partnership (MVP) chair is meeting with the Director of Midwifery and deputy head of Midwifery to collaborate on changes in maternity service. The MVP chair has been proactively seeking feedback about the service, and will share this at the meeting.

The feedback on the maternity Facebook page remains positive, and the International day of the Midwife created a lot of positive comments from recent users of the service.

Complaints are overseen by the deputy Head of Midwifery, and themes remain patient information and staff attitude.

6. HSIB/ NHSR / CQC or other investigation with a concern or request for action made directly to the Trust

None

7. Coroner PFDR (Reg 28) made directly to Trust

None

8. Progress in achievement of CNST

Year 4 CNST standards ongoing.
Recruitment for admin support and project management has commenced.

At risk standards are:
Safety Action 5 – Midwifery Workforce
Safety Action 8 – Training
Safety Action 9 – Safety & Quality due to change of Board level safety champion and interim NED
A meeting has been arrange with Abigail Trainer as the new Board level Safety Champion to review the plans going forward.

9. Progress in implementing Continuity of Carer (MCoC)

Currently MCoC is paused due to the number of midwifery vacancies.

A plan has been set to achieve the target set of the majority of women being in receipt of MCoC by March 2024. This will be commenced as soon the staffing position allows, and the national team will support engagement with staff commencing in September 2022 to support reintroduction of MCoC.

10. Board Level Safety Champion staff feedback from walkabout

A plan will be agreed with Abigail Trainer as the new Board Level Safety champion for regular walkabouts in the unit.

There has been a recent staff meeting with the DoM about the staffing strategy for the next three years. This was received well staffing remains the greatest concern.

Most recent feedback:

- Concerns about ongoing midwifery vacancies

Plans and mitigation is in place as described in the May report

There are ongoing freedom to Speak up (FTSU) session undertaken by FTSU guardian.

NE&Y Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: South Yorkshire and Bassetlaw

Reporting period: April 2022-June 2022

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

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
April		23%	
May	1:31.4	23%	
June	1:31.4	23%	

Maternity unit DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			April	May	June
Caesarean Section rate	Elective	<13.2 %	11%	14.1%	13.7%
	Emergency	<15.2 %	22.4%	24.7%	28.2%
Preterm birth rate	≤26+6 weeks	0	2 (twins)	2	1
	≤36+6 weeks	<6%	6.66%	11.02%	9.8%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.1%	2.4%	1.2%
Term admissions to NICU		<6%	2.56%	2.21%	4.8%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	0.7%	0	0.8%
	Instrumental (assisted)	<6.05 %	14.3%	0	.9%
Right place of birth		95%	99%	99%	99%
Smoking at time of delivery		<11%	13.4%	10.6%	14.7%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of		0 %	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths Early	Neonatal Deaths Late	Notification to ENS	Maternal Mortality (direct / indirect)	
2021/2022	April	45	22	0	0	0	0	2	1	0	0	1	0	0	0	0
	May	39	20	0	1	0	1	1	0	0	2	0	0	1	0	0
	June	38	46	0	0	0	0	1	0	0	0	0	0	0	0	0
	Q1	122	88	0	1	0	1	4	1	0	2	1	0	1	0	0

Maternity Red Flags (NICE 2015)

		April	May	June
1	Delay in commencing/continuing IOL process	43	38	38
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	1	0	0
4	Missed/delayed care for > 60 minutes	1	1	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 2022- June 2022

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

	MW to birth ratio : BR+ recommendation 1::28.25	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
Apr			
May			
June			

Maternity unit DBTH – Bassetlaw

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			April	May	June
Caesarean Section rate	Elective	<13.2 %	9.8%	9.7%	8.3%
	Emergency	<16.9 %	37.5%	31.5%	25.6%
Preterm birth rate	≤26+6 weeks	0	0	1	1
	≤36+6 weeks	<6%	5.35%	6.5%	6.6%
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.5%	4%	4.1%
Term admissions to NICU		<6%	11.42%	4.3%	4.5%
3rd & 4th degree tear	SVD (unassist'd)	<2.8%	3.8%	5.1%	4.4%
	Instrumental (assisted)	<6.06 %	0%	15.4%	9.1%
Right place of birth		95%	100%	99%	99%
Smoking at time of delivery		<11%	10.7%	5.6%	12.5%
Percentage of women placed on CoC pathway		35%	0%	0%	0%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0%
	Area of deprivation		0%	0%	0%

Month/Quarter		Red flag alert	Open > 30 days	Unactioned Datix	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	9	18	0	0	0	0	0	0	0	0	0	0	0	0	0
	May	4	27	0	0	0	0	1	0	0	0	0	0	0	0	0
	June	5	32	0	1	0	1	1	1	1	0	0	0	0	0	0
	Q1	18	77	0	1	0	1	2	1	1	0	0	0	0	0	0

Maternity Red Flags (NICE 2015)

		April	May	June
1	Delay in commencing/continuing IOL process	8	4	5
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	0
4	Missed/delayed care for > 60 minutes	1	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

Assessed compliance with10 Steps-to-Safety

		Apr	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			
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

		Apr	May	June
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)

	Apr		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						
Non Exec and Exec Director identified for Perinatal Safety						
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	>85% <90% CTG	PROMPT	>85% <90% CTG	PROMPT	90.2% CTG	PROMPT
Plan in place to meet birth rate plus standard (please include target date for compliance)						
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	January	February	March
Freedom to speak up / Whistle blowing themes	None	None	None
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	Weight unexpectedly below the 10th centile PPH 3rd 4th degree tear Shoulder dystocia	Weight unexpectedly below the 10th centile PPH 3rd 4th degree tear Shoulder dystocia Low cord gasses Unexpected admission to NNU	Weight unexpectedly below the 10th centile PPH Shoulder dystocia Low cord gasses Unexpected admission to NNU
Themes from Maternity Serious Incidents (Sis)	No SI declared for April One off pathway delivery and NND which will be presented at panel, LMNS peer review and the incident review meeting shortly	SI/HSIB/HIE declared 2 off pathway deliveries (NND at tertiary unit)	SI/HSIB/HIE declared bassetlaw intrapartum stillbirth 2 off pathway deliveries (NND at tertiary unit) one at bassetlaw and one at Doncaster
Themes arising from Perinatal Mortality Review Tool	April meeting graded 3 cases B and A AAA AA No themes highlighted	May meeting and adhoc meeting graded 4 cases A and A AAA AA BB	June meeting Graded one PMRT review BA No themes highlighted
Themes / main areas from complaints			
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP chair now in the role and they are actively being involved in the MVP meetings and activities being undertaken	MVP now involved with guidelines Will provided feedback	MVP ongoing
Evidence of co-production			
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	Feedback encouraged from recent inquests via an MST drop in session being arranged for May Ongoing OCR meeting Ongoing skills and drills scenarios	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT going back to face to face in July
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	WHATS HOT Ward briefs and emails Face to face discussions with staff LASER poster	WHATS HOT Ward briefs and emails Face to face discussions with staff LASER poster LMNS meetings	WHATS HOT Ward briefs and emails Face to face discussions with staff LASER poster LMNS meetings

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% EM 17%	<30% <13.2% <17%	NA	> 33% > 15% > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	<3.5%	>=3.5%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	<11%		>11%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2
	Red Flags						

Glossary of terms / Definition for use with Maternity papers

AN – Antenatal

ATAIN – term admission to neonatal unit (Term – 37-42 weeks gestation)

Cephalic – Head down

CNST – Clinical Negligence Scheme for Trusts

CTG – Cardiotocograph (fetal monitor)

Cooling – a baby is actively cooled lowering the body temperature

DoM – Director of Midwifery

EFW – Estimated fetal weight

FTSU – Freedom to speak up

G – Gravida (number of total pregnancies (including miscarriages)

HSIB – Health Service Investigation Branch

HIE – Hypoxic ischaemic encephalopathy (when the brain does not receive enough oxygen)

IUD – Intrauterine death

LMNS – Local Maternity and neonatal System

MVP – Maternity Voices Partnership

MSDS – Maternity Service dataset

NED- Non Executive Director

NICU - Neonatal Intensive care unit

NND – Neonatal death

NMPA –National maternity and perinatal Audit

OCR – Obstetric case review

Parity – Number of babies born > 24 weeks gestation (live born)

PFDR – prevention of future deaths

PMRT – Perinatal Mortality Review tool

PPH – Postpartum haemorrhage (after birth)

PROMPT – Practical Obstetric Multi- professional training

RIP – Rest in Peace

SVD – Spontaneous vaginal delivery

SBLCDV2 – Saving Babies lives care bundle version 2

MCoC – Midwifery Continuity of carer (6-8 midwives working in a team to deliver holistic are to a family)

MST – Microsoft teams

Other information

Term pregnancy is 37 – 42 weeks long

Viability is 24 weeks (in law) – gestation a pregnancy is considered viable

Resuscitation of a preterm baby can be offered from 22 weeks gestation (parent will need to be counselled)

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	C5		
Report Title:	**Executive Medical Director Update** • Hospital Mortality Report • Job Planning Update				
Sponsor:	Dr Timothy Noble, Executive Medical Director & Responsible Officer				
Author:	Julie Butler, Senior Manager to the Executive Medical Director				
Appendices:	n/a				

Report Summary					
Purpose of report:	To provide the Board of Directors with an update on key areas of work within the Executive Medical Directors Directorate.				
Summary of key issues/positive highlights:	• Monthly HSMR shows a continuing downward trend, contributing to a stable picture for the rolling 12 month period to the end of March 2022. • Good progress being made against the job planning action plan with 78% of job plans now on the Allocate system and a number of internal audit recommendations complete.				
Recommendation:	The Board is asked to note the update.				
Action Required:	~~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:	• Clinical Governance Committee – Mortality Summary Report • Audit and Risk Committee – Job Planning Update		
Date: 15/07/2022		**Decision:**	For Information and Assurance
Next Steps:	Presentation to Trust Board of Directors		
Previously circulated reports to supplement this paper:			

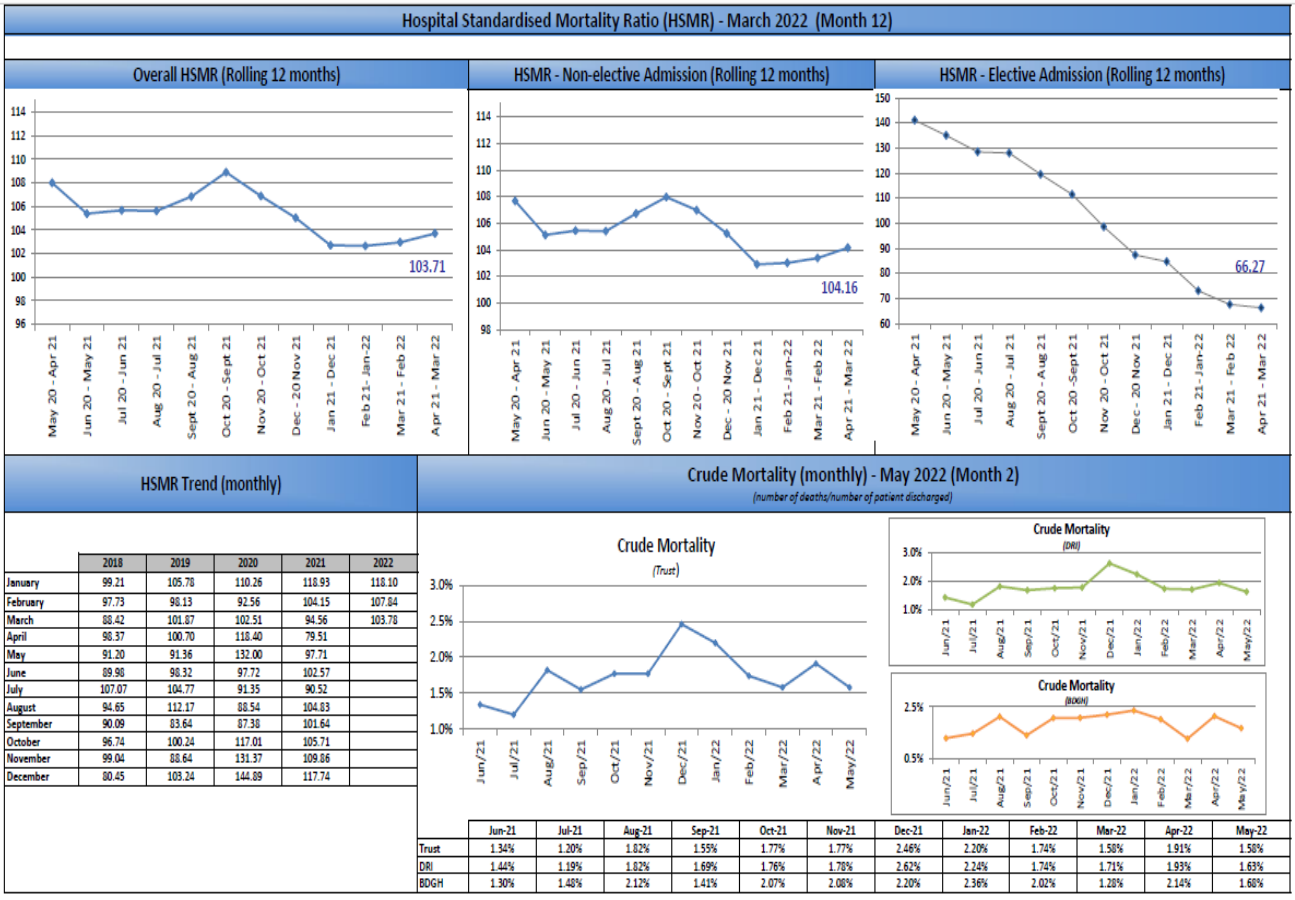
1. MORTALITY SUMMARY REPORT JULY 2022 (April data)

This report provides the monthly Hospital Standardised Mortality Ratio (HSMR) for the Trust to the end of March 2022. Unfortunately, there has been a delay in receiving the Hospital Episode Statistics (HES) data from NHS Digital, the provisional date for the next data release, which is Month 13 data (March 2022), is now 21st July, 2022.[1]

Mortality trends continue to show a good picture. Crude Mortality is the most imprecise of the mortality indicators but we continue to report a clear decrease (site specific value not available on the production of this report). The HSMR measures whether the number of people who die in hospital is higher or lower than would be expected in comparison with the national benchmark set at 100 and with upper and lower control limits for each of our hospitals.

Whilst the national tools are useful for picking up trends, there is a well-established process in place with the Medical Examiner (ME) Team who are now scrutinising almost 100% of adult deaths in the hospital. The ME process involves assessing adult deaths in detail with direct discussions with the family and the clinical teams involved in the care delivery to identify whether there are any care issues. They oversee referrals to the Coroner and pass cases on for further scrutiny with the Mortality review group using structured judgement reviews. In the Trust all other age groups are assessed via stillbirth review group, the perinatal mortality processes and the Child Death Overview Panel.

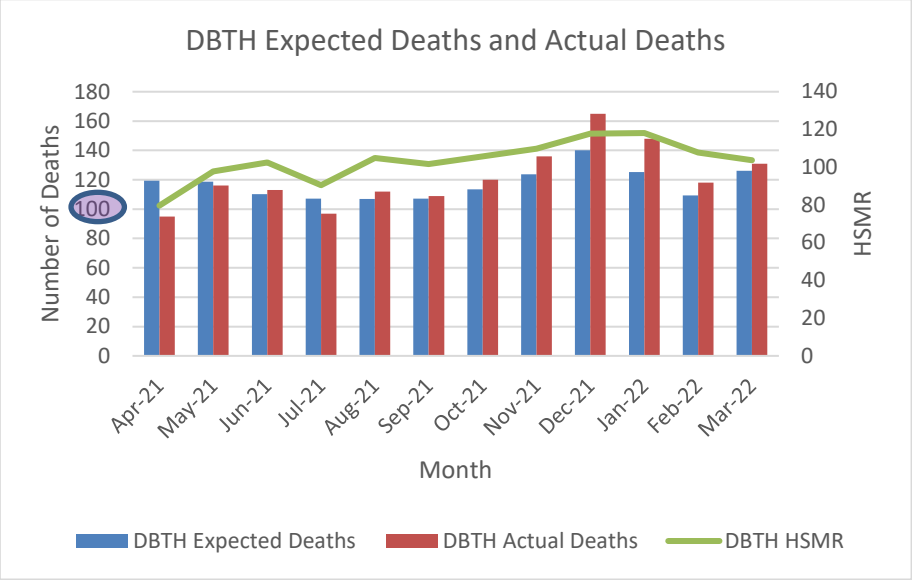
From the following charts, monthly HSMR shows a continuing downward trend with the March figure at 103.78 from 107.84 the previous month, contributing to a stable picture for the overall 12 month rolling which is now just over 104.



	2018	2019	2020	2021	2022
January	99.21	105.78	110.26	118.93	118.10
February	97.73	98.13	92.56	104.15	107.84
March	88.42	101.87	102.51	94.56	103.78
April	98.37	100.70	118.40	79.51	
May	91.20	91.36	132.00	97.71	
June	89.98	98.32	97.72	102.57	
July	107.07	104.77	91.35	90.52	
August	94.65	112.17	88.54	104.83	
September	90.09	83.64	87.38	101.64	
October	96.74	100.24	117.01	105.71	
November	99.04	88.64	131.37	109.86	
December	80.45	103.24	144.89	117.74	

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Trust	1.34%	1.20%	1.82%	1.55%	1.77%	1.77%	2.46%	2.20%	1.74%	1.58%	1.91%	1.58%
DRI	1.44%	1.19%	1.82%	1.69%	1.76%	1.78%	2.62%	2.24%	1.74%	1.71%	1.93%	1.63%
BDGH	1.30%	1.48%	2.12%	1.41%	2.07%	2.08%	2.20%	2.36%	2.02%	1.28%	2.14%	1.68%

[1] "At the end of each financial year we produce the official publication for that year. This is based on the March Post-Reconciliation submissions, also called Month 13". https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/how-we-collect-and-process-hospital-episode-statistics-hes-data



A recent internal audit analysis of DBTH activity has been carried out by 360 Assurance, following which two recommendations were made:

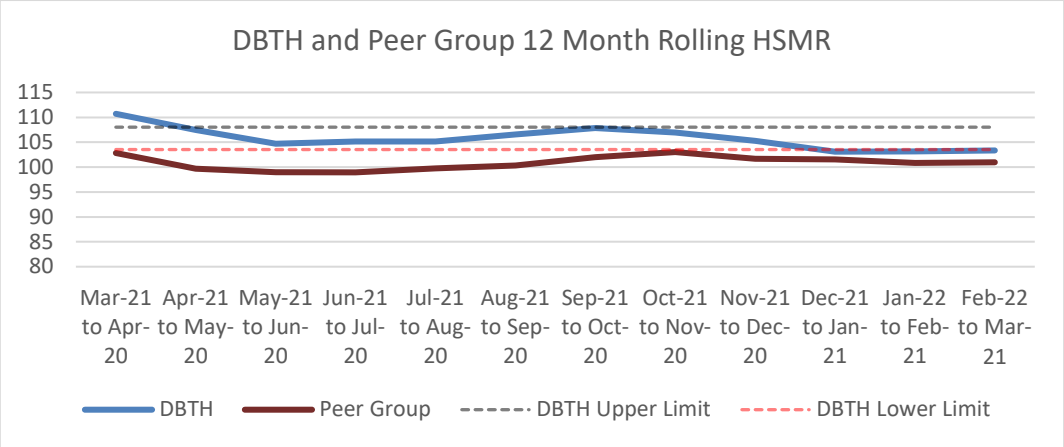
1. The Mortality Group will oversee the audits carried out by the Coding Department and analyse any concerns and recommendations made by them.

2. The upper and lower control limits will appear, for clarity and contextualisation of our figures, in our HSMR graphs.

Both actions were agreed by the Mortality Group and have already been implemented. A third recommendation has now been made, "Evaluation of factors affecting expected death rate calculation" which is also being implemented.

We compare our HSMR with a peer group composed by Trusts of similar sizes and characteristics:

- Doncaster and Bassetlaw Teaching Hospitals NHS FT
- Bradford Teaching Hospitals NHS FT
- York and Scarborough Teaching Hospitals NHS FT
- University Hospitals of Derby and Burton NHS
- United Lincolnshire Hospitals NHS Trust
- Calderdale and Huddersfield NHS FT
- Mid Yorkshire Hospitals NHS Trust



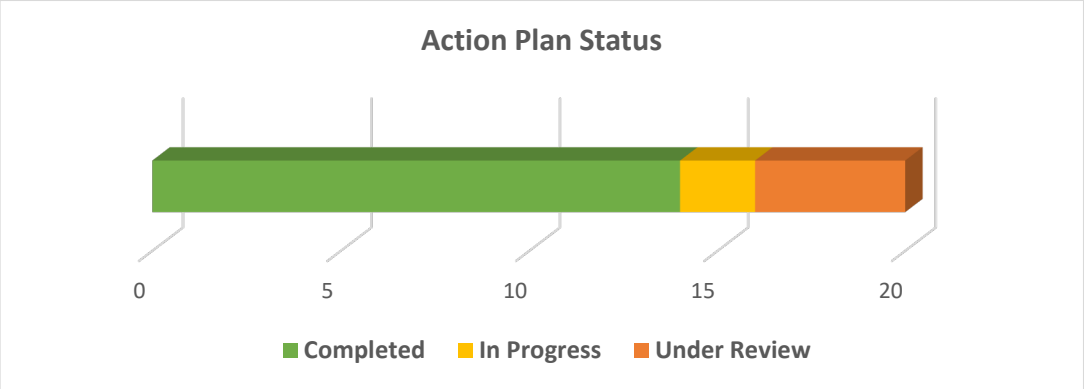
The Trust Mortality Group will closely monitor the position for any variations that may occur and investigate as necessary any worrying changes. The HSMR will be considered to be high and likely needing investigation if:

1. A full quarter local value lies above the upper control limit
2. If there are 6 or more consecutive points over 100 including the latest quarter
3. If there are 6 or more consecutive points each greater than the last (uninterrupted upward trend)

2. JOB PLANNING UPDATE

Originally undertaken by KPMG, the recommendations and action plan from the internal audit of the job planning process are now being monitored by 360 Assurance internal auditors.

Great progress has been made to-date, and of the 20 individual actions and sub-actions coming from the recommendations 14 have been implemented, providing 360 Assurance with the evidence and assurance needed to be able to sign off as complete. The graphic below gives a visual representation of the current action plan status:



The following actions remain open but with good progress being made with refreshed plans which have been discussed with 360 Assurance and revised timescales for review or completion agreed:

<u>Centralised Filing of Job Plans</u>
The Allocate system is the Trust's central repository for job plans. As at 27 June 2022, 78% of all job plans have been uploaded to Allocate. These are in various stages of review, discussion, agreement and sign off.

<u>Review and Approval of Job Plans and Administration Support</u>
These two actions are related to having dedicated administrative resource in place.

Following a successful recruitment process, a full time secretary commenced in post 29 June 2022. This post is funded for a period of 6 months as proof of concept.

The post holder will ensure the job planning timetable can take shape and the annual review and approval process established, working closely with senior medical staff, the medical HR team and Allocate systems team. In addition, they will provide support for clinical workshops, training sessions and produce a series of reports for clinicians from the Allocate system to assist the job planning process.

Due to the temporary nature of the post the actions will remain open and reviewed towards the end of the fixed term period to establish whether a business case for continued support can be renewed and the post made permanent.

Consistency in Job Planning Across Specialties

A Job Planning Consistency Committee has been established with the first meeting held 29 June, 2022. The Terms of Reference includes monitoring job planning performance, scrutiny of a number of anonymised job plans per Committee and the continued review of national guidance to ensure Trust compliance. The Committee is accountable to the Trust's Executive Group.

In terms of the sub-action relating to specific job planning training for clinical directors, a training package has been designed as part of the Leading to Outstanding programme. In addition, focussed job planning sessions have been scheduled which consist of two workshops led by the Medical Director for Workforce, the first session took place on 5th July and the second is planned for 20th September with external facilitation.

The deadline for completion of the action has been agreed and extended to the end of September 2022, following delivery of the second workshop.

Job Plan Activity

This action will remain open until all job plans have been reviewed and approved in the Allocate system.

In order to accelerate engagement with senior medical colleagues and progress towards 100% of job plans being signed off, the Medical Director for Workforce working with the Head of Recruitment and Medical HR, and Project Management support, have developed a series of "Sprint" activities across a number of specialties.

Consideration of Local Speciality Demand and Capacity in the Job Planning Process

There have been a number of meetings held with 360 Assurance with divisional teams and the MD Directorate to understand how the job planning process feeds into demand and capacity planning to ensure resource is utilised as efficiently as possible.

Following a meeting between 360 Assurance and Executive Medical Director on 29 June 2022, the position statement below was provided with a plan to evidence the links between capacity and demand planning and the job planning process as part of the 2023/24 planning cycle.

> *"Job planning involves some standard measures regarding the time allocated for activities and case rates per session. There are expectations within an individual job plan of the number of clinical sessions. This describes capacity. Once the contract is agreed, the balance of how that demand is managed with the allocated clinical time is determined. Where there is a mismatch or periodic peaks of demand then options to manage those peaks include, wider team involvement, efficiency of current processes and ensuring all job plans are appropriately occupied. From there any remaining demand needs to be considered for outsourcing or insourcing measures.*

As this is a dynamic and responsive adaptation according to fluctuating circumstances, it is not always reflected in job plans until they are due for review. Therefore the Medical Director for Workforce will have further internal discussions with divisional directors and clinical directors to agree that for the 2023/24 business planning cycle evidence of the links between capacity and demand planning and the job planning process are documented as evidence to demonstrate efficient and effective use of resource."

This will be subject to an internal audit revisit review during 2023/24.

3. Executive Medical Directors Directorate (EMDD) GENERAL UPDATE

Since the Executive Medical Directors team was established, the EMDD work-plan has developed over the months in response to the extensive portfolio of work. A brief summary of some of the areas currently being supported are:

Performance, Outcomes and Support (POS) Meetings

The MDD are involved in the newly established POS meetings and use these meetings with the divisional teams to gain a shared understanding of the operational challenges, recognise areas of good performance and provide support with delivering service efficiencies and stability within each of their specialty areas.

Medical Advisory Committee (MAC)

Following a survey of senior medical colleagues at the start of the year, lots of feedback was received on topics for discussion which are now being planned into the monthly meeting agendas. A MAC planning committee being established to take this forward.

In addition to planned topics of discussion, there is also an opportunity for colleagues across the Trust to come and provide updates on emerging areas of work, and for executive and non-executive directors to attend to observe or contribute to discussions. There is also regular attendance from GPs to improve engagement and collaborative working between primary and secondary care.

The newly appointed consultants into the Trust will also have an opportunity to present to the Committee once they are settled in post as an introduction and observations following their first few months in post.

Revalidation and Appraisal

The data extract from the appraisal system is shown in the table below. The 'Total Completed Appraisals' line shows the last four quarters give a rolling 12 month position of 77% completed appraisals. Those in the latest quarter still have time to complete and if that matches previous 100% achievement, then overall performance for the last 12 month period will be 96%.

2021/22	Q2 01/07/2021	Q3 01/10/2021	Q4 01/01/2022	Q1 01/04/2022
No of doctors due to hold an appraisal (month part of their yearly appraisal date falls in this quarter)	80	156	39	107
No of doctors with appraisals scheduled	67	100	49	87
Total Completed Appraisals	**67 (100%)**	**92 (92%)**	**44 (89.8%)**	**30 (34.48%)**
Incomplete Appraisals	0 (0%)	8 (8.0%)	5 (10.2%)	57 (65.52%)

Workforce

The Medical Director for workforce is working with colleagues in difficult to recruit specialties with workforce challenges, alongside medical HR, the leadership and development team and education to support with workforce planning and recruitment and retention strategies to improve the position. In addition, working with medical colleagues within education on junior doctor placements to increase junior doctor numbers and

enable protected educational time within rotas.

Health Inequalities

Health Inequalities is a high priority on the NHS agenda, increasing the scale and pace of action to tackle health inequalities to protect those at greatest risk. Therefore, funding has been identified at Place level to recruit a Public Health Consultant hosted by DBTH within the Medical Director Directorate. There has been a lot of interest in this post and interviews are scheduled for 20th July, 2022.

This post will:

- Provide a strong public health lens to both planned care recovery and emergency pathways within DBTH and RDASH, increasing staff and community awareness of health inequalities and their impact on life expectancy and healthy life expectancy
- Review health, social care and socioeconomic system intelligence and work with teams ensuring it is used to its full potential and identify any gaps in data or reporting
- Lead on improving health and social outcomes, contribute to the Doncaster PLACE Health Inequalities Action Plan, representing DBTH and RDASH and sharing learning from public health lens review of planned and emergency pathways.
- Providing public health consultant clinical leadership in the aspiration for DBTH and RDASH to become successful Anchor Institutions

Clinical Governance

The clinical governance framework is well established within the Trust and the responsible lead within the team continues to drive the agenda working closely with senior nursing teams and colleagues across the Trust.

The restructure of Clinical Governance is prepared and awaiting the outcome of the Peer review of services by Jo Mason-Higgins for final agreement and implementation.

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 – Director POD **Committee: People**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed :July 2022**		
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.** **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.	**Risk Appetite:** The Trust has a **low appetite** for risks **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 • Capacity of teams to undertake appraisals in a timely manner • Reliance on international recruitment whilst increase in education places come to fruition • Levels of sickness absence impacting on staffing levels	**Initial Risk Rating** **Current Risk Rating** **Target Risk Rating**	4(C) x 5(L) = 20 extr 4(C) x 4(L) = 16 extr 3(C) x 3(L) = 9 low	Risk Trend ⟷
		Rationale for risk current score: Impact: • Impact on performance • Impact on Trust reputation • Impact on safety of patients & their experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-colleague/team relationships		
	Risk references: PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working • Increase skill set learning	**Future risks:** Morale and resilience of colleagues as we move into recovery phase **Comments:** • Considerations – capacity & capability of workforce including our leaders		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Monitoring progress of appraisal completion through central regular reporting within P&OD indicating compliance	Jul 2022	Aug 2022	ZL	Appraisal Season launched 01 June 2022, ongoing monitoring of completion rates through appraisal season window, fortnightly reports and reviewed at Performance, Overview and Support meetings with divisions
Staff survey and focus groups – positive feedback on staff knowing Trust vision	Apr 2022	2022 staff survey results	JC/ZL	No gaps identified. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022
Staff survey action plans to ensure appraisal conversations are meaningful as defined by the staff survey	Jul 2022	Jul 2022	JC	Paper on People Committee Agenda 5 July 2022. Appraisal season monitoring through fortnightly reporting and Performance, Overview and Support meetings with divisions
Communication – Staff Brief, Listening Events, Facebook	Jun 2022	Oct 2022	ES/AJ	None – ongoing communication process. Additional of work on Board/Exec visibility
Numbers accessing Leadership Development Programme, including QI	Jul 2022	Sept 2022	JC	None identified – Prospectus of Leadership Programme Training & Development launched Mar 2022

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3	Feedback from the appraisal season and quarterly staff survey results	Jul 2022	People, Board	Full	Paper to People Committee 05 July 2022
L1,L2,L3	KPMG Job Planning Audit	Nov 2021	People, ARC, Board	Partial	Action plan actively monitored by ARC and People Committee

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
Active monitoring on KPMG Job Planning audit to ensure all actions completed	**Ongoing – 12 month from audit date**	**Amber -ongoing**	**TN**	**Summer 2022**

Appendix Level1

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

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 – Director POD **Committee: People**	**People, Partners, Performance, Patients, Prevention**	**Date last reviewed : July 2022**		
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** **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	**Risk Appetite:** The Trust has a **low appetite** for risks **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 • Low response rate for staff survey • Low response rate in learner feedback • Staffing levels impacting on how colleagues feel	**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	Risk Trend ⟷
		Rationale for risk current score: Impact: • Impact on Trust reputation • Impact on safety of patients & their experience • Possible Regulatory action • Recruitment and retention issues • Increased staff sickness levels • Deterioration in management-staff relationships • Financial impact for the Trust if increased levels of absence and gaps		
	Risk references: PEO1 & PEO2 **Opportunities:** • Change in practices, new ways of working incl agile working • Future new build • Focus on wellbeing and EDI across the Trust • Focus on opportunities for flexible working	**Future risks:** Morale and resilience of colleagues as we move into recovery phase **Comments:** • Requires good OD plan “fit for purpose” • Staff survey impact • Need good data • Recruitment & retention – refresh of workforce plan • Involvement in regional retention programme of work		

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Support introduction of Freedom to Speak Up Champions	Nov 2021	Nov 2022	PH	No gaps identified
Our people asked to respond to Payroll KPI questionnaire - improvements from previous payroll provider noted	Jun 2022	N/A	MB	Positive response to survey – no gaps identified / regular performance meetings with Payroll provider in place. Action closed
Staff survey action plans to ensure improvement	Jul 2022	2022 staff survey results	JC/ZL	Staff Survey Paper on People Committee Agenda 5 July. Updates provided at Performance, Overview and Support meetings with divisions. Approach for 2022 staff survey action planning presented to People Committee, TEG and Board in July 2022
Communication – Staff Brief, Listening Events, Facebook	Jul 2022	Oct 2022	ES/AJ	None – ongoing communication process. . Addition of work on Board/Exec visibility
Development programme to include Everyone Counts/Civility	Jun 2022	Aug 2022	JC	No gaps currently identified
Strong partnership working with Partnership forum and JLNC	Jul 2022	Sep 2022	AJ/ZL	No gaps currently identified
Race Code Audit commenced	Jul 2022	Sept 2022	JC	Audit in process, result to be fed back to People Committee and ARC
Actions to improve sickness absence, linked to ongoing health and wellbeing programme of work	Jul 2022	Sept 2022	AJ	Actions and next steps identified in plan presented to People Committee – work in progress

Assurances received (L1 – Operational L2-Board Oversight L3 External) **		**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1,L2	Standard POD and Education & Research reports for Board. Research Strategy presented to Board July 2022	Jul 2022	People, Board	Full	None

Appendix Level1

L1,L2	Staff networks (BAME, LGBTQ+, Dyslexia & long term conditions; Reciprocal Mentoring programme – feedback to learning partners	-	People, Board		People Committee work plan to be reviewed to ensure appropriate attention given to EDI including networks. Reciprocal Mentoring Programme – graduation in July 2022, TEG supported next cohort to launch planned Sept 2022
L3	KPMG Job Planning Audit	Jun 2022	People, ARC, Board	Partial	Action plan actively being monitored
1.3	Internal Audit – 360 Assurance Race Code advisory audit	Jul 2022	Audit in progress		Audit in progress – verbal update provided at People Committee July 2022

Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
Active monitoring on KPMG Job Planning audit to ensure all actions completed	**Ongoing – 12 month from audit date**	**Amber -ongoing**	**TN**	**Summer 2022**

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	D2		
Report Title:	**People Update**				
Sponsor:	Zoe Lintin, Chief People Officer				
Author:	Zoe Lintin, Chief People Officer				
Appendices:	N/A				
Report Summary					
Purpose of report:	To provide Board with an update on developments in relation to activities to support staff engagement and experience together with key national updates.				
Summary of key issues/positive highlights:	There is a Board commitment and ambition to improve staff experience and engagement across DBTH, with a key indicator being our annual national staff survey results. This paper highlights some of the recent developments at DBTH in relation to engagement and staff experience, including: - Our approach to the annual national staff survey - Team Engagement and Development (TED) tool - Reciprocal Mentoring Programme In addition, updates are provided on the Leadership for a collaborative and inclusive future report (Messenger review) and changes in relation to national terms and conditions on COVID-19 sick pay provisions.				
Recommendation:	The Board is asked to note the actions being taken and to support the work programmes described.				
Action Require:	Approve	**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:		People Committee Trust Executive Group	
Date:	July 2022	**Decision:**	Aspects shared and support for approach outlined
Next Steps:			
Previously circulated reports to supplement this paper:		N/A	

1. Introduction

The people metrics are presented to Board each month via the IQPR and the People Committee also receives additional information at each meeting. The People Update reports to Board will focus on activities being undertaken to improve our people metrics and staff experience together with relevant system and national updates.

This report provides an update in relation to our key areas of focus following the 2021 staff survey and our approach to the 2022 survey, work ongoing in relation to aspects of team development and diversity and inclusion, and national updates on the Messenger leadership review and COVID-19 terms and conditions.

2. Staff survey

There is a Board ambition to continue to improve the experiences at work of our people and to further develop and build on our approach towards staff engagement. The annual national staff survey is a key indicator of our progress in this regard.

2.1 2021 staff survey results and themes

The Chief People Officer has reviewed the 2021 staff survey results, discussed with People & OD and other colleagues and considers the key engagement themes for Trust-wide focus for the coming months to be:

- Leadership
- Appraisals and personal development
- Team working and development
- Health and wellbeing
- Diversity and inclusion

These themes were supported by People Committee at their July meeting with details provided of activities underway and planned against each theme.

2.2 2022 staff survey

The communications and engagement planning preparations are underway to encourage participation in the 2022 national staff survey, which will launch in the Autumn.

It is the intention that a more co-ordinated approach towards engaging with and involving our teams in the survey results will be adopted with the 2022 survey. This approach has been shared with and supported by People Committee and Trust Executive Group (TEG) at their July meetings.

The expectation will be that each team, which is large enough to have their own set of results, will hold one or a series of engagement sessions about the results and these will be diarised to begin to start happening as soon as the embargo date is lifted in Spring 2023 (date to be confirmed nationally). This gives an opportunity for results to be shared and discussed in a timely manner, positive aspects to be highlighted, areas of concern to be raised and improvement ideas to be generated within the team.

This demonstrates that we are listening to what people tell us through the survey, value their feedback and that we are interested in their views on how to keep making their working experiences better. Staff engagement is a year-round activity, with the staff survey being an important element of this.

Themes for action planning will be identified, with a mixture of consistent Trust-wide themes and local themes at divisional/directorate level. Engagement improvement plans at a Trust-wide and divisional/directorate level will have central oversight with progress being reported through to People

Committee. This facilitates sharing of good practice and ideas and enables support to be provided as needed. Leaders will also be encouraged to keep their teams involved and updated on steps being taken in response to their feedback.

3. Leadership for a collaborative and inclusive future report – the Messenger review

On 8 June 2022, General Sir Gordon Messenger and Dame Linda Pollard published their report on the review of leadership and management in health and social care, as commissioned by the Secretary of State for Health and Social Care in October 2021. It has become known in the service as the Messenger review. The review involved engaging with a range of stakeholders and was focused on the impact of leadership on the workforce.

3.1 Summary of recommendations

The link to the full report is here: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future.

The recommendations are as follows, with detail beneath each in the full report:

1. Targeted interventions on collaborative leadership and organisational values
    - A new national entry-level induction for all who join health and social care
    - A new national mid-career programme for managers across health and social care

2. Positive equality, diversity and inclusion (EDI) actions
    - Embed inclusive leadership practice as the responsibility of all leaders
    - Commit to promoting equal opportunity and fairness standards
    - More stringently enforce existing measures to improve equal opportunities and fairness
    - Enhance CQC role in ensuring improvement in EDI outcomes

3. Consistent management standards delivered through accredited training
    - A single set of unified, core leadership and management standards for managers
    - Training and development bundles to meet these standards

4. A simplified, standard appraisal system for the NHS
    - A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system

5. A new career and talent management function for managers
    - Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers

6. More effective recruitment and development of Non-Executive Directors
    - Establishment of an expanded, specialist non-executive talent and appointments team

7. Encouraging top talent into challenged parts of the system
    - Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles

Two observations are presented in the report as being almost universal: firstly, the real difference that first-rate leadership can make in health and social care; secondly that the development of quality leadership and management is not adequately embedded in our health and care communities.

Amongst the key findings, the report also suggests that we have a culture in health and care which is unfriendly to collaboration and talks about system working with Integrated Care Systems (ICS) developments providing opportunities to change this dynamic, leading to better outcomes for our patients and our workforce – the 'culture of collaboration'. The report also talks about 'the culture of respect' and EDI is integral throughout the themes.

3.2 Implementation

The recommendations are far-ranging with much of the activity to be led at a national level. There will be an agreed mechanism through the national bodies to oversee the implementation of these recommendations and details of this are to be confirmed. Recommendations 3 – 7 are targeted at the NHS so there will be a Senior Responsible Officer (SRO) within the national NHS leadership structure, whereas there will be a joint SRO for Recommendations 1 and 2 which span health and care.

Sub-groups will be established to support implementation and the authors have expressed that the report is intentionally not over-prescriptive to allow for some co-creation. It is expected that increased standardisation and consistency across NHS organisations will be an outcome, perhaps phased over time, whilst also recognising the different cultures which exist within organisations.

The Chief People Officer will continue to engage in this work as it progresses, through the regional and national networks. Consideration will be given to potential national changes and alignment to national resources when developing our approach to leadership and culture at DBTH.

4. Team Engagement and Development (TED) tool

We are part of a national pilot to adopt a structured organisational development approach to team development and effectiveness. A recent DBTH 'Here Masterclass' delivered on the Team Engagement and Development Tool (TED) in June provoked a huge interest with around 80 of our leaders joining the call.

TED is an evidence-based tool to help teams and team leaders understand where to focus their efforts in improving staff experience and engagement and provides another mechanism for seeking regular feedback. The tool is supported by a wealth of resources and a range of team leaders from across the organisation are currently adopting TED to inform their team development and staff experience improvement work. A number of colleagues spoke positively about their early experiences at the masterclass. The intention is to roll-out the tool further across the organisation with support for leaders from the Leadership and OD team.

5. Reciprocal Mentoring Programme

Following a successful first year and a celebratory graduation in July 2022, TEG has supported a second cohort of the Reciprocal Mentoring Programme to begin in the Autumn. This programme has been an experiential learning opportunity for Executive leaders and Aspirant leaders from ethically diverse backgrounds working together in learning partnerships. The programme has brought benefits for both sets of partners in terms of personal experiences, challenging mindsets and organisational learning.

This programme is a key part of our ongoing work to further develop and embed a diverse and inclusive culture at DBTH. The criteria for the second cohort will be broadened to seek participants from colleagues from a range of under-represented groups and in line with the recognised protected characteristics.

6. Change to COVID-19 national terms and conditions

Following consultation with national stakeholders including NHS England, NHS Employers, trade union and employer colleagues, the Government has decided that now is the right time to withdraw the national terms and conditions in relation to COVID-19 sick pay. In summary, and using a phased approach, this means that COVID-19 related sickness absence sickness will be treated in the same way as other sickness absence. Individuals who are isolating pending a test or asymptomatic with COVID-19 will be classed as being on authorised absence and paid accordingly.

The People and OD team has been undertaking a detailed piece of work to prepare for this change, which came with relatively short notice nationally, and working with the Communications team to ensure messages are shared with our colleagues and leaders. Colleagues impacted by these changing provisions will be supported through individual meetings.

An update will be provided at the next People Committee meeting.

7. Recommendations

The Board can be assured that actions are being taken to continue to improve our approach to staff experience, that plans are in place for the 2022 national staff survey and that we are connected with the national leadership review.

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: Trust Board – Director of Finance (AC)
Committee: F&P & QEC

People, Partners, Performance, Patients, Prevention

Date last reviewed : July 2022

Strategic Objective
In recurrent surplus to invest in improving patient care

Breakthrough Objective
Every team achieves their financial plan for the year

Measures:

- Delivery of in year financial plan/budgets
- Underlying/recurrent financial position of the Trust
- Trust Cash Balances
- External and Internal Audit outcome

Risk Appetite:
The Trust has a **low appetite** for risks

Risks:

- There is a very significant challenge in 22/23, with the current Trust plan showing a deficit of £10m. The Trust will be likely challenged to reduce its deficit plan further in year.
- The Trust is reporting a c £4.3m deficit at the end of Q1 which is c£1m off plan. This is in part being driven by high temporary staffing usage due to the impact of vacancies, high levels of COVID sickness (£0.7m), operational pressures (high bed occupancy) along with higher-than-expected inflationary pressures including utilities pressures (£0.3m).Offsetting this the Trust is currently benefiting from underspend against the independent sector plan.
- Income allocations have been significantly reduced from pandemic levels, including Commissioners removal of previously provided non-recurrent funding. Therefore, focus on efficiency and productivity (see below) and cost reduction in 22/23 is paramount.
- Agency spend remains at historical levels and has been very high in the last two months (£1.9m in Month 3), particularly nursing spend which in turn is being driven by operational and workforce pressures. The agency position is unsustainable and unaffordable with a sustainable solution required regarding temporary staffing along with finalisation of the recurrent nursing workforce requirements which remains outstanding. The Chief Nurse is currently pulling together a plan to support reducing temporary staffing spend. The workforce plan assumes vacancies are recruited to on a substantive basis and the reliance on temporary staffing is reduced. The financial plan and CIP plan is aligned to this and is therefore heavily reliant on the tight management of vacancies and temporary staffing.
- COVID assumptions in the plan are based on low levels of COVID as seen in Summer 2021 and are consistent with the ask of the planning guidance. However COVID levels are higher than plan impacting on bed occupancy and sickness driving expensive agency usage.
- Non-pay inflation is currently very high in the economy and is not funded at those levels within the funding allocations. For example we have seen a £0.3m pressure on utilities within the Q1. Pay award is yet to be confirmed including any funding.
- Whilst cash is currently in a healthy position the deficit this financial year along with the significant capital programme will potentially cause cash flow issues in 22/23 impacting on the ability for the Trust to meet its financial obligations, without NHSE/I intervention. This is being closely monitored.
- Productivity reductions have been seen during COVID, where activity being delivered is significantly below pre-pandemic levels, whilst resource (especially clinical resource) has increased. Challenge in 22/23 is to deliver pre-pandemic levels of activity within pre-pandemic resources whilst providing safe and sustainable services.
- Trust's underlying deficit financial position has worsened during the pandemic. There is increasing focus nationally on underlying positions entering 22/23.
- Culture Risk – Impact of COVID on re-engaging Divisions with financial processes and controls (by 22/23 will have been two years) and refocus on efficiency.
- Impact of major incident at W&C. The incident highlights significant risks concerning the funding route for and delivery of backlog maintenance costs. However, some additional capital funding has been provided in year of c£1.8m to support this. There however remains limited capital funding especially for significant builds given the Trust's estates risks.
- Impact of inflationary pressures on capital projects with allocated funding – BEV, RAAC, ePR

Initial Risk Rating	4(C) x 5(L) = 20	Risk Trend
Current Risk Rating	4(C) x 4(L) = 16	⟷
Target Risk Rating	3(C) x 3(L) = 9	

Rationale for risk current score:
Impact:

- Currently the Trust is in a significant underlying deficit position with significant uncertainty regarding the future financial regime.
  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 financial landscape, regulatory intervention
- Impact of reduced revenue funding allocations for 22/23 and beyond.
- Change in financial regimes in relation to ICS and Place budgets
- Return to control totals and trajectories in future years including agency caps.
- Increasing costs relating to old and poorly maintained buildings

Risk references:
F&P 1, F&P 2, F&P 3

Opportunities:

- Change in practices, new ways of working
- The Trust is looking at opportunities for funding to support elective recovery and operational requirements, including capital bids.
- Implementation of new Directorate to support improvements in productivity and efficiency.

Comments:

- See risks section

Appendix Level1

Controls (mitigation to lead to evidence of making impact):	**Last Review date**	**Next review date**	**Reviewed by**	**Gaps in Control**
Key Financial Control Processes: Vacancy Control Panel, CIG, Grip and Control, Capital Monitoring Committee, Cash Committee. Reintroduction of financial escalation process with Divisions from June.	June 2022	Ongoing	AC	Ongoing review of financial controls. No unexpected exceptions identified
Budget Setting and Business Planning	June 2022	N/A	AC/JS	No unexpected exceptions identified
Internal & External Audit programme design & compliance outcomes	June 2022	May 2022	AC	Recent Internal Audit provided significant assurance. External Audit on 21/22 provided an unqualified audit opinion.
Establishment of new Directorate: Recovery, Innovation and Transformation.	April 2022	Ongoing	JS	
Working with the ICS through CEO's and DoFs regarding funding arrangements. Reporting back through F&P and Board.	June 2022	Ongoing	AC/JS	Ongoing monitoring
Assurances received (L1 – Operational L2-Board Oversight L3 External) **	**Last received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, L3 Internal Audit Annual report including Head of Internal Audit Opinion	May 21	ARC, Board	Significant Assurance with minor improvements	None outstanding
L2,L3 Feedback from NHSI/E on statutory returns	Ongoing	F&P, Board	Full	None outstanding
L2 LCFS Annual Report	July 21	ARC	Full	None outstanding
L1,L2,L3 Internal Audit: General Ledger and Financial Reporting	March 22	ARC	Significant Assurance	Nothing significant noted in the Internal Audit
L2, L3 External Auditors Annual Report	June 22	ARC, F&P, Board	Unqualified Opinion	Nothing high risk identified in ISA 260, but some control recommendations to work on through the financial year.
Corrective Actions required	**Action due date**	**Action status**	**Action owner**	**Forecast completion date**
1. Delivery of external and internal audit recommendations	Ongoing	Ongoing	AC	Q2 2022. Internal audit recommendations implemented on time.
2. Working with the ICS regarding funding allocations for Doncaster	Ongoing	Ongoing	AC	Ongoing
3. Delivery of reduced temporary staffing spend especially in Nursing	Ongoing	Ongoing	All Exec Directors especially Chief Nurse	Ongoing
4. Development and delivery of CIP plan	Ongoing	Ongoing	All Exec Directors, JS lead for Efficiency and Effectiveness	Ongoing
5. Development and implementation of financial assurance processes in line with new Governance proposals (including escalation and monitoring processes).	June 22	Ongoing	AC	June 22 - implemented

Assurances received (L1 – Operational L2-Board Oversight L3 External) identify the range of assurance sources available to an entity:
—L1 Management –such as staff training and compliance with a policy
—L2 Internal Assurance –such as sub-committees receiving evidence of L1 working effectively; and
—L3 External Assurance –such as internal and external audits.

Areas in yellow highlight indicate change from last version

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	E2
Report Title:	**Financial Performance – Month 3 (June 2022)**		
Sponsor:	Alex Crickmar – Acting Director of Finance		
Author:	Jenny Marsh – Acting Deputy Director of Finance		
Appendices:			
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 deficit for month 3 (June 2022) was £1.5m, which was in line with plan. However, the Trust has a Year to Date (YTD) deficit financial position of £4.3m as at the end of month 3 which is adverse to plan by £1.1m. This position is largely driven by pay being overspent by £2.4m (due to high agency usage as a result of workforce and operational pressures including levels of vacancies, COVID and sickness) offset by favourable variances on clinical and non-clinical income (£0.7m) and continued independent sector underspend relating to elective recovery (£0.7m). Key highlights by category of income and expenditure are set out below: • **Clinical Income:** £0.4m favourable to plan, driven by non-recurrent funding from Doncaster CCG, including the Lung Health Checks project which is offset with expenditure. ERF has been assumed to be fully received for Q1 from Commissioners, with the ICB notifying Trusts' that there will be no national clawback of ERF from systems for underperformance in Q1. • **Non-Clinical Income:** £0.3m favourable to plan, with recharges favourable to plan by £0.7m offset by testing income (£0.3m) and education CPD income (£0.2m) being adverse to plan, all of which have offsetting increases/reductions in expenditure. Overseas income is £0.1m favourable to plan. • **Pay:** £2.4m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. Agency spend remains high at £1.8m in month, an increase of £0.1m compared to month 2, mainly on Medical and Nursing staff. Temporary staffing spend remains significantly higher than pre-pandemic levels (c £0.9m pre-pandemic) and above last year levels, with the trend for spend is currently rising rather than falling. COVID is having a significant impact with spend over budget including £0.7m spent on backfill for COVID sickness. Both the Medicine and Children and Families Divisions are under financial escalation and enhanced support given the Division's pay positions. Meetings chaired by the Acting Director of Finance have been held with each, with a		

	number of actions being agreed with the Divisions to try and support an improved position. • **Non-Pay**: £0.5m favourable to plan. This is largely due to an underspend on independent sector spend (£0.7m), an overspend on utilities due to further price increases on electric (£0.3m), and an overspend on drugs (£0.3m), netted off by an increase in stock of £0.3m on clinical supplies. **Capital** Capital spend in month was £759k against the plan of £2,802k giving an in-month under-performance of £2,043k. The key variances to plan are underspends in Estates of £1,626k, Medical Equipment of £19k and an overspend in IT of £60k. It should be noted that whilst the Trust is behind plan, most of the Estates capital schemes have now been approved through Corporate Investment Group (CIG). ICT cases are also progressing through CIG, with medical equipment cases taking longer due to the delays in signing off the plan. The memorandum of understanding (MOU) for the preliminary work on RAAC (c£2.5m) has now been signed off in line with Board approval last month with funding expected to be received in July. **Cash** The cash balance at the end of June was £27.7m (May: £26.6m). Cash has increased by c £1.1m compared to month 2 largely as a result receiving clinical income totalling £38.5m, which is c. £3m above normal, as the Trust received income that it had previously accrued (in line with the revised financial plan). This cash balance is broadly in line with the cash forecast for 22/23. **CIPs** In Month the Trust has delivered £1.05m of savings versus the plan submitted to NHSI of £1.17m, an under-delivery of £121k. YTD the Trust has delivered £3.49m of savings against a planned £3.53m, an under-delivery of £37k. Plans are being developed with Divisions to identify further opportunities.
Recommendation:	The Board is asked to note: • The Trust's deficit for month 3 (June 2022) was £1.5m, which was favourable to plan by £6k. • The Trust's deficit YTD at month 3 (June 2022) was £4.3m, which was adverse to plan by £1.1m.

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:	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:			Finance and Performance Committee
Date:	21st July	**Decision:**	N/A
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 3 – June 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

P3 June 2022

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance			YTD Performance		
	Actual £'000	Variance to budget £'000		Actual £'000	Variance to budget £'000	
Income	(41,971)	(668)	F	(124,691)	(637)	F
Pay	28,165	1,107	A	83,351	2,397	A
Non Pay	14,831	(388)	F	44,111	(457)	F
Financing Costs	560	(61)	F	1,693	(169)	F
(Profit)/Loss on Asset Disposals	0	0	A	(97)	(97)	F
(Surplus)/Deficit for the period	**1,585**	**(10)**	**F**	**4,368**	**1,038**	**A**
Donated Asset Adjustment	(39)	4	A	(116)	13	A
Adjusted (Surplus)/Deficit for the period	**1,546**	**(6)**	**F**	**4,252**	**1,050**	**A**
Less gains on disposal of assets	0	0	A	97	97	A
Adjusted Surplus/(Deficit) for the purposes of system achievement	**1,546**	**(6)**	**F**	**4,349**	**1,147**	**A**

Income: Over-achieved F | Under-achieved A

Key

F = Favourable **A** = Adverse

Expenditure: Underspent F | Overspent A

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual
	Plan £'000	Actual £'000		Plan £'000	Actual £'000		Plan £'000
Local	0	39	F	0	241	F	0
Workforce (vacancy control)	549	549	F	1,866	1,866	A	5,500
ERF productivity	458	458	A	1,375	1,375	A	5,500
Temporary staffing	100	0	A	100	0	A	1,000
Procurement	63	3	A	188	10	A	750
Non-pay cost containment	0	0	A	0	0	A	2,000
Unidentified	0	0	A	0	0	A	4,500
	1,170	**1,049**	A	**3,529**	**3,492**	A	**19,250**

3. Statement of Financial Position

	Opening Balance £'000	Closing balance £'000	Current Balance £'000	Movement in year £'000
Non Current Assets	**247,896**	**246,595**	**246,595**	**-1,301**
Current Assets	71,448	62,494	62,494	**-8,954**
Current Liabilities	-84,805	-77,772	-77,772	**7,033**
Non Current liabilities	-13,867	-13,286	-13,286	**581**
Total Assets Employed	**220,672**	**218,031**	**218,031**	**-2,641**
Total Tax Payers Equity	**-220,672**	**-218,031**	**-218,031**	**2,641**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance		27,700		27,700	29,164
Capital Expenditure	2,802	759	4,601	2,114	34,190

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	6,475.60	5,545.55	386.41	197.21	6,129.17
Previous Month	6,426.14	5,540.93	367.35	183.75	6,092.03
Movement	49.46	4.62	19.06	13.46	37.14

1. Month 3 Financial Position Highlights

Executive Summary Income and Expenditure – Month 3

	Month 3			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	**-41,304**	**-41,971**	**-668**	**-124,054**	**-124,691**	**-637**
Pay						
Substantive Pay	25,534	23,384	-2,150	75,891	69,125	-6,766
Bank	40	1,798	1,758	115	5,167	5,052
Agency	246	1,793	1,547	780	5,206	4,426
Recharges and Reserves	1,238	1,189	-49	4,169	3,853	-316
Total pay	**27,058**	**28,165**	**1,107**	**80,954**	**83,351**	**2,397**
Non-Pay						
Drugs	903	926	23	2,709	2,908	198
Non-PbR Drugs	1,822	1,796	-26	5,467	5,576	109
Clinical Supplies & Services	3,047	3,012	-36	9,142	8,944	-199
Depreciation and Amortisation	1,074	1,250	177	3,500	3,748	247
Other Costs (including reserves)	6,927	6,128	-799	19,411	17,950	-1,461
Recharges	1,446	1,719	273	4,338	4,985	647
Total Non-pay	**15,219**	**14,831**	**-388**	**44,568**	**44,111**	**-457**
Financing costs & donated assets	**578**	**521**	**-57**	**1,733**	**1,481**	**-252**
(Surplus) / Deficit Position	**1,552**	**1,546**	**-6**	**3,202**	**4,252**	**1,050**
Less gains on disposal of assets	**0**	**0**	**0**	**0**	**97**	**97**
(Surplus) / Deficit Position for the purposes of system achievement	**1,552**	**1,546**	**-6**	**3,202**	**4,349**	**1,147**

The Trust's deficit for month 3 (June 2022) was £1.5m, which was in line with plan. However, the Trust has a Year to Date (YTD) deficit financial position of £4.3m as at the end of month 3 which is adverse to plan by £1.1m. This position is largely driven by pay being overspent by £2.4m (due to high agency usage as a result of workforce and operational pressures including levels of vacancies, COVID and sickness) offset by favourable variances on clinical and non-clinical income (£0.7m) and continued independent sector underspend relating to elective recovery (£0.7m). Key highlights by category of income and expenditure are set out below:

- **Clinical Income:** £0.4m favourable to plan, driven by non-recurrent funding from Doncaster CCG, including the Lung Health Checks project which is offset with expenditure. ERF has been assumed to be fully received for Q1 from Commissioners, with the ICB notifying Trusts' that there will be no national clawback of ERF from systems for underperformance in Q1.

- **Non-Clinical Income:** £0.3m favourable to plan, with recharges favourable to plan by £0.7m offset by testing income (£0.3m) and education CPD income (£0.2m) being adverse to plan, all of which have offsetting increases/reductions in expenditure. Overseas income is £0.1m favourable to plan.

- **Pay:** £2.4m adverse to plan, with the variance mainly driven by Medical and Nursing spend in Medicine, Surgery and Children and Families Divisions. Agency spend remains high at £1.8m in month, an increase of £0.1m compared to month 2, mainly on Medical and Nursing staff. Temporary staffing spend remains significantly higher than pre-pandemic levels (c £0.9m pre-pandemic) and above last year levels, with the trend for spend is currently rising rather than falling. COVID is having a significant impact with spend over budget including £0.7m spent on backfill for COVID sickness.

  Both the Medicine and Children and Families Divisions are under financial escalation and enhanced support given the Division's pay positions. Meetings chaired by the Acting Director of Finance have been

held with each, with a number of actions being agreed with the Divisions to try and support an improved position.

Further detail

Income

The month 3 position for CCGs is aligned to the contract values submitted in the final plan on the 20th of June, this includes growth assumptions, inflationary uplift, and ERF allocations.

Within the plan the Trust included a contract risk relating to growth assumptions outside of the SY ICB as discussions (mainly relating to Notts ICB) continue to be held at a regional level. The risk included in the position at month 3 is £424k. It was also agreed with the ICB to include in the plan the RDASH funding issue of £1.5m, with £375k of income assumed in the month 3 position. The Board should note that this is a potential risk whilst we await progress from the ICB regarding arbitration on the issue.

The contract with the Trusts lead Commissioner has been signed based on an Aligned Payment Incentive arrangement. The contract includes the right for commissioners to claw back up to 75% of the Elective recovery funding should the Trust fail to deliver the associated activity requirements. For Q1 it has been confirmed that the clawback will not be invoked and therefore 100% of ERF income relating to SY commissioners has been included. Inter-system commissioners have yet to confirm agreement on ERF funding and therefore a risk of £146k is included at Q1.

Non-clinical income was £0.3m favourable to plan, with a number of key variances to note:

- £0.7m favourable variance on recharges (mainly associated with the Wholly Owned Subsidiary and Western Park) which is offset with a corresponding increase in expenditure.
- £0.1m favourable variance on overseas income, partly offset by increased bad debt provision (60% provision is used for overseas debt).
- £0.3m under achievement on testing income which is offset with an underspend on expenditure.
- £0.2m under achievement on Education Continuing Professional Development (CPD) income which is offset with an underspend on expenditure.

Pay

Pay expenditure was £1.1m adverse to plan in month 3 and £2.4m adverse to plan YTD. The key areas to note are:

- The main areas of overspend remain in Medical & Dental (£1.9m adverse to plan) and Nursing (£2.0m adverse to plan). These are offset by underspends on admin, HCAs and science and therapy staff.
- Medicine is overspent on medical pay by £0.8m and on Nursing pay by £1.0m – due to agency backfill for junior doctors mainly within ED, and agency and bank usage for nursing within ED, Acute Medicine and Care of the Elderly. This is mainly driven by vacancies (both qualified and unqualified nursing), high sickness rates (including COVID), and operational pressures (high bed occupancy rates).
- Surgery is overspent on medical pay by £0.5m and on Nursing pay by £0.4m – due to agency backfill for junior doctors' gaps mainly within T&O, staffing on the Trauma Ambulatory Care unit (TACU) which is now open 24/7 and Ward 19 which has opened earlier than anticipated, and agency and bank usage for nursing due to covid sickness and supernumerary international nurses undertaking training prior to starting in role.

- Children and Families Division are overspent on medical pay by £0.5m and on Nursing by £0.6m – due to covid absence, maternity, and long-term sickness, along with nursing and midwifery pressures due to increased premiums for bank and agency backfill.
- Both the Medicine and Children and Families Divisions are under financial escalation and enhanced support given the Division's pay positions. Meetings chaired by the Acting Director of Finance have been held with each, with a number of actions being agreed with the Divisions to try and support an improved position. The Surgery financial position is being reviewed at Month 4, with the expectation if there is not an improvement in the position further action will be required.

Agency spend remains high at £1.8m in month, an increase of £0.1m compared to month 2, mainly on medical staff (£0.9m) and nursing staff (£0.6m). The table below sets out the agency spend by type for quarter 4 of 2021/22 and month 1 to month 3 of 2022/23, demonstrating the continued agency spend on Medical and Nursing staff. This level of spend is c.£0.8m more than pre-pandemic levels and is an increasing trend over last year.

Total agency spend by category	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Administration and estates	42	55	33	63	70	55
HCA and other support staff	82	64	82	26	66	97
Medical and dental	760	722	886	805	881	943
Non Medical Non Clinical	43	37	78	64	68	56
Nursing & midwifery	380	418	755	702	616	626
Scientific, therapeutic and tech	31	25	40	28	22	17
Total	**1,338**	**1,321**	**1,874**	**1,688**	**1,724**	**1,793**

Non-pay

Non-pay was £0.5m favourable to plan YTD. This is largely due to an underspend on independent sector spend in surgery (£0.7m), an overspend on utilities due to further price increases on electric (£0.3m), and an overspend on drugs (£0.3m), netted off by a benefit on stock of £0.3m on clinical supplies which is being investigated further.

CIP Delivery

In Month the Trust has delivered £1.05m of savings versus the plan submitted to NHSI of £1.17m, an under-delivery of £121k. YTD the Trust has delivered £3.49m of savings against a planned £3.53m, an under-delivery of £37k. Plans are being developed with Divisions to identify further opportunities. An outline plan was presented to the Finance and Performance Committee on the 21st of July.

Capital

Capital spend in month was £759k against the plan of £2,802k giving an in-month under-performance of £2,043k. The key variances to plan are underspends in Estates of £1,626k, Medical Equipment of £19k and an overspend in IT of £60k. The YTD spend is £2,114k against the plan of £4,601k. It should be noted that whilst the Trust is behind plan, most of the Estates capital schemes have now been approved through Corporate Investment Group (CIG). ICT cases are also progressing through CIG, with medical equipment cases taking longer due to the delays in signing off the plan. The memorandum of understanding (MOU) for the preliminary work on RAAC (c£2.5m) has now been signed off in line with Board approval last month with funding expected to be received in July.

Cash

The cash balance at the end of June was £27.7m (May: £26.6m). Cash has increased by c £1.1m compared to month 2 largely as a result receiving clinical income totalling £38.5m, which is c. £3m above normal, as the Trust received income that it had previously accrued. This cash balance is broadly in line with the cash forecast for 22/23.

2. Recommendations

The Board is asked to note:

- The Trust's deficit for month 3 (June 2022) was £1.5m, which was favourable to plan by £6k.
- The Trust's deficit YTD at month 3 (June 2022) was £4.3m, which is adverse to plan by £1.1m.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	E3
Report Title:	**The Premises Assurance Model (NHS PAM) Assessment Report 2021/2022**		
Sponsor:	Alex Crickmar, Acting Director of Finance		
Author:	Howard Timms, Acting Operational Director of Estates and Facilities		
Appendices:	Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2021/2022 Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2021/2022 Appendix 3: Premises Assurance Visual Dashboard Summary – Efficiency 2021/2022 Appendix 4: Premises Assurance Visual Dashboard Summary – Effectiveness 2021/2022 Appendix 5: Premises Assurance Visual Dashboard Summary – Organisational Governance 2021/2022		
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. Therefore the PAM is providing assurance the organisation has systems and processes which aim to mitigate the risks associated with non-compliant 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 Report identifies the Trust Overall Summary Position for 2021/2022 for all five mandated domains is Good in 100 Self-Assessment Question elements (SAQs), requires Minimal improvement in 158 elements, requires Moderate improvement in 42 elements, not applicable in 40 elements with 1 element rated as inadequate, as a result of the lack of policies and procedures in place for air pollution control. • 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). • Minor improvements within the PAM overall Safety domain allocated scores for the reporting period with an increase in 13 Good rated elements, a decrease in requires Minimal improvement of 5 elements and a decrease in requires Moderate improvement of 7 elements, resulting in overall improvement within this domain from the 2020/2021 PAM assessment. • The Patient Lead Assessment of the Care Environment (PLACE) is scheduled to commence on the 19th September 2022, which is anticipated to deliver improvement in the majority of 'Requires Minimal Improvement' elements in the Patient Experience Self-Assessment Questions (SAQ's) for the following 2022/2023 PAM assessment year. • Estates and Facilities Management (EFM) Strategic objectives directly aligned to improving the elements requiring Inadequate, Moderate and Minimal improvement within the Efficiency, Effectiveness and Organisational Governance PAM assessment SAQ action are included, explaining identified actions to achieve identified goals. • Capital Costs associated with the annual Backlog maintenance figure of £149,930,048 reported through the ERIC returns is provided in the report as requested by NHSE/I 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 of £35,000 to deliver improvement in the Health and Safety at Work SAQ and requirement for a new H&S responsible person training and development programme linked to the organisations vision, values and objectives, aligned to actions 12 and 13 of the Granger report recommendations are presented. • Revenue consequence costs of approximately £300,000 for the Trust being able to achieve the required 90% completion rate for scheduled PPM against the PAM SAQ Assessment, SFG 20 and associated Health Technical Memorandums (HTM,'s), Health Building Notes (HBN's). This is aligned to the Estates workforce Review Business case (2019) and 7 point plan agreed with NHSE/I to review the current maintenance strategy required to deliver a good rating in all PAM safety domain maintenance SAQ element fields. • Revenue consequence costs of £120,000 to deliver improvement in the E&F Operational Management SAQ associated with the delivery of the proposed Medical Technical Services Department Labour Force Re-structuring Business case (2021). • Revenue consequence costs of approximately £1Million to deliver the agreed National Standards of Healthcare Cleanliness Plan. An agreed action plan has been developed in consultation with NHSE/I to achieve the standards by March 2023 which will deliver an improvement in the cleanliness and infection control SAQ. • Finally, due to the continued COVID-19 Pandemic experienced towards the end of 2021, that reduced staffing levels and available resource which directly affected the ability to complete a number of identified actions, resulting in limited progress in the overall PAM continual improvement process. Foundations are now firmly in place to deliver improvements in all domain SAQ's scores that require moderate and minimal improvement.

Recommendation:	The Board of Directors to note that the information within the report and PAM assessment 2021/2022 data will be submitted and committed through the NHSE/I on line reporting system before the deadline of the 9th of September 2022.				
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:	Capital Costs associated with SH1 and SH4 Compliance Revenue Consequences Costs associated with requirements to achieve PPM compliance with SFG20, Estates and Medical Technical Services Workforce Review and the National Standards of Healthcare Cleanliness.

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. Therefore 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. It 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 2021/2022 which must be uploaded on the NHSE/I on line reporting system prior to the 9th of September 2022. This ensures Mandatory Status for all five Domains 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 2021/2022 and covers the five mandated PAM domains. The Key issues from the report include:

The Trust Overall Summary Position for 2021/2022 for all five mandated domains is Good in 100 Self-Assessment Question elements (SAQ), requires Minimal improvement in 158 elements, requires Moderate improvement in 42 elements, 40 elements are Not applicable with 1 element rated as inadequate, which relates to policies and procedures in place for air pollution control.

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).

There has been an improvement in the PAM Safety domain elements with an increase in 13 Good scores, a decrease of 5 elements that require Minimal improvement, and 7 elements that require Moderate improvement resulting in an overall improvement from the previous years 2020/2021 PAM assessment.

The Patient Lead Assessment of the Care Environment (PLACE) is scheduled to commence on the 19th September 2022, it is anticipated that this will deliver improvement in the majority of 'Requires Minimal Improvement' elements in the Patient Experience Self-Assessment Questions (SAQ's) for the following years 2022/2023 PAM assessment report.

Estates and Facilities Management (EFM) Strategic objectives are directly aligned to improving the elements requiring Inadequate, Moderate and Minimal improvement within the Efficiency, Effectiveness and Organisational Governance PAM assessment. SAQ action plans are included, explaining identified actions to achieve identified goals.

Revenue consequence costs of approximately £300,000 for the Trust being able to achieve the required 90% completion rate for scheduled PPM against the PAM SAQ Assessment, SFG 20 and associated Health Technical Memorandums (HTM,'s), Health Building Notes (HBN's). This is aligned to the Estates Workforce Review Business case (2019) and 7 point plan agreed with NHSE/I to review the current maintenance strategy required to deliver a good rating in all PAM safety domain maintenance SAQ element fields.

Revenue consequence costs of £120,000 to deliver improvement in the E&F Operational Management SAQ associated with delivery of the proposed Medical Technical Services Department Labour Force Re-structuring Business case (2021).

Revenue consequence costs of approximately £1Million to deliver the agreed National Standards of Healthcare Cleanliness Plan. An agreed action plan has been developed in consultation with NHSE/I to achieve the standards by March 2023 which will deliver an improvement in the cleanliness and infection control SAQ.

Capital Costs associated with the annual Backlog maintenance figure of £149,930,048 reported through the ERIC returns is provided in the report as requested by NHSE/I 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 of £35,000 to deliver improvement in the Health and Safety at Work SAQ and requirement for a new H&S responsible person training and development programme linked to the organisations vision, values and objectives, aligned to actions 12 and 13 of the Granger report recommendations.

Finally, due to the continued COVID-19 Pandemic experienced towards the end of 2021, that reduced staffing levels and available resource which directly affected the ability to complete a number of identified actions, resulting in limited progress in the overall PAM continual

improvement process. Foundations are now firmly in place to deliver improvements in all domain SAQ's scores that require moderate and minimal improvement.

2. Introduction

The assessment of the DBTH PAM has been undertaken using the revised and updated PAM 2022 model and reflects the Trust's position as at 2021/2022. The methodology utilised adopts the PAM 2022 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 different functionalities and then an overview taken as to the Organisational position in relation to the evidence provided from the different functional areas. This enables 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 2021/2022 and covers all five mandated PAM domains including an overall summary position illustrated in figure 1 and distribution of SAQ Ratings numbers for Hard/Soft Facilities Management (FM), Patient Experience, Efficiency, Effectiveness and Organisational Governance 2021/2022 illustrated in figure 2. The Trust Overall Summary Position for 2021/2022 for all five domain SAQ's is; Good in 100 elements, requires Minimal improvement in 158 elements, requires Moderate improvement in 42 elements, is inadequate in 1 element with 40 elements scoring as Not Applicable (N/A). 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.

The PAM report itself, is included within the Acting Operational Director of Estates and Facilities/Chair of the Trust H&S Committees KPI Board report, as a declaration of Trust H&S compliance against the NHS PAM Safety Domain for 2021/2022, and ensures the Trust meets the current CQC Key Lines of Enquiry (KLOE).

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

The Patient Experience domain results are also presented on an annual basis to the Patient Experience & Involvement Committee (PEIC) for information and assurance.

The reporting features of PAM as issued by the NHSE/I 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 2021/2022 still draws on the reports that are currently available within the PAM spreadsheet working documents and the commentary provided by the PAM working group exercises undertaken at the Trust.

The current Trust PAM process commenced at the beginning of August 2021, but due the continued COVID-19 Pandemic experienced towards the end of 2021, resulting in reduction in staffing levels and availability of resource which directly affected the ability to complete identified actions, resulting in limited progress in the overall PAM continual improvement process. As a consequence only a small number of improved scores from moderate to minimal improvement and minimal improvement to Good have been achieved overall.

To note; although limited movement in progress is evident for this reporting period, foundations are firmly in place to deliver improvements in all domain SAQ's scoring that requires moderate and minimal improvement for the following 2022/2023 PAM assessment Year. A continual process to regularly review all five domain SAQ working groups is now embedded within the E&F management team, with agreed actions circulated to the responsible managers for each specialist SAQ including updates, progress notes and completion dates with summary positions for the reporting period provided from the DBTH PAM electronic assurance dashboard in Appendices 1 to 5.

For the areas requiring improvement in the overall PAM assessment, PAM allows for the entry of "Capital Costs for compliance'' and "Revenue Consequences" to achieve compliance. The capital cost to achieving the compliance figure provides the link to the Trust's Estates Strategy, Capital, and Business plans 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.

The accompanying information identifies the Revenue Consequences associated with individual domain summaries and scores to enable the Trust to achieve compliance and an overall good rating.

Figure 1: Overall Summary Position of Self-Assessment Question (SAQ) Scores 2021/2022

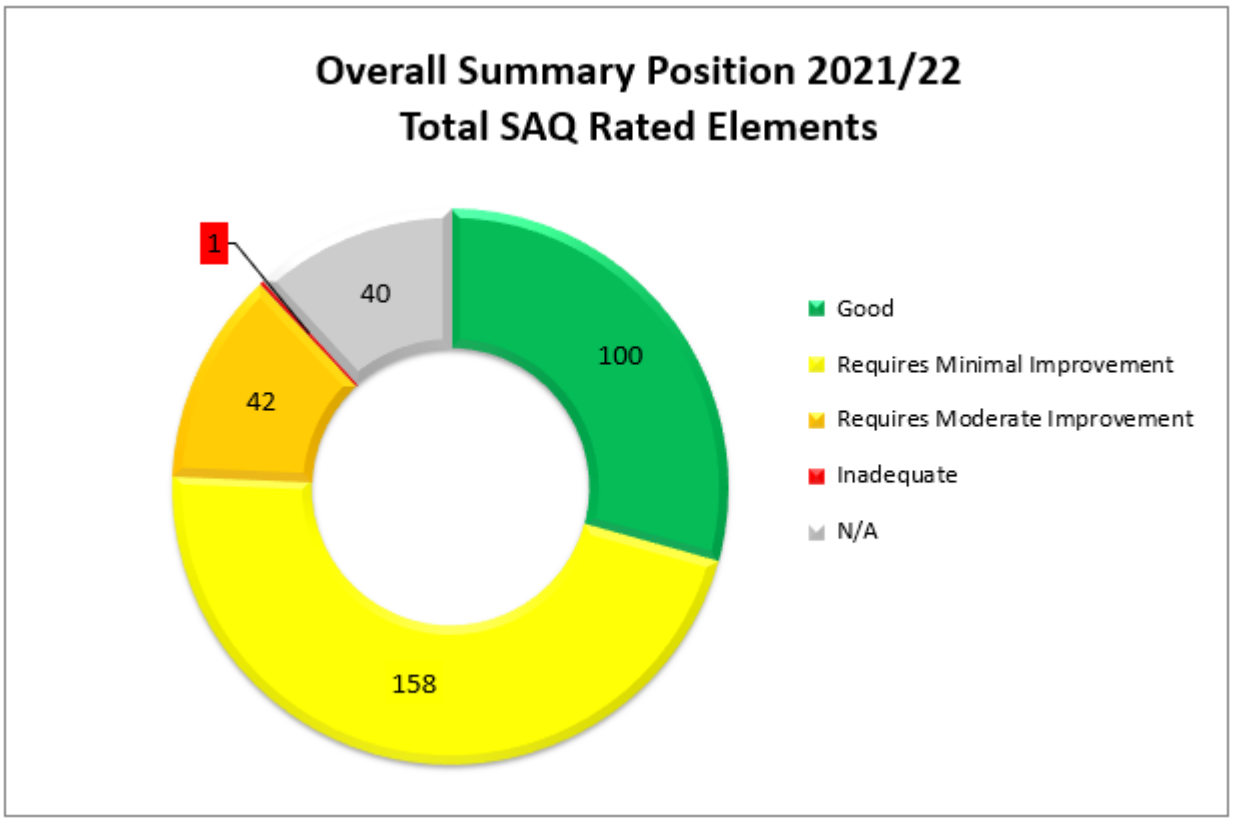
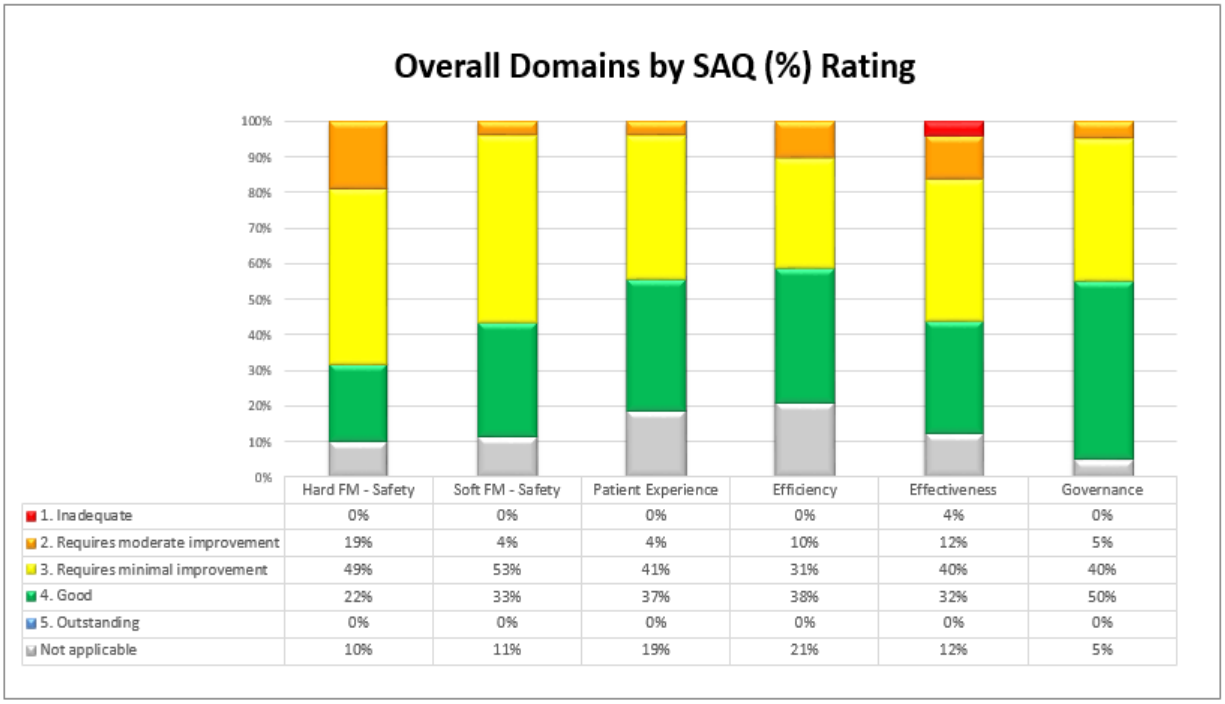


Figure 2: Overall Distribution of Self-Assessment Questions (SAQ) Ratings (%) for 2021/2022



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
1. Inadequate	0%	0%	0%	0%	4%	0%
2. Requires moderate improvement	19%	4%	4%	10%	12%	5%
3. Requires minimal improvement	49%	53%	41%	31%	40%	40%
4. Good	22%	33%	37%	38%	32%	50%
5. Outstanding	0%	0%	0%	0%	0%	0%
Not applicable	10%	11%	19%	21%	12%	5%

5. Safety Domain

The PAM Overall Distribution of SAQ Ratings for the Safety Domain in 2021/2022 has identified the Trust to be Good in 61 elements, requiring Minimal Improvement in 121 elements, requiring Moderate Improvement in 33 elements and 25 Not Applicable with no elements rated as inadequate. 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, the Domain is split into two sections; Safety Hard 'Hard FM' and Safety Soft 'Soft FM'. There have been improvements within the PAM overall Safety domain allocated scores for the reporting period with an increase in 13 Good rated elements, a decrease in requires Minimal improvement of 5 elements and a decrease in requires Moderate improvement of 7 elements resulting in overall improvement. Continual progress is being made to the majority of SAQ elements, with a solid foundation to deliver anticipated overall reductions in Moderate and minimal scores within the following 2022/2023 PAM assessment reporting year.

5.1 Safety (Hard FM)

Figure 3 presents the PAM distribution of Hard FM SAQ ratings for 2021/2022 with figure 4 providing the DBTH PAM Distribution of SAQ Ratings for 2021/2022. Table 1 provides a legend listing the Hard FM SAQ's individual elements.

Figure 3: Safety Domain Hard FM Summary Position for 2021/2022

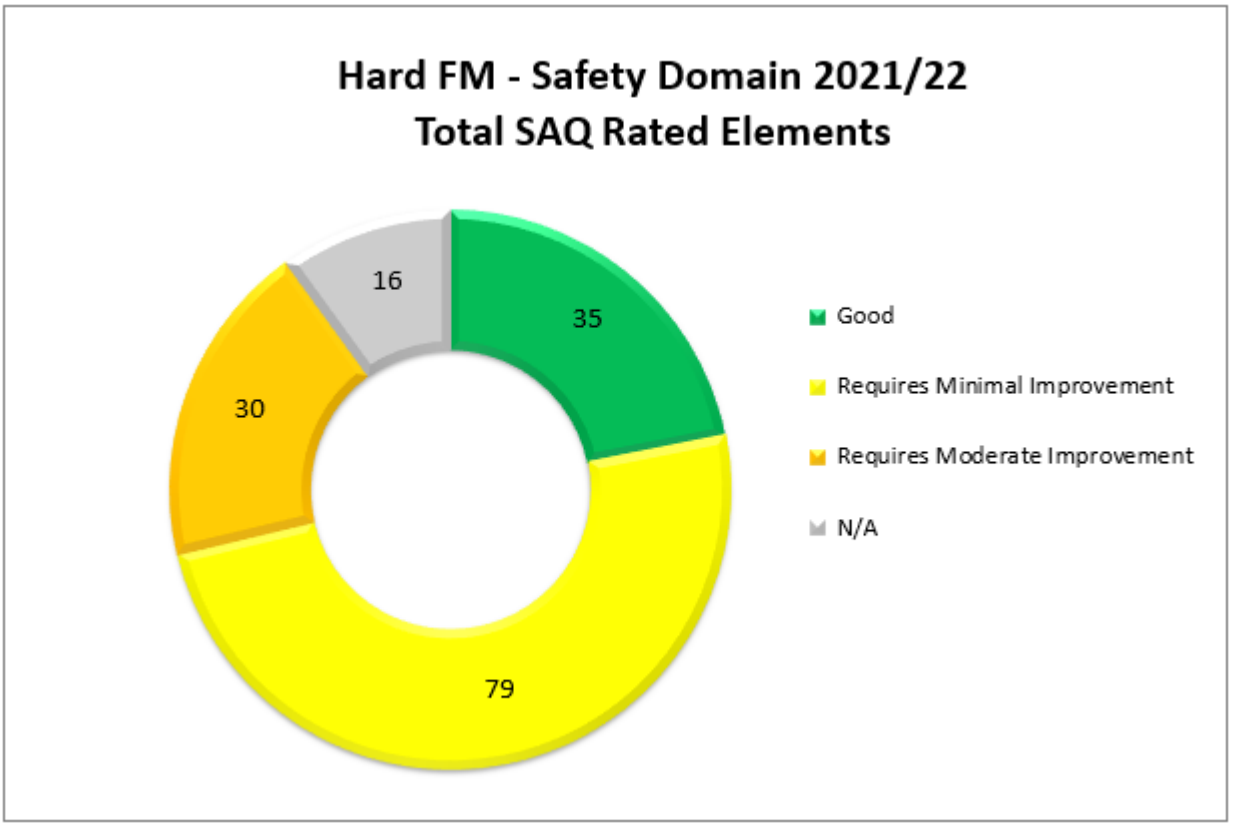


Figure 4: Distribution of SAQ Ratings (%) for Safety Hard 2021/2022

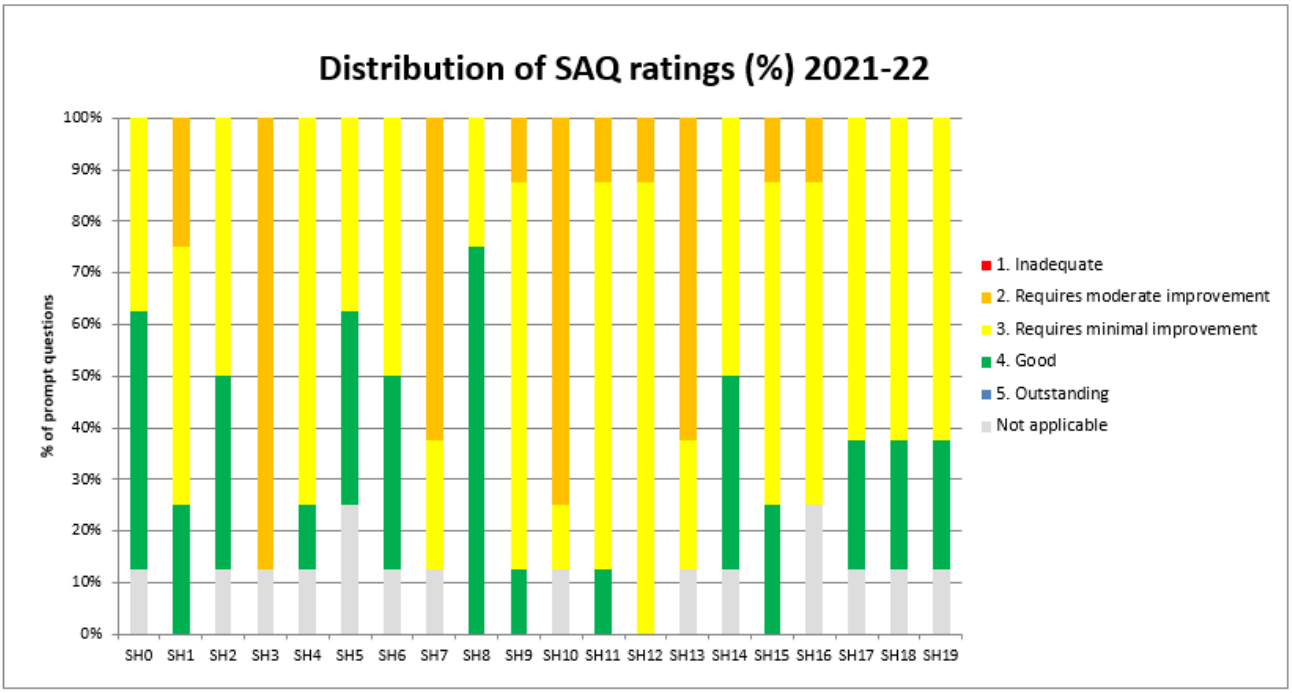


Table 1: Safety Hard FM Individual SAQ Element Legend 2021/2022

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

Continued COVID restrictions, increased audit actions by Authorising Engineers (AE's) within individual SAQ's, increased AP requirements to individual SAQ's and further updates to the latest PAM scoring matrix with regard to PPM and completion percentage rates, have slowed progress to improve the overall management processes and procedures.

The majority of elements requiring Minimal and Moderate improvement with allocated individual actions are; policies and procedures, roles and responsibilities, risk assessments, training and development and business continuity. These deficiencies will continue to be reviewed through the PAM working group process for 2022/2023, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

5.2 Safety (Soft FM)

Figure 5 presents the PAM distribution of Safety Soft SAQ ratings for 2021/2022 with figure 6 providing the DBTH PAM distribution of SAQ Ratings for 2021/2022. Table 2 provides a legend listing the Soft FM SAQ's individual elements.

Figure 5: Safety Domain Soft FM Summary Position for 2021/2022

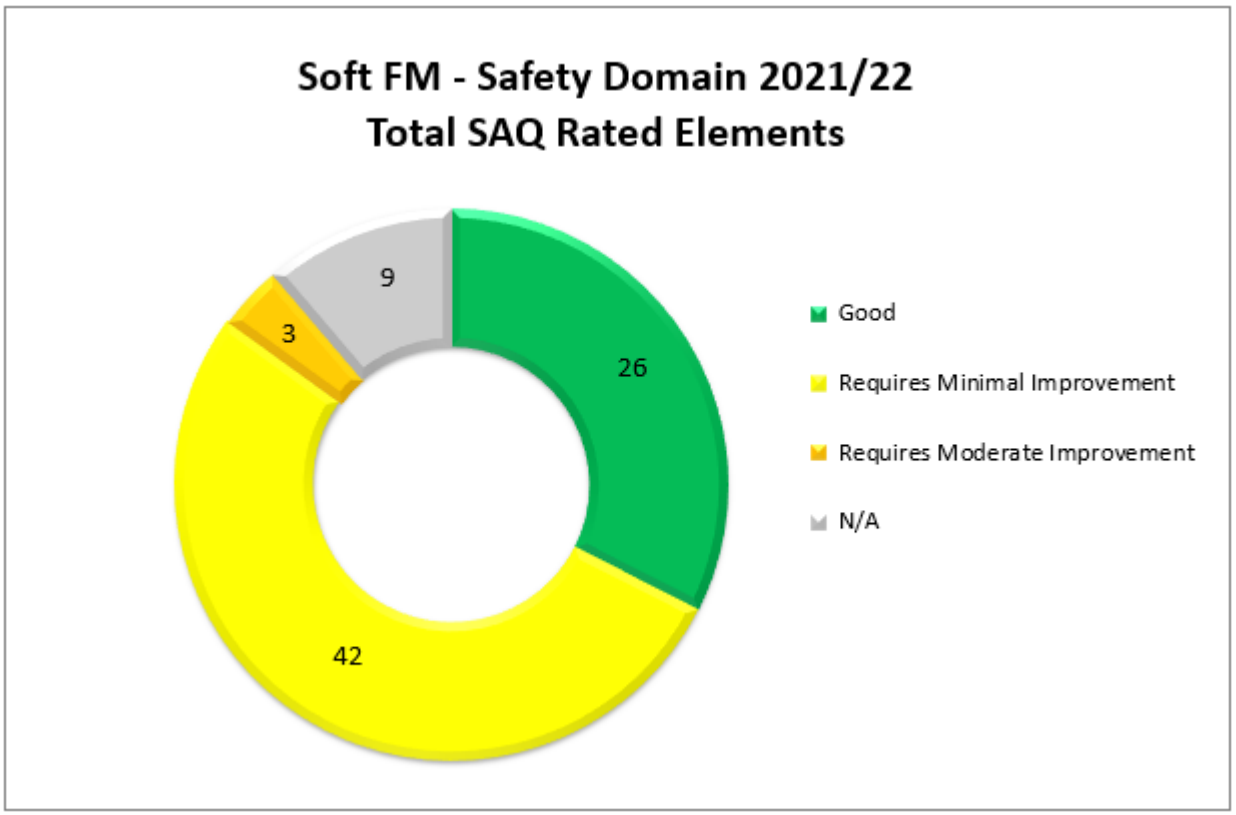


Figure 6: Distribution of SAQ Ratings (%) for Safety Soft 2021/2022

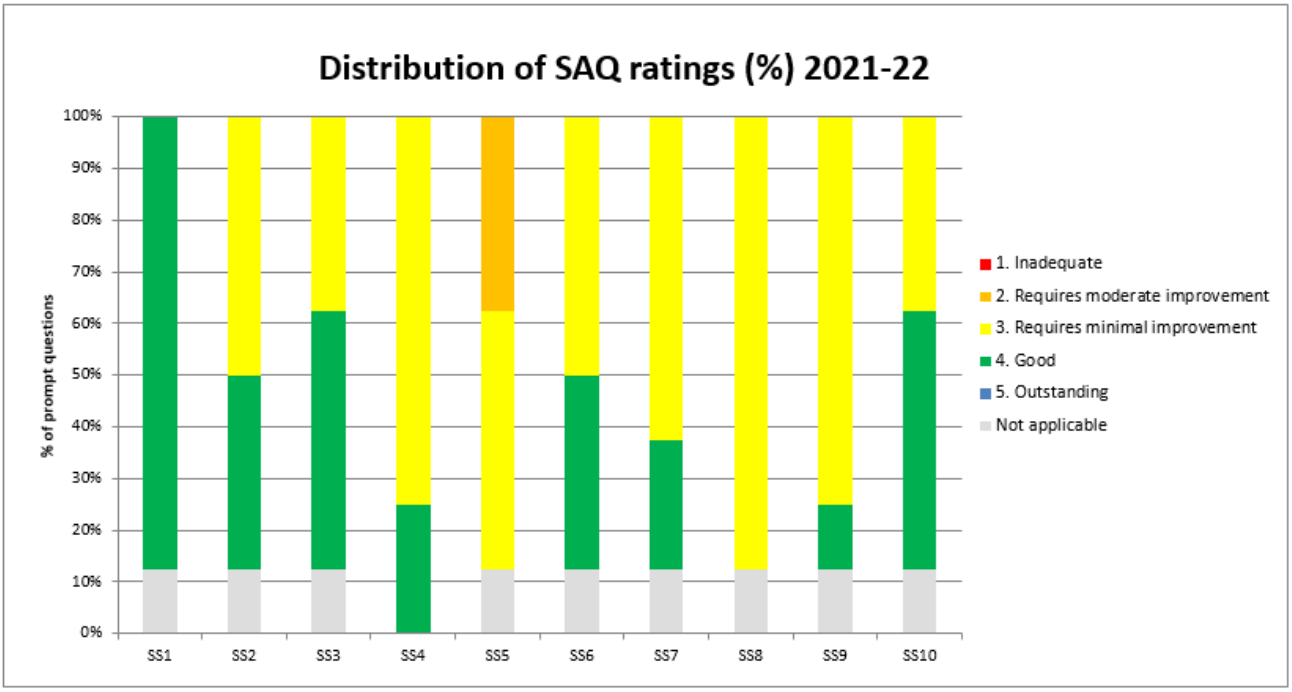


Table 2: Safety Soft FM Individual SAQ Element Legend 2021/2022

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 key Soft FM elements requiring improvement are cleaning and infection control due to the Trust not currently achieving the National Standards of Healthcare Cleanliness. The Trust has agreed a derogation and an agreed Action Plan in consultation with NHSE/I to meet the standards by March 2023. A Business Case is currently being developed to address the shortfall in recurrent funding, and workforce requirements to ensure that we meet the March deadline. The approximate Revenue Consequences to achieve compliance with the Cleaning Standards and deliver an overall good rating within PAM is identified in Table 5.

The majority of all other elements requiring Minimal and Moderate improvement within this domain reflect the Hard FM elements, with individual allocated actions to improve policies and procedures, roles and responsibilities, training and development and business continuity. These

deficiencies will continue to be reviewed through the PAM working group process for 2022/2023, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

6. Patient Experience Domain

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

The Trust PAM Patient Experience summary position is illustrated in figure 7 and shows the breakdown of the PAM SAQ score ratings for the assessment year 2021/2022 and figure 8 provides the PAM distribution of Patient Experience SAQ ratings. Table 3 provides a legend listing the Patient Experience SAQ's individual elements. 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 again by NHSE/I to suspend the full PLACE programme due to the continued 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 again requiring minimal improvement in all 4 PLACE related elements within the domain.

For the reporting period 2022/2023 PLACE is scheduled to commence with the Trust now in a position to participate. The full PLACE assessments have been arranged for week commencing the 19th September 2022 by the Trust Deputy Director of Nursing (Patient Experience) along with the E&F management team. The reintroduction of PLACE will result in an overall improvement of scores within the Patient Experience domain, reducing the scores from Minimal improvement to elements of Good.

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 2022/2023 with action plans and review dates presented to the individual responsible managers.

Figure 7: Patient Experience Domain Summary Position for 2021/2022

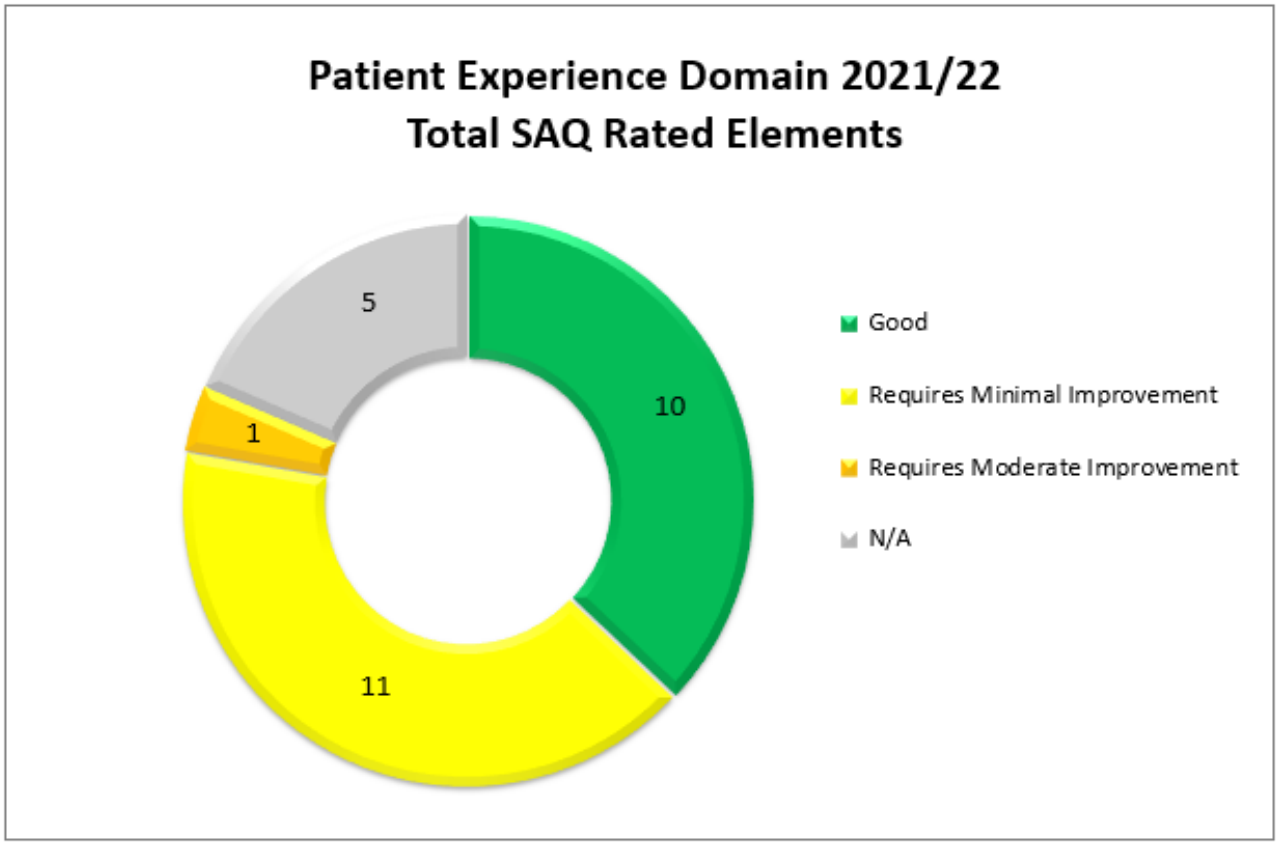


Figure 8: Distribution of SAQ Ratings (%) for Patient Experience 2021/2022

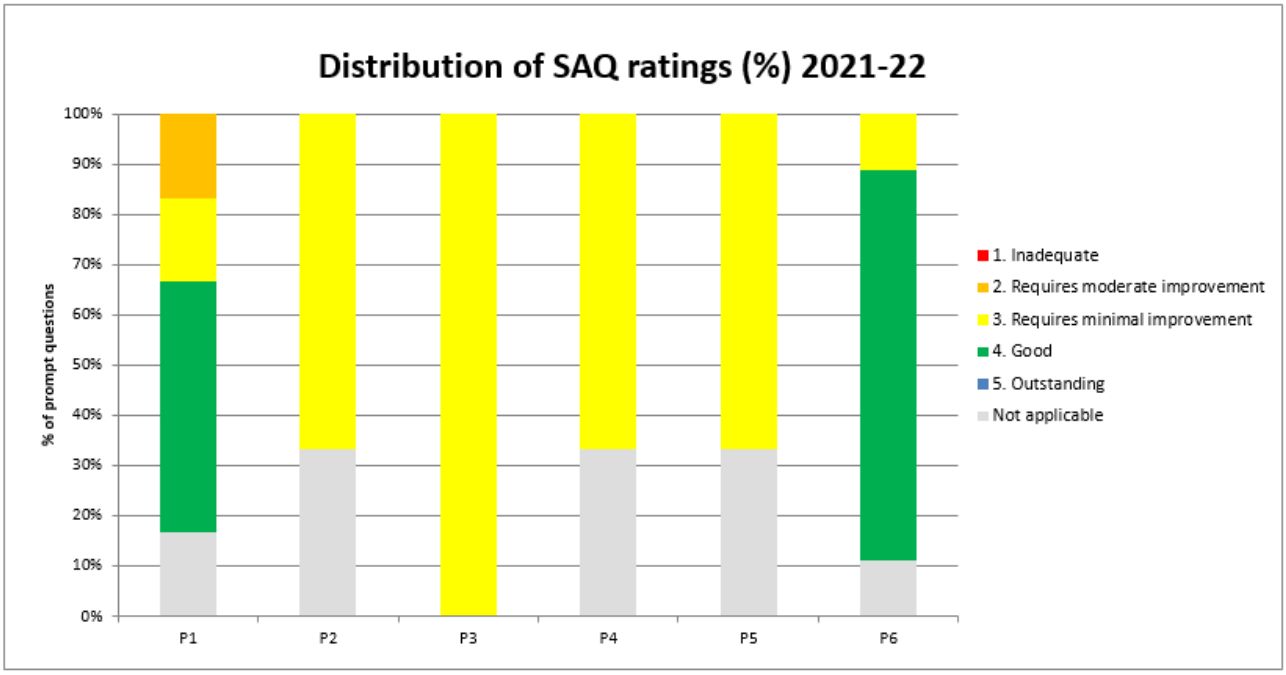


Table 3: Patient Experience Individual SAQ Element Legend 2021/2022

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. Efficiency, Effectiveness and Organisational Governance

Figure 9 presents the PAM distribution of Safety Hard SAQ ratings for 2021/2022 including the individual domain statement, with figure 10 providing the DBTH PAM Distribution of SAQ Ratings for 2021/2022. Table 4 provides a legend listing the Efficiency, Effectiveness and Organisational Governance SAQ's individual elements.

The PAM Distribution of SAQ Ratings for Efficiency, Effectiveness and Organisational Governance for 2021/2022 shows the trust to be Good in 29 elements, requiring Minimal Improvement in 27 elements, requiring Moderate Improvement in 7 elements, Inadequate in 1 element and Not Applicable in 10 elements. The evidence gained during the PAM assessment process has identified the need for Minimal and Moderate Improvement in the majority of elements within the individual PAM SAQ's, with a focus on the inadequate and requires Moderate improvement elements. All elements requiring Improvement will again be targeted within the review process of each individual domain through the PAM working group process for 2022/2023 with agreed action plans and review dates presented to individual responsible managers.

To note there are two overarching EFM Strategic objectives directly aligned to the Efficiency, Effectiveness and Organisational Governance PAM assessment SAQ action plans to deliver sustained improvement;

1. The Board approved Green Plan including 4 year strategy to improve the Trusts position with regards to sustainability, and achieve its objectives identified within the Strategy to;

    a. Develop a costed action plan for the delivery of the Green Plan over the next 4 years.
    b. Complete a climate change risk assessment.
    c. Work in conjunction with EPRR team to develop adaptation plans to mitigate the risks associated with a changing climate.

d. Implement Green Shared Governance Groups to achieve progress against priorities for FY22/23 identified within DBTH's and the ICS Green Plan.
e. Develop a decarbonisation strategy for DBTH explaining how the organisation will move away from the use of fossil fuels on the lead up to 2045.

2. Development and implementation of an EFM staff engagement plan aligned to the NHSE/I Estates and Facilities Workforce Action Plan for 2022. The EFM team have identified a need for improved staff engagement within their business plan for FY22/23 following the PAM assessment process and responses from the annual staff survey. This includes the formulation and implementation of an action plan to improve all elements identified as requires Moderate or Minimal improvement. As part of the monthly EFM senior management team strategy workshops a draft EFM Charter is being produced in conjunction with a dedicated EFM mission statement aligned to the Trust vision and mission.

   The staff engagement action plan priorities FY22/23 are built around the NHSE/I EFM priorities and nine key actions raised from the workforce action plan and focusing on the following key themes;

   a. Improving the health and wellbeing of the EFM staff, with a focus on driving improvements in mental health and wellbeing
   b. Strengthening the compassionate and inclusive culture the Trust need to enable delivery of the best possible patient outcomes.
   c. Develop and invest in the EFM workforce, future proofing skills and developing managers.
   d. Embed equality, diversity and inclusion making EFM an inclusive place to work
   e. Build the next generation of EFM people and become the local workforce area employer of choice.

Figure 9: Overall Summary Position - Efficiency, Effectiveness, Organisational Governance 2021/2022

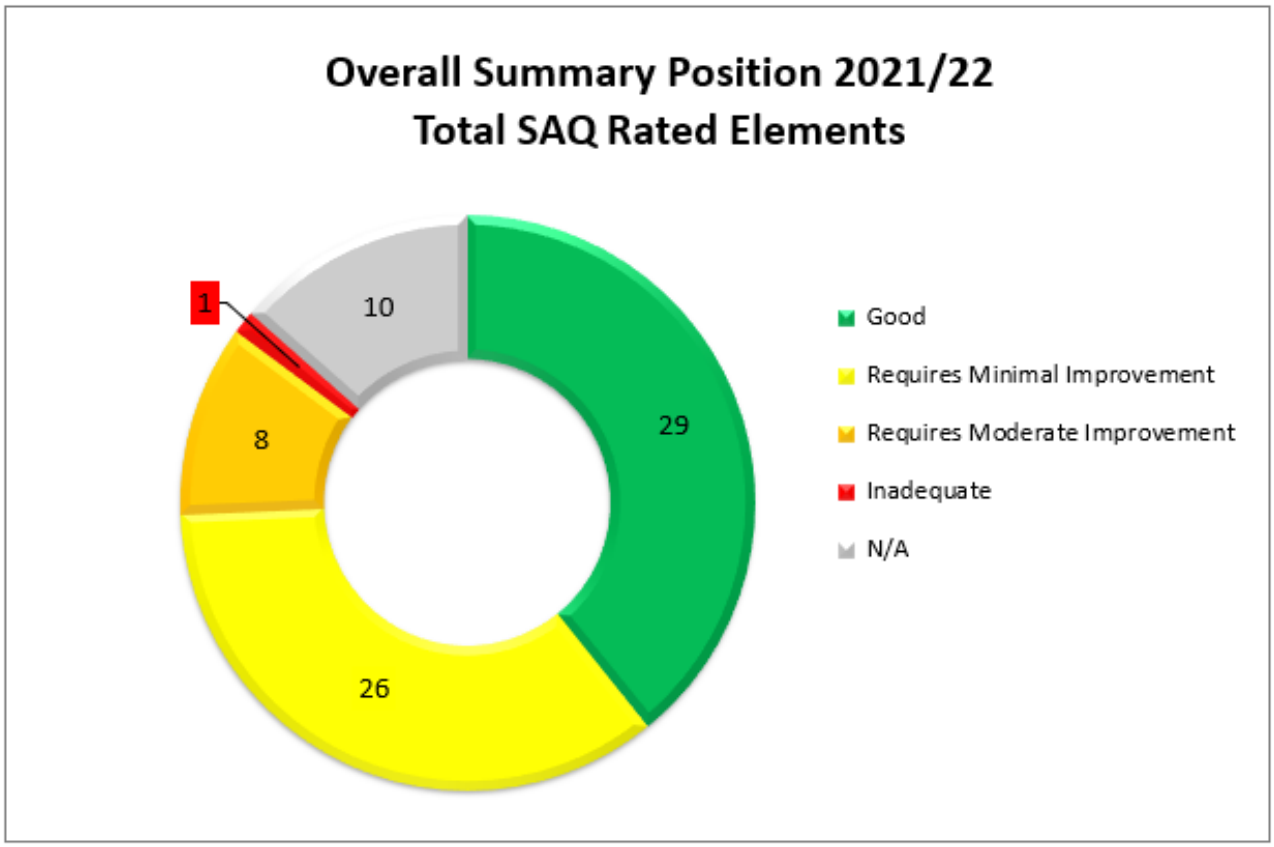
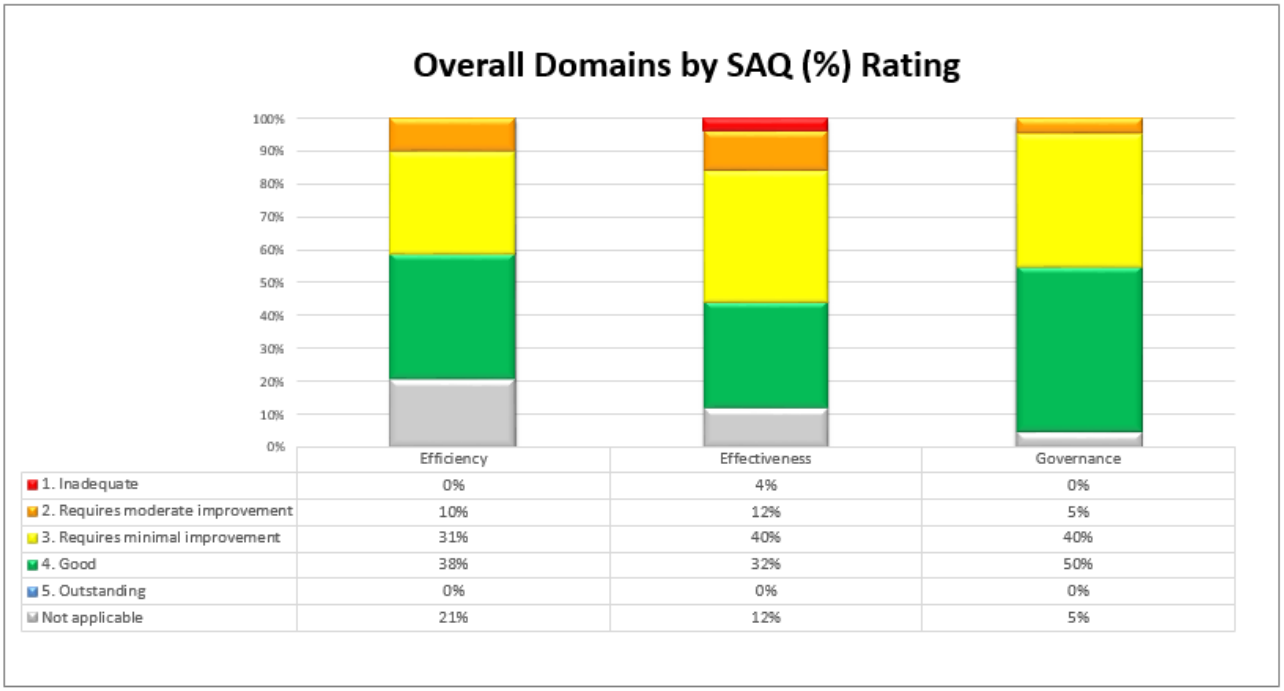


Figure 10: Overall Distribution of SAQ Ratings (%) for Efficiency, Effectiveness, Organisational Governance 2021/2022



	Efficiency	Effectiveness	Governance
1. Inadequate	0%	4%	0%
2. Requires moderate improvement	10%	12%	5%
3. Requires minimal improvement	31%	40%	40%
4. Good	38%	32%	50%
5. Outstanding	0%	0%	0%
Not applicable	21%	12%	5%

Table 4: Efficiency, Effectiveness and Organisational Governance SAQ Element Legend 2021/2022

Legend	
SAQ Code	**Self-Assessment Question –Efficiency**
F1	With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation provide evidence?
F2	With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation provide evidence?
F3	With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation provide evidence?
F4	With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation provide evidence?
F5	With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation provide evidence?
SAQ Code	**Self-Assessment Question –Effectiveness**
E1	With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation provide evidence?
E2	With regard to having a well-managed approach to town planning can the organisation provide evidence?
E3	With regard to having a well-managed robust approach to management of land and property can the organisation provide evidence?
E4	With regard to having a well-managed annually updated board approved sustainable development management plan can the organisation provide evidence?
SAQ Code	**Self-Assessment Question –Organisational Governance**
G1	With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation provide evidence?
G2	With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation provide evidence?
G3	With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation Provide evidence?

10. Capital Costs for Compliance and Revenue Consequences

Capital Costs for Compliance associated with SH1 Operational Management (maintenance SAQ element) have been identified through the annual 6 facet survey undertaken by external surveying consultancy Oakleaf. Costs associated with annual Backlog maintenance figure reported through the ERIC returns is provided in table 5 as requested by NHSE/I 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 a new H&S responsible person training and development programme linked to the organisations vision, values and objectives, aligned to actions 12 and 13 of the Granger report recommendations and documented at the Trust Health and Safety Committee and QI H&S Management System review project is identified in table 5.

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 in the number of AP's and CP's required to deliver a good rating in all maintenance SAQ element fields is provided in table 6. This information is extracted from the Estates Workforce Review Business case produced in (2019), more concise data will be provided for the 2022/2023 annual PAM review report from the current Asset capture surveys. The Asset Capture has been commissioned following approval of the 7 point plan to review the Trust's maintenance strategy in line with the guidance provided in BS8210:2020 'Facilities Maintenance Management – A Code of Practice'.

Revenue consequences (costs) associated with delivery of the proposed Medical Technical Services Department Labour Force Re-structuring Business case (2021) and associated entry on the Trust Risk Register (E&F 2335) are provided in table 5.

Revenue consequences (costs) associated with the agreed action plan with NHSE/I and the Trust to meet the current National Standards of Healthcare Cleanliness 2021 across all Trust sites, with a completion date of the end March 2023 is also included in table 5. This figure indicates the approximate recurrent budget requirements to provide the workforce establishment, structure and equipment to meet the agreed March 2023 deadline.

Table 5: Capital Costs for Compliance and Revenue Consequence 2021/2022

SAQ	Capital Cost for Compliance	
SH1: E&F Operational Management	Trust Backlog Maintenance (For information Only)	£149,930,048
SH4: H&S at Work	Health and Safety Developmental Management Training	Approximately £35,000
SAQ	**Revenue Consequence**	
SH1: E&F Operational Management	Estates Workforce Review	Approximately £300,000
SH1: E&F Operational Management	Medical technical Services Department Labour Force Re-structuring	£120,000
SH8: Water Safety	Water Safety Healthcare Technician Training	£19,000
SH9: Electrical Systems	Electrical Low Voltage (LV) Approved Person (AP) and Competent Person Training (CP)	£19,000
SH11: Ventilation, Air Conditioning and Refrigeration Systems	CP Heating, Ventilation and Air Conditioning (HVAC) training (HTM03)	£18,000
SH12: Lifts, Hoists and Conveyance Systems	Passenger Lift Training	£14,000
SS4: Cleanliness and Infection Control	Compliance with NHS Cleaning Standards	Approximately £1Million

11. Conclusion and Recommendations

The report has explained the PAM assessment process and information from the PAM assessment working groups for 2020/2021 for all five mandated domains; including Safety, Patient Experience, Efficiency, Effectiveness and Organisational Governance, and provides an overall Summary Position to provide assurance to the Board on a consistent basis.

The report has identified improvements within the PAM overall Safety domain scores with an increase in 13 Good rated elements, a decrease in requires Minimal improvement of 5 elements and a decrease in requires Moderate improvement of 7 elements, this has resulted in overall improvement within this domain from the 2020/2021 PAM assessment.

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 the full PLACE assessments which have been arranged for week commencing the 19th September 2022 by the Trust Deputy Director of Nursing (Patient Experience) along with the E&F management team.

The report has also explained the positive work EFM Senior management team have been undertaking with the EFM Strategic objectives directly aligning to the Efficiency, Effectiveness and Organisational Governance PAM assessment SAQ action plans. The intention to deliver sustained improvement for the following reporting year through the Board approved Green Plan and associated 4 year strategy to improve the Trusts position with regards to sustainability. The proposal to develop and implement an EFM staff engagement plan aligned to the NHSE/I Estates and Facilities Workforce Action Plan for 2022.

The report has identified the Capital Costs for Compliance associated with the Health and Safety at Work SAQ and the requirement for a new H&S responsible person and a management training and development programme aligned to the organisations vision, values and objectives, directly linked to actions 12 and 13 of the Granger report recommendations explained in detail.

Revenue consequences associated with the required completion rate for scheduled PPM against SFG 20 and the Estates and Medical Technical Services Workforce Review, and an agreed action plan with NHSE/I and the Trust to meet the current National Standards of Healthcare Cleanliness 2021 across all Trust sites, with a completion date agreed for the end March 2023.

Finally, to note; due the continued COVID-19 Pandemic experienced towards the end of 2021, reduced staffing levels and available resource directly affected the ability to complete a number of identified actions, resulting in limited progress in the overall PAM continual improvement process. Foundations are now firmly in place to deliver improvements in all domain SAQ's scoring that requires moderate and minimal improvement for the following 2022/2023 years PAM assessment.

8. Appendices - Appendix 1: Premises Assurance Visual Dashboard Summary – Safety 2021/2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | DBTH Policies | Scoring Criteria

NHS PAM-Safety-Hard & Soft FM Summary

Jul-22

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

Progress: Up | Down | No Movement | Not Applicable

Safety Domain (Combined Soft and Hard FM) Links below to Evidence >>>		SAQ/Prompt Questions 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	KPI Target % Target	Stretch Target	Actual %	Present Status/Performance Overall (100 / Equal to/ ≥80 / Equal to/ ≥60 / Equal to/ ≥40 / <20)		CareQuality Commission Key Lines of Enquiry: Safe	Effective	Caring	Responsive	Well-Led	Action Log/Progress Link >>	Commentary
SH0	Windows								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	60	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	69	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	63	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	70	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	75	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	60	Req's Minimal 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	60	Req's Minimal Improvement							
SH12	Lifts, Hoists and Conveyance Systems									80	100	58	Req's Moderate Improvement				✓			
SH13	Pressure Systems								N/A	80	100	46	Req's Moderate Improvement							
SH14	Fire Safety								N/A	80	100	69	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	63	Req's Minimal Improvement			✓				
SH16	Resilience, Emergency and Business Continuity Planning						N/A		N/A	80	100	57	Req's Moderate 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	66	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	69	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. Contract extended .
SS4	Cleanliness and Infection Control									80	100	74	Req's Minimal Improvement			✓				Cleaning standards monitored and managed through the E&F CAFM System Micad - MICAC
SS5	Laundry Services and Linen									80	100	51	Req's Moderate Improvement			✓				Linen and Laundry currently outsourced through external contract to Synergy.Contract extended.
SS6	Security Management								N/A	80	100	69	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	60	Req's Minimal Improvement							Pest control contract for all Trust premises with current provider Enserve. Information obtained in Estates and Facilities office DRI Room DR29L02R0012.
SS9	Portering Services								N/A	80	100	63	Req's Minimal Improvement			✓				Monitored and managed through the E&F CAFM System Tele-Tracking

Link to:- NHS Premises Assurance Model - SAQ

Appendix 2: Premises Assurance Visual Dashboard Summary – Patient Experience 2021/2022

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Front Screen | Scoring Criteria | DBTH Policies

NHS PAM-Patient Experience Summary

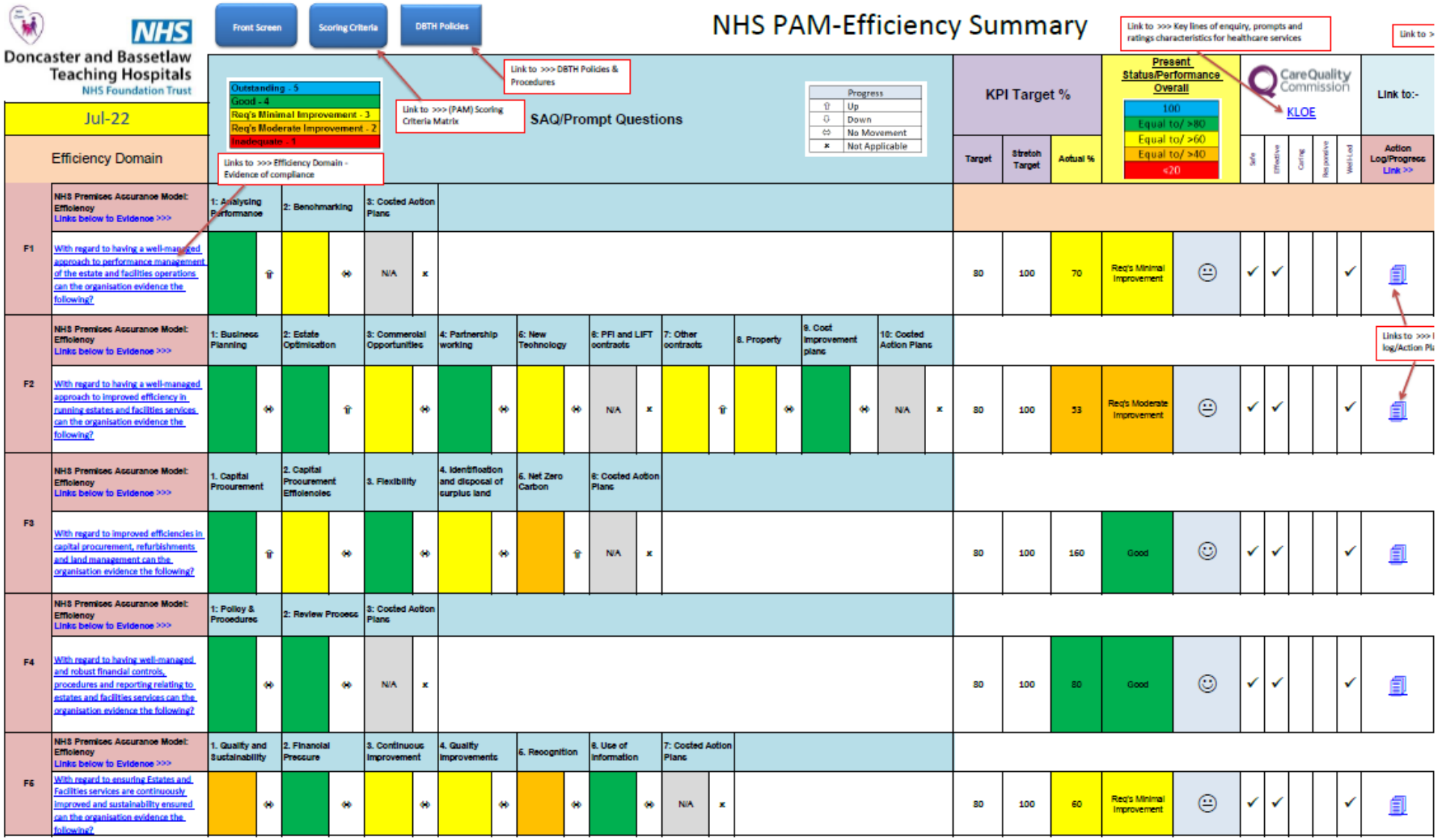
Jul-22

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

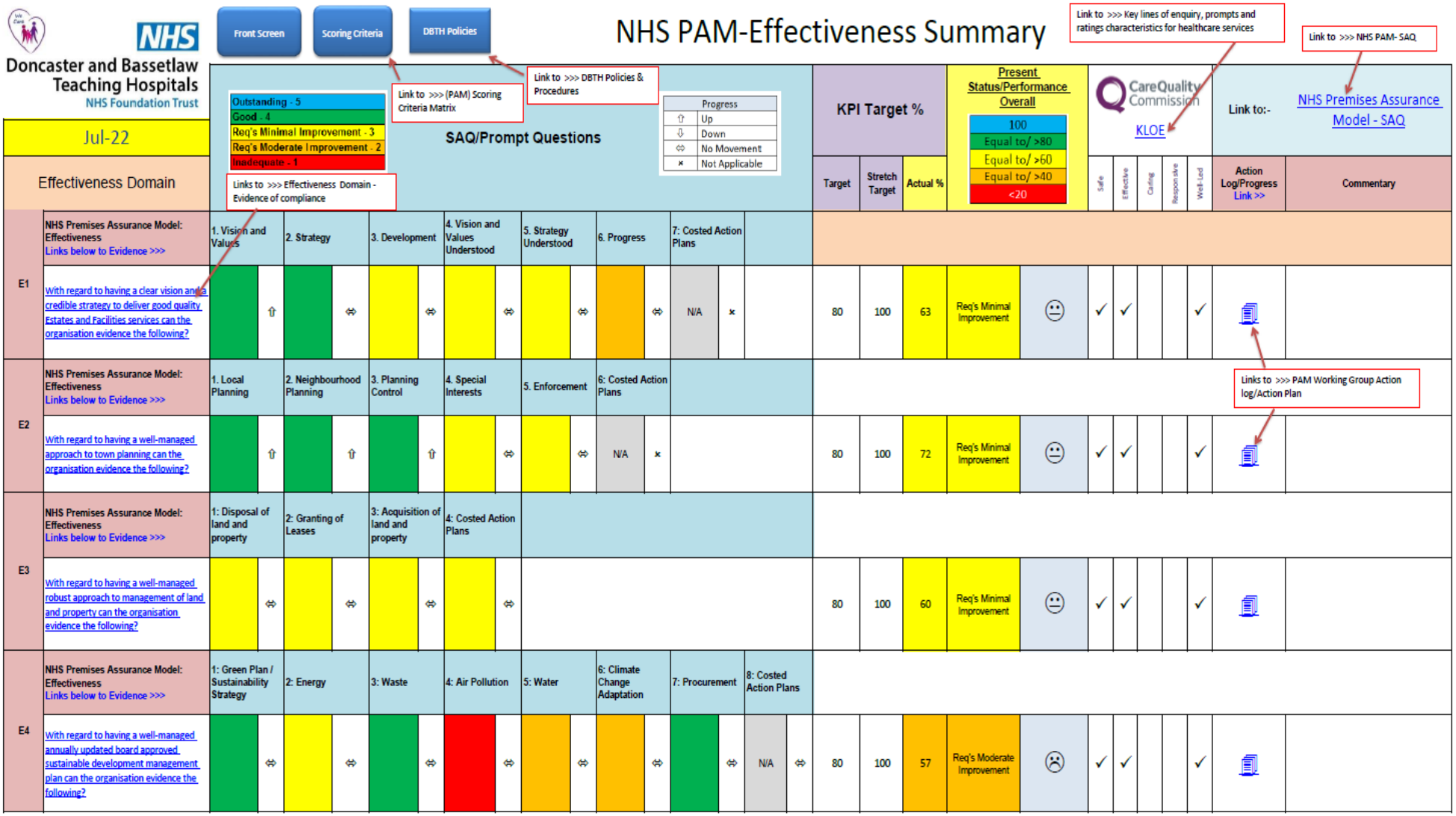
Progress: Up | Down | No Movement | Not Applicable

Patient Experience Domain		SAQ/Prompt Questions	KPI Target % Target	Stretch Target	Actual %	Present Status/Performance Overall	CQC KLOE: Safe	Effective	Caring	Responsive	Well-Led	Link to:- Action Log/Progress Link >>
		100 Equal to/ >80 Equal to/ >60 Equal to/ >40 <20										
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	60	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	✓		✓		✓	

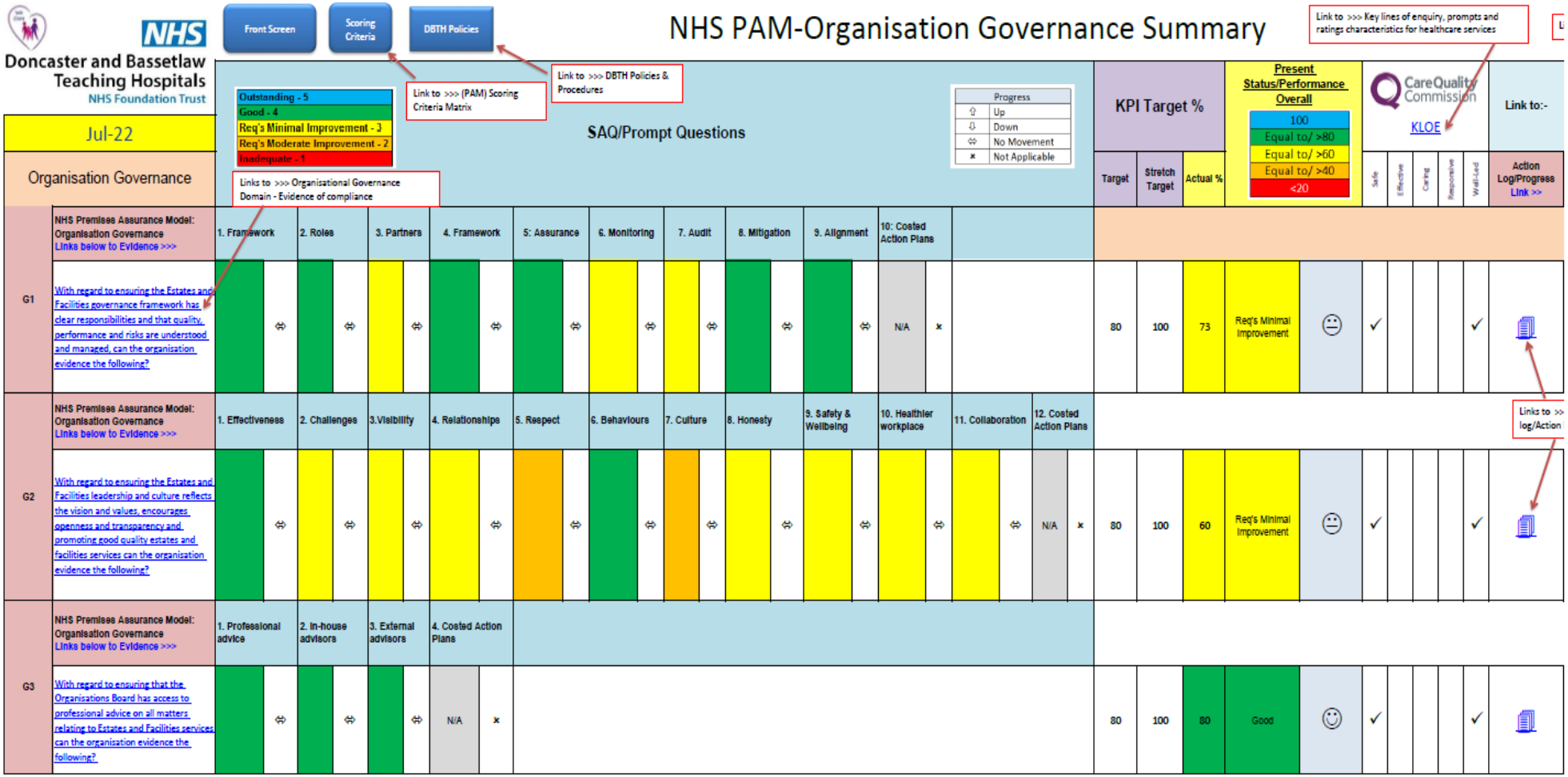
Appendix 3: Premises Assurance Visual Dashboard Summary – Efficiency 2021/2022

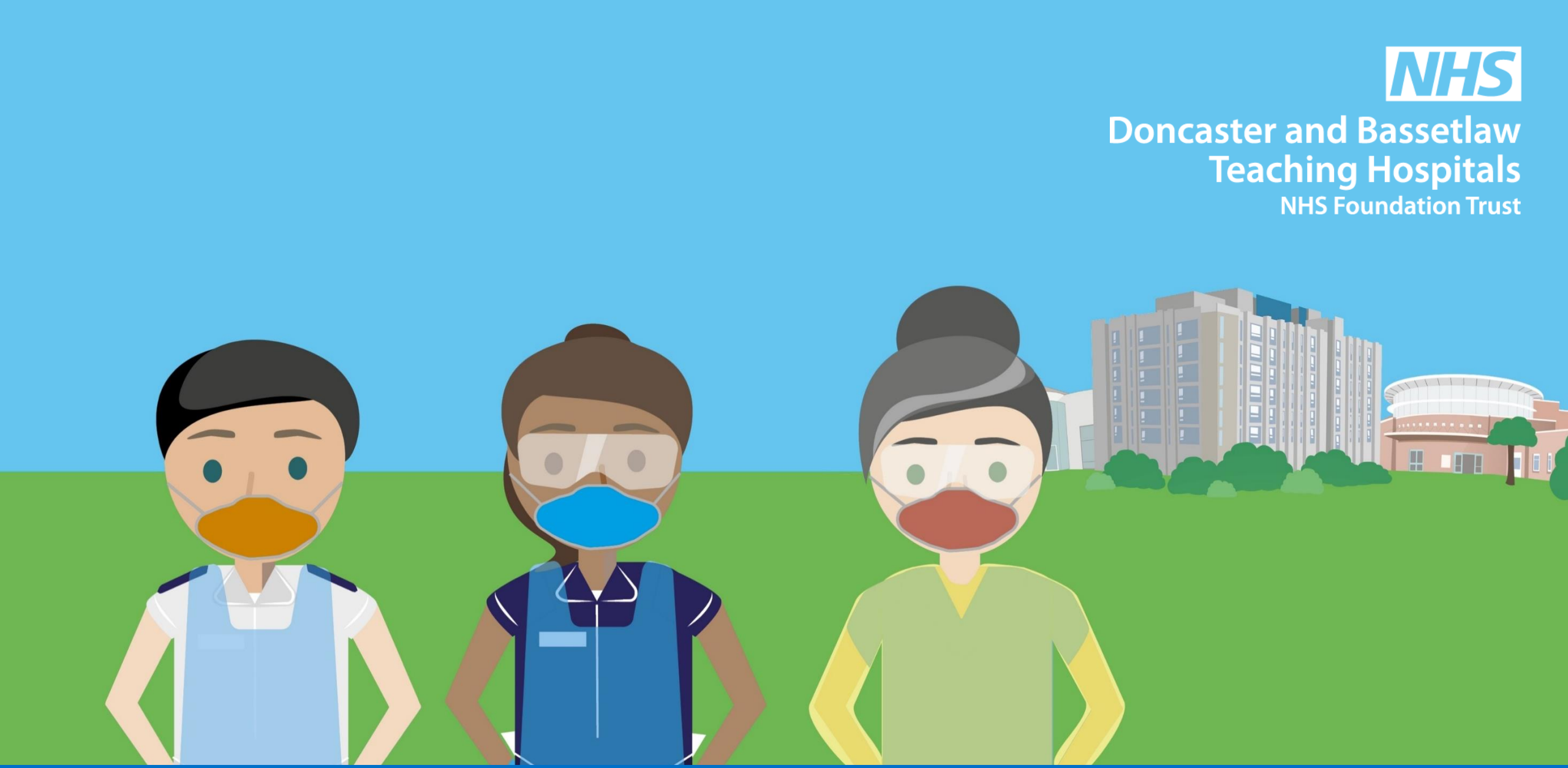


Appendix 4: Premises Assurance Visual Dashboard Summary – Effectiveness 2021/2022



Appendix 5: Premises Assurance Visual Dashboard Summary – Organisational Governance 2021/2022





Operational Plan Update - data as at 4 July 2022

Today

- Operational trends – where are we now
- Operating Plan – Summary & Priorities

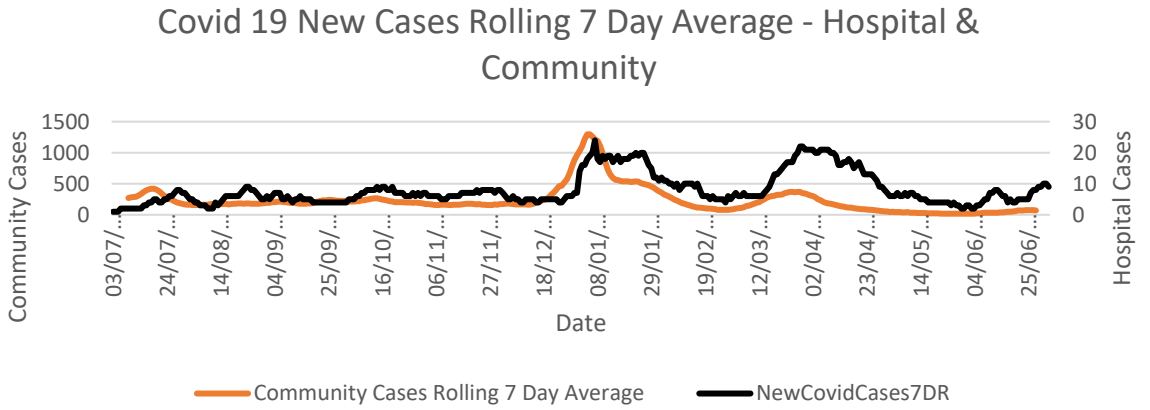
C19 Infection & Admission

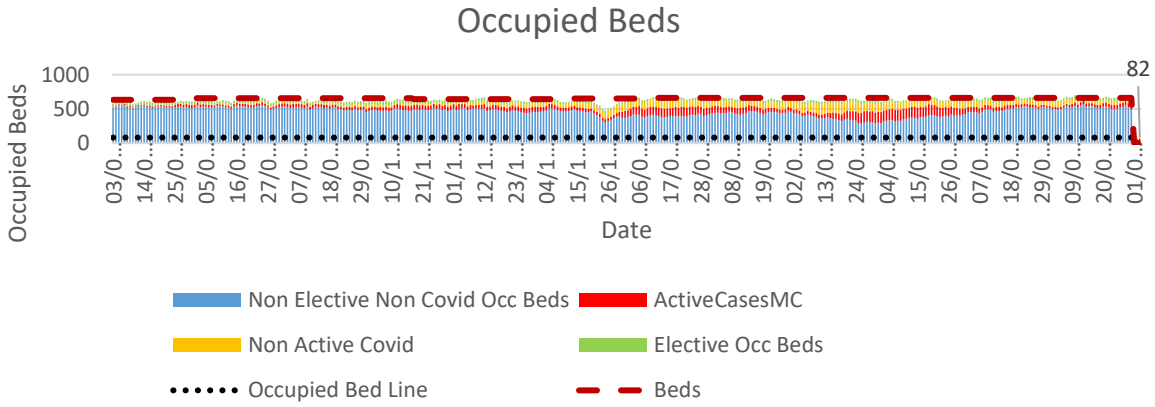
- COVID numbers reduced from mid Jan 22

- Total COVID occupancy 115
- Active case occupancy 87

- Threat from COVID rising again through June.

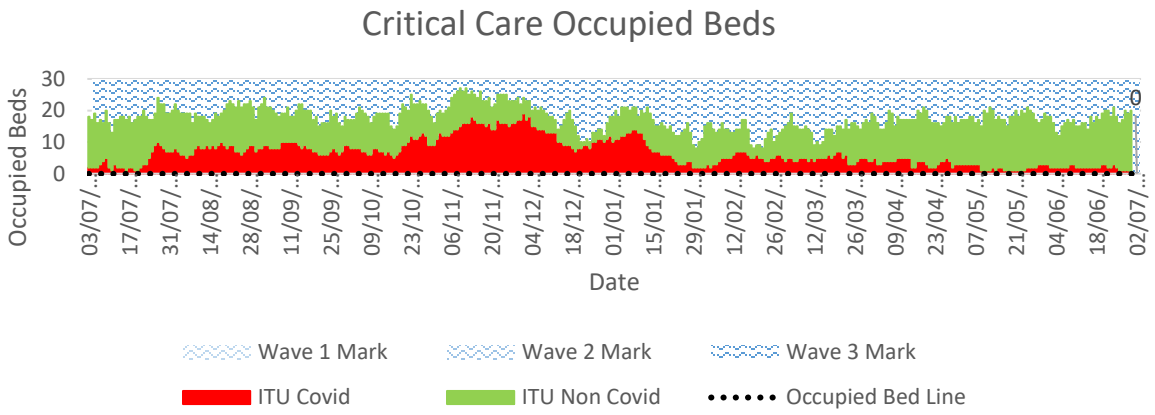
- Overall occupancy c 96%. Running at particularly high level of occupancy





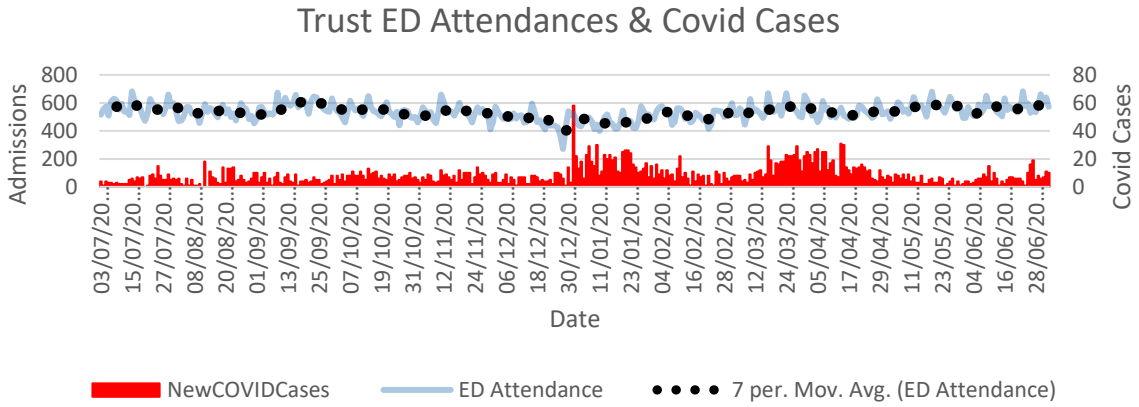
Critical Care

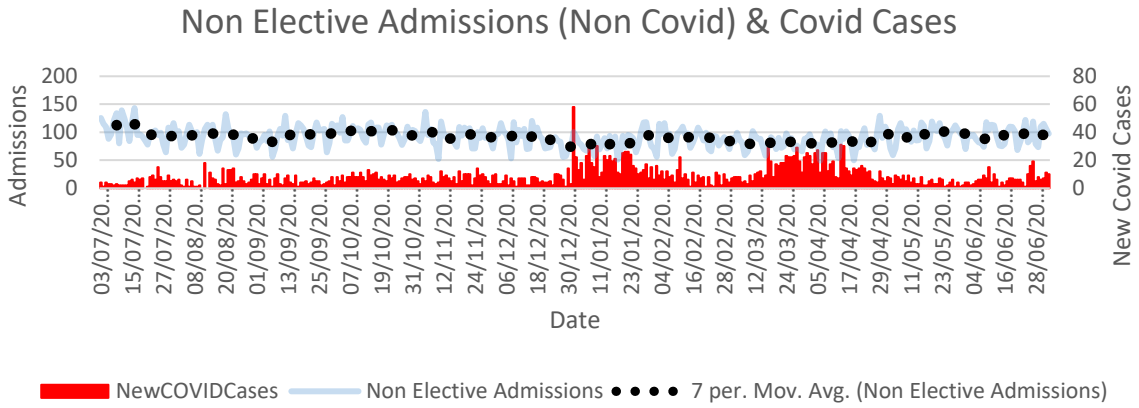
- Critical care occupancy reduced. COVID causing less critical care admissions.
- Elective activity has been cancelled due to flow out of Critical Care this has improved slowly.
- Ward 22 used for additional medical beds as per winter plan.



Emergency Flow

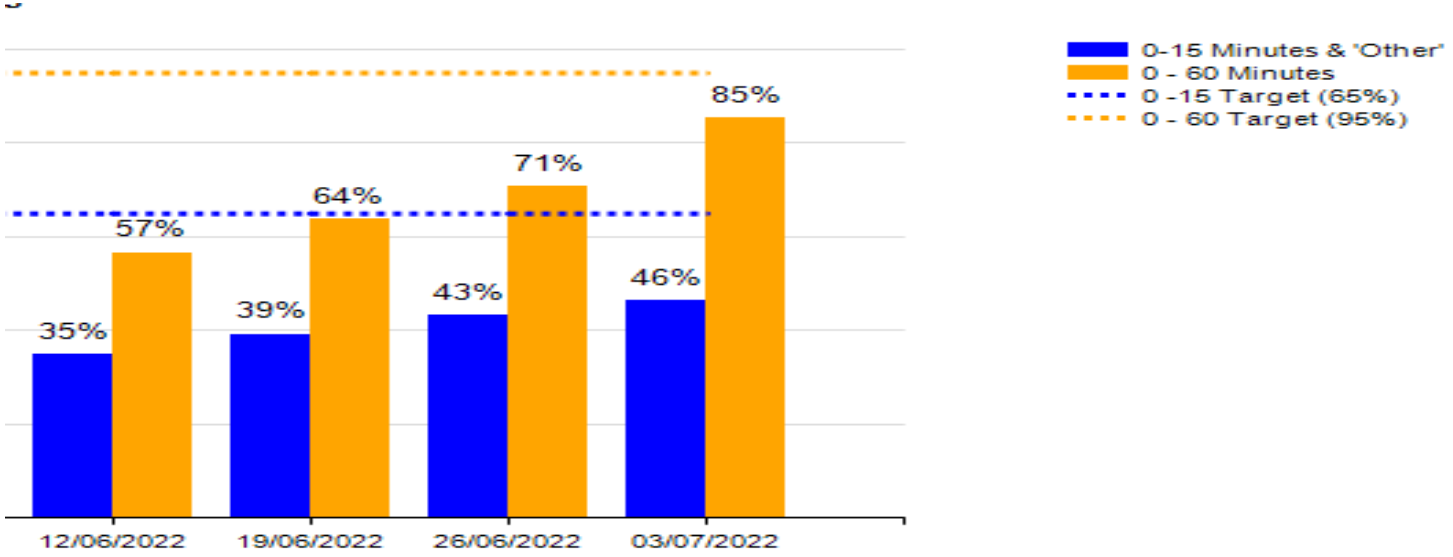
- Increased ED attendance both walk in and Ambulance conveniences.
- Acute Medical Delivery Unit (AMDU) open at the front door staffed by Acute Physicians. Focus on increasing avoiding admission.
- Post Real World work to reduce “Long length of stay” & SAFER, R2G implementation on wards improving Emergency Flow. Now handed back to the ops teams
- Focus on Ambulance Handovers with partners, especially at Doncaster.
- Ambulances ability to refer straight to SDEC being developed as part of the combined SEDC project.





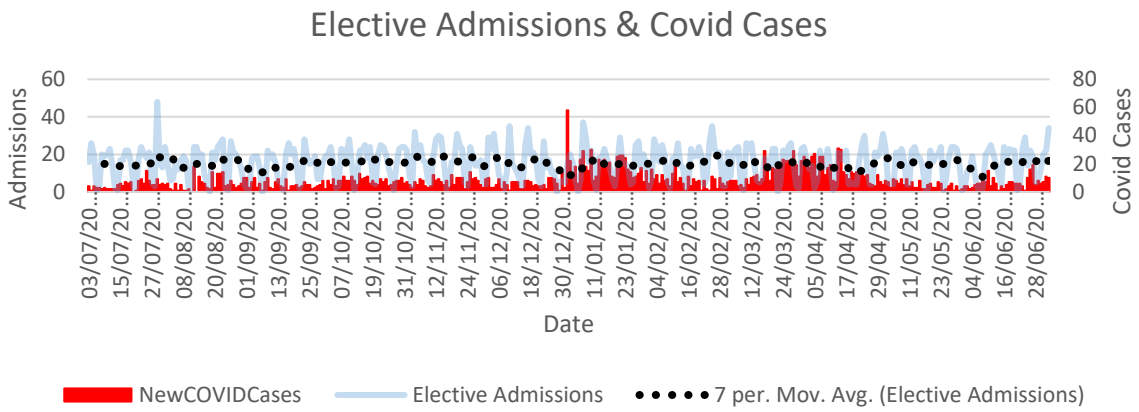
Work on Handovers throughout the EAU PDSA cycle in June has shown improvements despite this being early days the team are continuing with the pilot

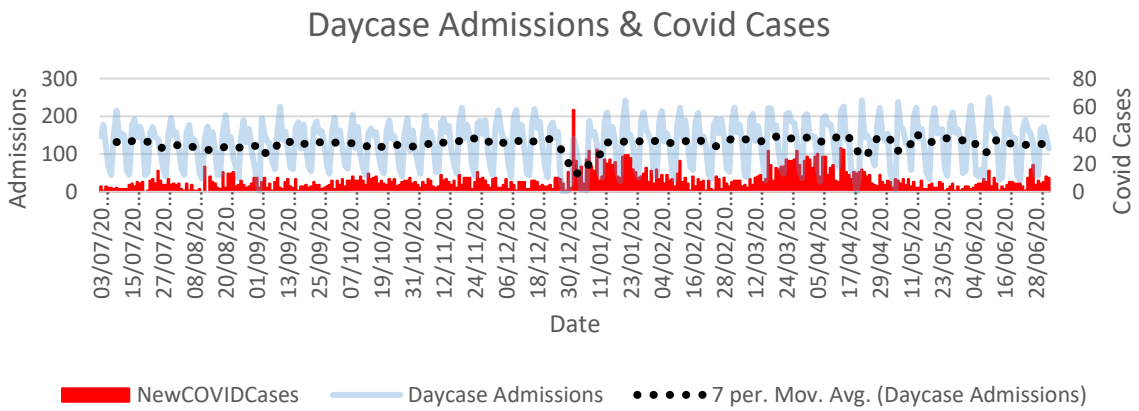
YAS have agreed a co-horting policy live from 11th July



Elective

- Continued to provide all P1 & P2 elective activity. Schedule long waiting patients onto lists
- Total PTL at 46,428 June 22 target <43,125
- RTT Incomplete Performance was 70% at beginning of Dec
    - Using the Value Weighted Activity corresponding to 2019/20 DBTH is at 84.8% May Latest un-validated position is 81.8%
- 52 week wait position at 1369 12th June 22 (1175 at end of February 22)
- PIFU across 5 specialties now (target 5 or more) and rolling out across 5 more, national bid submitted for digital PIFU support submitted
- Good performance against cancer standards
- Zero 104 ww patients by end March maintained
- Initially plan to return to full theatre timetable from May/ June
- Our A&G (advice and Guidance) is increasing exponentially we are working through what that will look like and whether it will effect our EFR





Radiology

MRI

- Investment in Accelerator Schemes – 3 fixed assets plus 2 mobile vans now on site
    - Montague
- Zero waiting list by year end (based on current demand) Reduced demand supporting recovery

Non Obstetric Ultrasound

- Additional sessions in in place from AQPs, sonographers and radiologists/agency to create additional capacity
    - New radiologist
    - Insourcing
- Waiting list will show a 50% reduction from its highest level

CT

- Additional capacity in March onwards and for the next 3 months
- Additional CDC capacity to support delivery and reduction in waiting list going forwards

DM01 will be achieved March 23

Elective Program:- Next Steps 22/23

- Increase in elective surgical bed base to regain 18 elective beds on Ward 19 (12 then 18)
  - Create a ring-fenced 12 bedded elective hub for orthopaedics in the modular ward
  - Dedicated use of the modular theatre (co-located next to modular ward) to support orthopaedic recovery
- Incorporate outsourcing into recovery plan and front load contracted IS activity into the first 6 months of the year, such that this can be extended if funding allows
  - IS activity is below plan
- Re-introduction of Recovery Board to bring together theatres, anaesthetics and surgery into a single programme of work to support recovery
- Review recommendations from KPMG consider all opportunities to maximise throughput for 22/23
- Significant delays with progress on particular schemes
- Feb discussions re the need for enhanced rates. BMA have recommended some rates
- Implement these will support additional lists and activity
- Pilot in T&O re additional activity
- We are 3-4 months behind plan.
- Consistency of message/approach via POSSM and Elective recovery Board .

Winter Plan / Omicron Surge Plan

- COVID related staffing issues ongoing expect continual surges throughout the winter.
- Impact on community & hospital capacity.
- DCOO meetings shore up partner actions especially
  - additional home care capacity
  - additional 5 beds on Hazel / Hawthorne
  - Improved hospice pathways
- OPEL Escalation framework & partnership arrangements in place.
- Super Surge Plan for COVID worked up with triggers developed for exceptional actions.
- Additional beds on ward 22?
- Reduce long length of stay and no right to reside

Overall Operational Plan – Next Steps

- Build on **urgent and emergency care improvement plan**
- Significant focus on **ambulance handovers** in line with NHS E/I requirement
- Continue focus on **“hotspots”** to improve performance
- **Progress on elective new standards** and focus on key risk areas

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	**E5**
Report Title:	**INTEGRATED QUALITY & PERFORMANCE REPORT (IQPR) / Performance Exception Report (June 2022)**		
Sponsor:	*George Briggs,Interim Chief Operating Officer* *Gill Marsden, Deputy Chief Operating Officer (Elective)*		
Author:	*Laura Fawcett-Hall, Head of Performance*		
Appendices:			
Purpose of report:	The overall integrated performance report aims to: • Deliver an executive summary – summarising the operational context, performance headlines and the forward plan. • Share the full performance metrics through the IQPR at a glance charts. • Provide the full Performance Exception report for the headline metrics.		
Summary of key issues:	**1. <u>Operational Context – Headlines of Data Trend Analysis</u>** a. Covid patients have continued to affect flow through the organisation due to infection control measures in June 2022 b. Staff absence due to Covid 19 continued to cause significant pressure during June 2022 which has impacted on service delivery in all areas. c. ED attendance levels remain higher than previous 4 years with the majority of the increase in the minors pathway d. In common with all Trusts, emergency demand and staffing pressures have impacted on elective delivery, however, the Trust maintained a programme of elective work through June 2022. e. The performance report for June 2022 is presented in this operational context. **2. <u>Headlines from Integrated Performance Report (June 2022)</u>** *Emergency* a. **4 Hour Access** – in June 2022 the Trust delivered 70.08% achievement against national target of 95%, which was is a slight improvement from the May 2022 position of 69.97%. Performance for the month benchmarks "in the pack" across Northeast and Yorkshire. A wide-ranging action plan is in place. b. **12 Hour Waits -** The Trust are reporting 277 12-hour trolley breaches in June 2022. The Trust continues to experience patient flow challenges 205 at DRI and 72 BDGH. An increase from May 104 at DRI and 44 at BDGH The Trust are reporting 3.9% (663) 12 hour waits from time of arrival. c. **Ambulance Delays -** There are continued challenges on the Doncaster site and a full action plan has been developed to address this quality issue for patients with support from NHSE / ICS. An exception report is provided & the Trust remains an outlier although an improving position is showing. d. **Emergency Care Bundle –** The new standards are now live and being reported. e. **Length of Stay** Focused work to reduce LoS has started for both elective and non-elective admissions. A partnership patient focused Wednesday Walkaround continues with focus on patients with a 7 day + length of stay ensuring all patients have a discharge plan in place.		

	Red to Green roll out continues with an improving data capture showing reason codes, supporting improved discharge processes. Partnership working continues twice daily to review patients who no longer have a right to reside. Additionally, partnership working to develop Transfer of Care Hubs and a discharge to assess model of care. *Elective* a. **Activity** - Overall, the Trust was not on plan for June 2022 and had lower activity levels compared to 19/20 – (91.6% of 19/20 day case activity, 84.8% of IP activity, of 89.4% new outpatients and 84.6%of 19/20 follow ups). b. **52 Week Breaches** – in June 2022 the Trust reported 1310 breaches due to Covid 19 delays, a decrease from last month. c. **104 week waits** – At the end of June 2022, there was 1 patient waiting over 104 weeks, this patient had an incorrect clock stop during covid d. **Referral To Treatment (RTT)** - in June 2022 the Trust delivered 69.1% performance within 18 weeks, below the 92% standard. This position was slightly lower from last month (70.7%) and is still affected by covid bed and staffing constraints. e. **The total waiting list** increased again during June 2022 to 48517. 2910 patients above the trajectory f. **Diagnostics** – in June 2022 the Trust achieved 53.41% against a target of 99%. This is a deterioration of performance from last month. **Cancer** a. **Faster Diagnosis Standard –** In May 2022 the Trust achieved the FSD standard with 76.2% against the performance target of 75%. b. **31 Day Standard** – in May 2022 3 out of 3 nationally reported measures were achieved. c. **62 Day Standard –** in May 2022 0 out of 2 nationally reported measures were achieved. d. **Open Pathways over 104 Days –** in May 2022 the number of open pathways was 10, an increase from 3 in April 2022 e. Cancer performance still performs well compared to peers **Next Steps on Performance & The Operational Plan** For elective and cancer performance, the key next steps are: a. Maximise opportunity of recently opened Ward 19 to support Emergency Surgery b. Develop recovery plans to mitigate under delivery of elective activity in Q1 to include use of modular theatre and ward on DRI site as ring-fenced elective surgical hub c. Retain focus on diagnostic modalities d. Expand capacity to reduce backlogs and reduce waiting times e. Continue to increase productivity f. Extend referral triage and options for use of A&G **From an emergency perspective, the key next steps are:** a. Reduce the number of patients who do not meet the criteria to reside b. Improve ambulance handover times c. Focus on Urgent & Emergency care recovery including extension of the frailty pilot **Overall,** the Trust continues to experience significant operational challenges and will continue to focus on safety, sustainability and supporting its teams, people and patients
	Board is asked to note and comment as appropriate on the attached.

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:	*Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation*
Corporate risk register:	*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*
Regulation:	*Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.*
Legal:	*Report outlines performance against standards, published annually by NHS England, some of which are outlined in the NHS Constitution.*
Resources:	*Impact on resources of delivering activity taken account of in Trust plans*

Assurance Route			
Previously considered by:		Finance & Performance Committee	
Date:	21/07/2022	**Decision:**	
Next Steps:		Agreement of 2022/23 performance trajectories to be monitored via new IQPR & related documentation	
Previously circulated reports to supplement this paper:			

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	Board of Directors		
Meeting Date:	26 July 2022	**Agenda Reference:**	E6
Report Title:	Patients waiting less than 15 minutes for ambulance handover from time of arrival		
Sponsor:	George Briggs, Interim Chief Operating Officer		
Author:	Andrea Squires, Divisional Director of Operations for Urgent & Emergency Care		
Appendices:	Supporting graphs		
Report Summary			
Purpose of report:	To provide information and assurance in relation to actions ongoing to improve the number of patients waiting more than 15 minutes for ambulance handover from time of arrival		
Summary of key issues/positive highlights:	• NHSE (2020) guidance states that ambulance handovers should reliably be completed within 15 minutes and that an handover escalation process should be enacted where time to handover exceeds or is likely to exceed 30 minutes • The current national standards state that all patients should be handed over within 15 minutes with none waiting over 60 minutes for handover • The month of April was a challenging period with an increase of ambulances attendances vs March where the trend was decreasing. • Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trusts (DBTH) June performance for patients waiting less than 15 minutes for ambulance handover deteriorated slightly from 41.69% to 36.82%, with an increase from 13.62% to 18.33% of patients waiting over 60 minutes. • Performance improvement has been affected by bed waits specifically w/e 12th & 19th June, which aligned to activity increases, Covid sickness absence and increasing bed occupancy (98%) resulting in exit block in ED. • We have noted an improvement from w/e 26th June. • Doncaster Royal Infirmary (DRI) in June continue to be the 3rd highest reporting Trust for 60-minute ambulance handover breaches in Yorkshire. • Actions started – Ambulance direct referrals at DRI & BDGH, Early Senior Assessment reconfiguration to improve triage and ED Streaming PDSA cycles commenced in June, 2hrly online ED escalation tools for immediate support as Opel levels increase. Regular meetings with YAS/EMAS focusing on early notice of patient acuity prior to arrival, continued development of Consultant Connect for ED streaming. • Key actions continue to be implemented to ensure ambulance handover times across DBTH are in accordance with national guidance and ensures patients receive safe and high quality care. • Further work around pathways such as Same Day Emergency Care is also being completed to improve ambulance handover times as part of the UEC Recovery and Transformation programme. • This paper will provide a monthly update against national standards and highlight improvements moving forwards		
Recommendation:	For information/assurance purposes only		

Action Required:	~~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:	Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation
Corporate risk register:	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 • Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards Report outlines actions plan to make progress on this specific requirement related to ambulance handovers, no change to risks on CRR
Regulation:	NHS England (2020) Reducing Ambulance Handover Delays: key lines of enquiry
Legal:	N/A
Resources:	N/A

Assurance Route			
Previously considered by:	Divisional Management Board for Medicine		
Date:	28/07/22	**Decision:**	TBC
Next Steps:	Continued monitoring of recovery and associated action plans at Divisional Management Board for Medicine, Finance & Performance Committee and monthly escalation to Board. Work forms part of Urgent and Emergency Care Programme.		
Previously circulated reports to supplement this paper:	N/A		

Doncaster Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 43.03% for Doncaster.

Current Trend: Performance against the Ambulance handover within 15 minutes deteriorated over the month of June, decreasing to 43.03% compared to 46.91% in May.

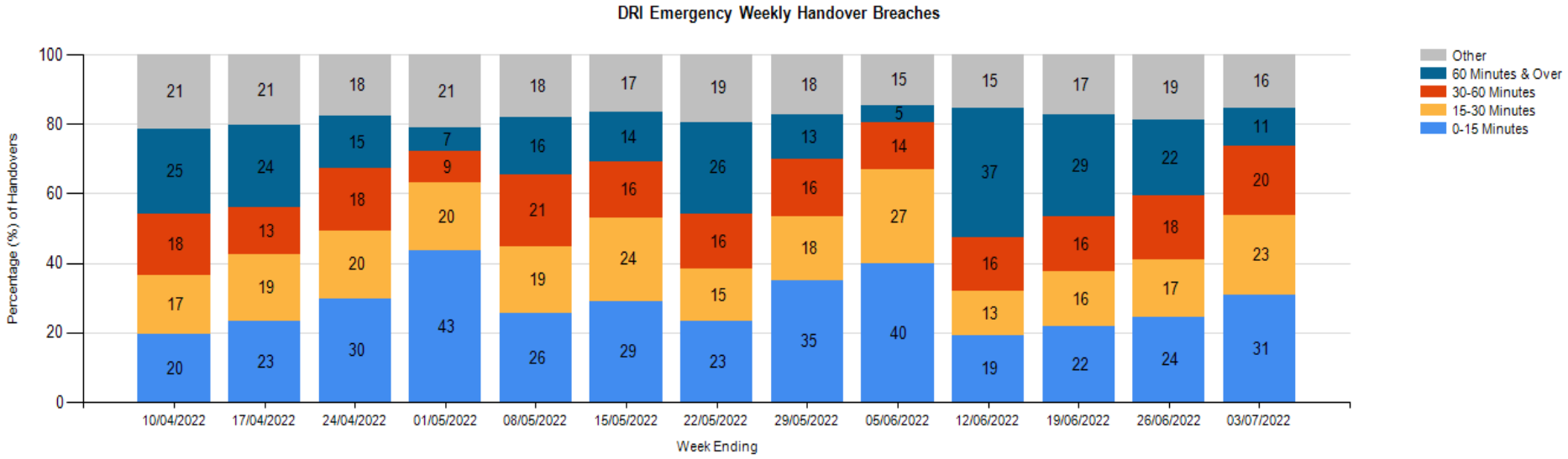
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

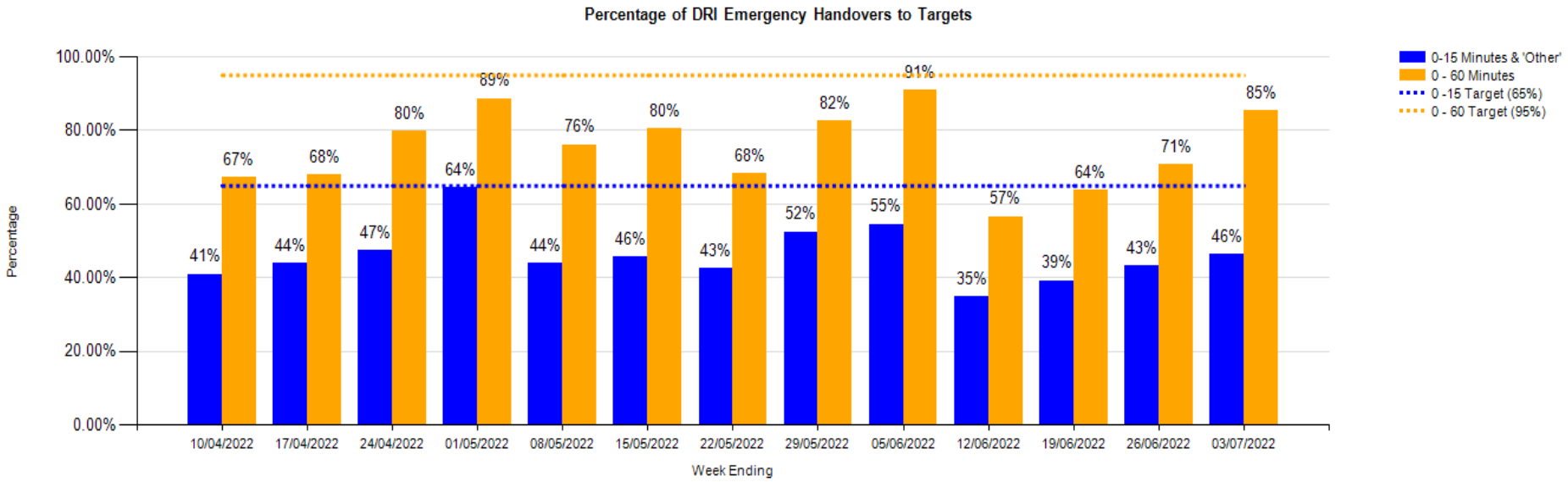
Metric: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes

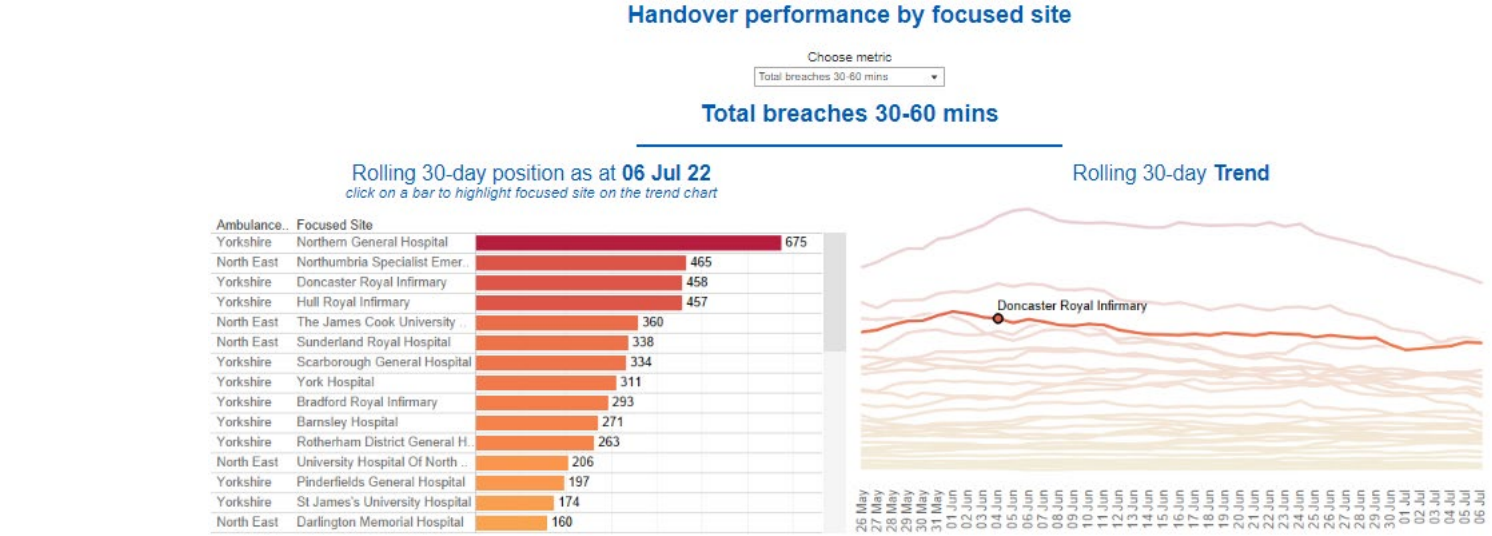
Desired Trend:

May Performance:

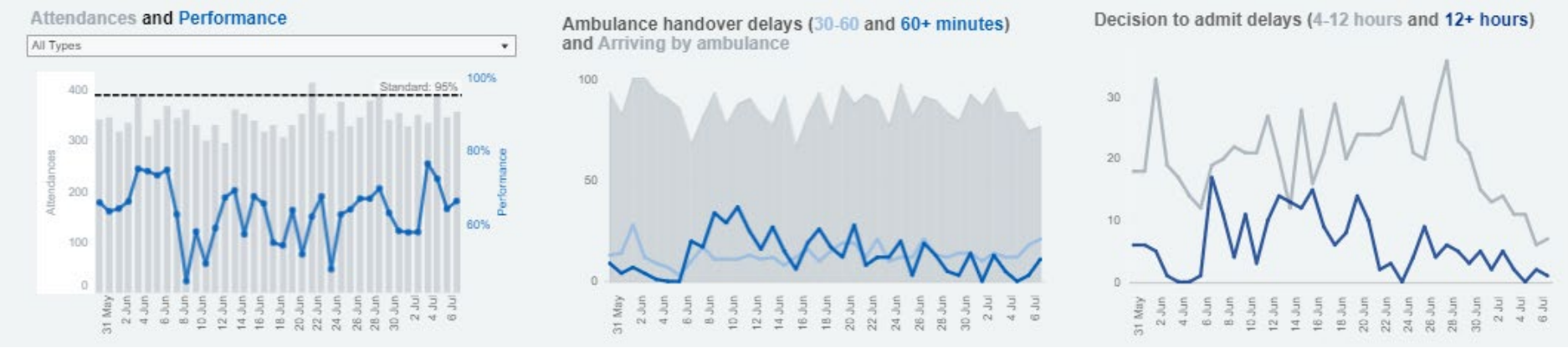
Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
June 2022	**Doncaster**	1959	43.03%	17.71%	22.97%	04:17
	Bassetlaw	812	22.17%	49.88%	7.14%	04:03
	Trust	**2771**	**36.92%**	**27.14%**	**18.33%**	**N/A**




Percentage of DRI Emergency Handovers to Targets
Percentage
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
41% 67%
44% 68%
47% 80%
64% 89%
44% 76%
46% 80%
43% 68%
52% 82%
55% 91%
35% 57%
39% 64%
43% 71%
46% 85%
10/04/2022
17/04/2022
24/04/2022
01/05/2022
08/05/2022
15/05/2022
22/05/2022
29/05/2022
05/06/2022
12/06/2022
19/06/2022
26/06/2022
03/07/2022
Week Ending
0-15 Minutes & 'Other'
0 - 60 Minutes
0 -15 Target (65%)
0 - 60 Target (95%)


Handover performance by focused site
Choose metric
Total breaches 30-60 mins
Total breaches 30-60 mins
Rolling 30-day position as at 06 Jul 22
click on a bar to highlight focused site on the trend chart
Rolling 30-day Trend
Ambulance..
Focused Site
Yorkshire Northern General Hospital 675
North East Northumbria Specialist Emer.. 465
Yorkshire Doncaster Royal Infirmary 458
Yorkshire Hull Royal Infirmary 457
North East The James Cook University .. 360
North East Sunderland Royal Hospital 338
Yorkshire Scarborough General Hospital 334
Yorkshire York Hospital 311
Yorkshire Bradford Royal Infirmary 293
Yorkshire Barnsley Hospital 271
Yorkshire Rotherham District General H.. 263
North East University Hospital Of North .. 206
Yorkshire Pinderfields General Hospital 197
Yorkshire St James's University Hospital 174
North East Darlington Memorial Hospital 160
Doncaster Royal Infirmary

Key associated metrics that also support the standard:



Bassetlaw Summary: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Problem Statement: Performance against the Ambulance handover within 15 minutes standard is currently 22.17% for Bassetlaw.

Current Trend: Performance against the Ambulance handover within 15 minutes has deteriorated over the month of June decreasing to 22.17% compared to 24.52% in May.

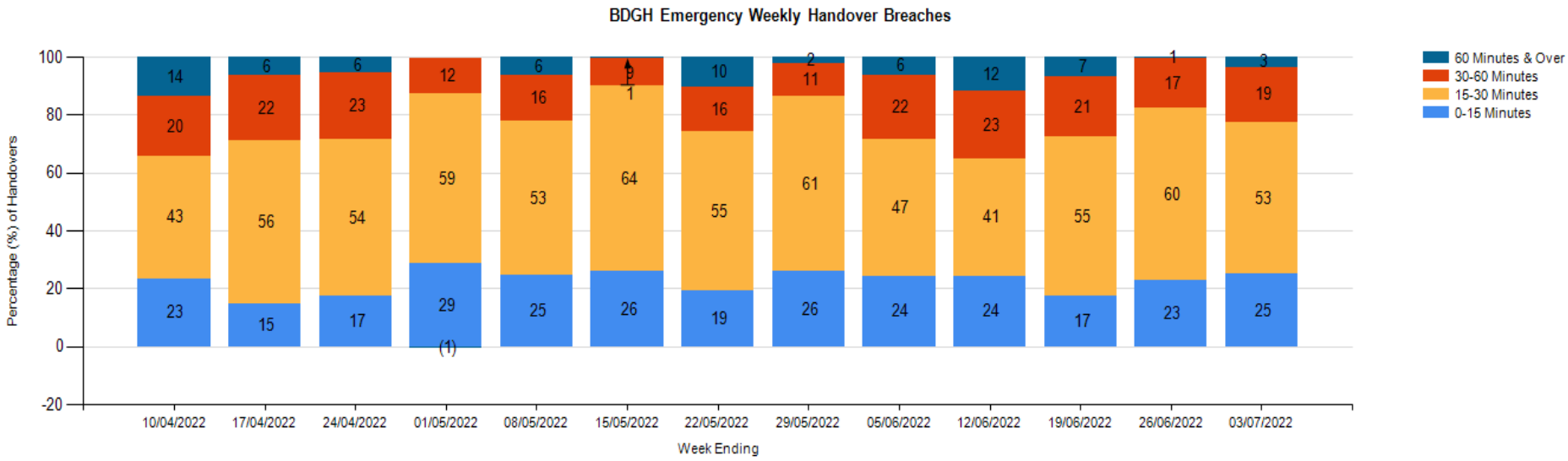
Metric Owner: Divisional Director of Operations (DDO) for Urgent & Emergency Care

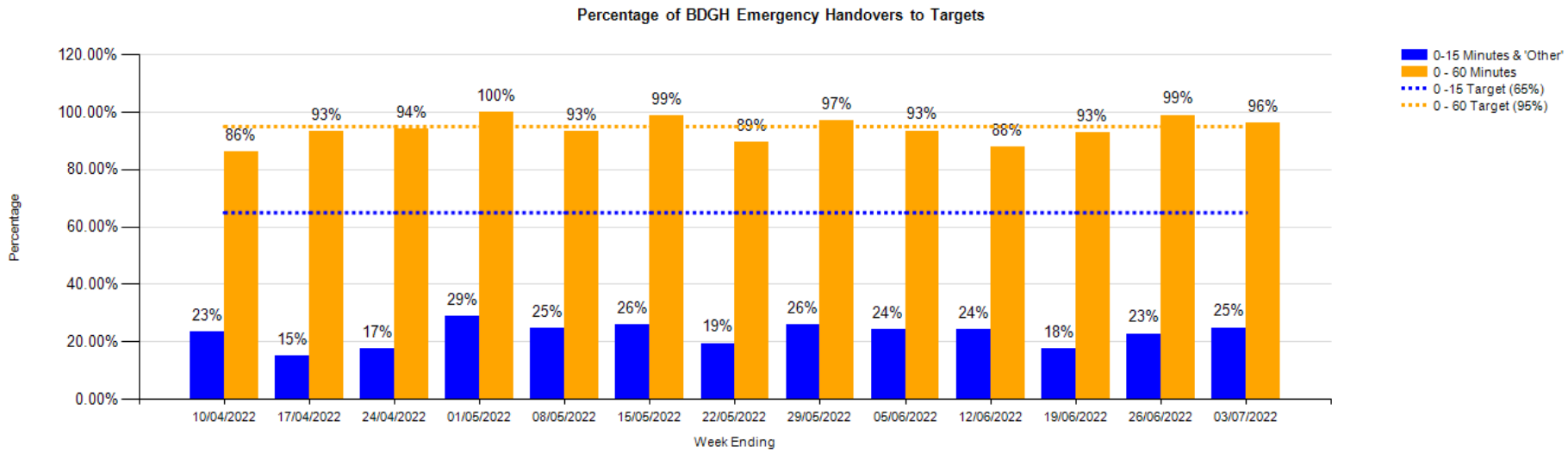
Metric: Ambulance Handover Time: Ambulance handover within 15 minutes – with none over 30 minutes

Desired Trend:

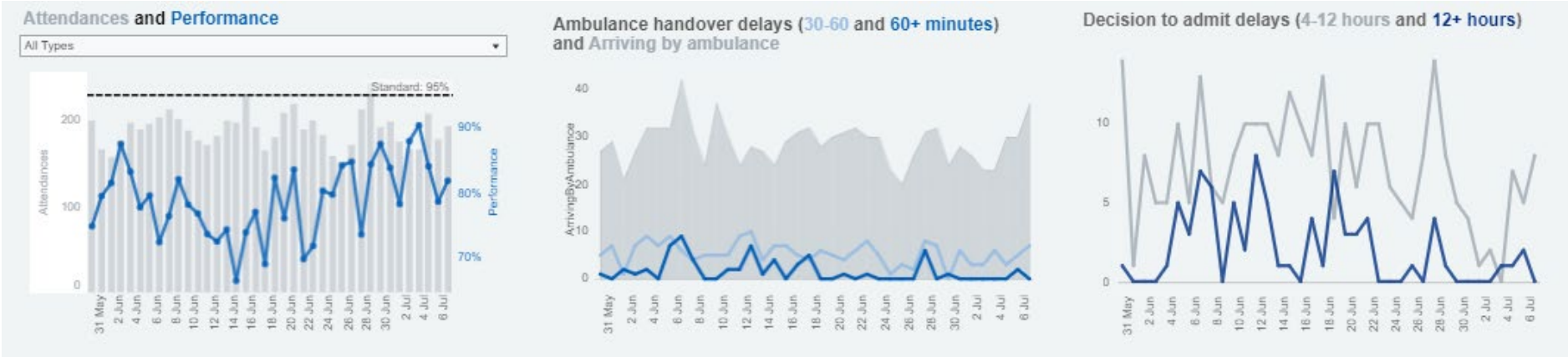
May Performance:

Month	Hospital	No of Arrivals	% less than 15 minutes	% between 15 & 30 minutes	% over 60 minutes	Longest Wait (hrs & minutes)
June 2022	Doncaster	1959	43.03%	17.71%	22.97%	04:17
	Bassetlaw	812	22.17%	49.88%	7.14%	04:03
	Trust	**2771**	**36.92%**	**27.14%**	**18.33%**	**N/A**





Key associated metrics that also support the standard:




Escalation beds, core beds and bed occupancy
Beds
Bed occupancy
100.0%
95.0%
90.0%
100
50
0
31 May
2 Jun
4 Jun
6 Jun
8 Jun
10 Jun
12 Jun
14 Jun
16 Jun
18 Jun
20 Jun
22 Jun
24 Jun
26 Jun
28 Jun
30 Jun
2 Jul
4 Jul
6 Jul
7+, 14+ and 21+ day long stays
% of beds occupied by long stay patients
% of beds occupied by long stay patients
60%
40%
20%

Key Summary & Actions: Patients waiting less than 15 minutes for ambulance handover from time of arrival

Top contributor	Potential Root Cause	Countermeasure	Owner	Status
Pre-hospital / Front Door Issues	• Difficulty accessing primary care services for advice and guidance • Difficulty accessing assessment services for advice and guidance • Difficulty accessing community response services	• Additional GP hours in urgent primary care to support ambulance crews where discussion needed with GP • Extend Same Day Health Centre offer to YAS and South Yorkshire Police for patients that need minor injuries support • Extended pilot with new geriatrician at DRI to support conveyance avoidance particularly around frailty • Work underway to promote the Rapid Response service with ambulance crews • YAS direct pathway to medical and surgical same day emergency care services now implemented, to be duplicated at Bassetlaw • Single point of access for GPs to facilitate direct admission to medical and surgical same day emergency care services • Early senior review in ambulance bay to identify patients suitable for medical and surgical same day emergency care services and fit to sit • Implement Screening and Redirection tool, supported by signposting away and early senior review	Fylde Coast Medical Services (FCMS) FCMS DDO for UEC / Care of the Elderly Consultant CCG DDO for UEC / Clinical Director (CD) DDO for UEC / CD DDO for UEC / CD DDO for UEC / CD	Monitoring Monitoring Monitoring Monitoring Monitoring Monitoring Delivery Delivery
Patient Flow issues	• Current Trust bed occupancy of 98% resulting in lack of available beds to move patients into from ED • Increased LoS across the Trust (7, 14 and 21 days) • Lack of available beds in	• Re-configuration of acute medicine to include re-location of 12 beds to existing Early Assessment unit in ED to become an Acute Medical Decisions Unit resulting in an additional 12 beds for Care of the Elderly and General Medicine • Additional 10 beds to be opened on Ward 22 for respiratory patients	DDO for UEC / CD DDO for UEC / CD	Monitoring Paused

	community	• A full review of the Discharge Lounge to increase capacity to support decompression of ED in a morning has been completed • Implementation of Criteria to Reside, Red to Green, and MDT Long Stay Wednesday walk-arounds aim to reduce LoS and increase discharges • Mutual aid is also in aid at Place and across SYB • Partnership winter plans to identify additional community bedded capacity and increased care homes and domiciliary care capacity	DDN for Medicine DDNO (new post) Chief Operating Officer (COO) COO	Delivery Delivery Monitoring Delivery
Operational Grip and Escalation	• Lack of awareness of new clinical national standards for emergency care • Lack of awareness of Trust position for ED and on call teams • Delays in escalation process within and outside of ED • Process delay issues impacting on handover efficiency	• Trust wide roadshow to share new clinical standards for emergency care • Development of new Inter-professional standards for emergency care • Development of Clinical Harm Review for patients waiting longer than 60 minutes for ambulance handover • Fully revised Emergency Care Escalation Protocol incorporating an Ambulance Handover Escalation Protocol • Fully revised Trust OPEL policy • Development of guidance and training for all on call managers • Time In Motion Study to be support by QI Team to identify any delay in handover processes • Interim COO appointed and will review existing UEC Transformation Programme	DDO for UEC DDO for UEC DDO for UEC DDO for UEC COO COO DDO for UEC COO	Monitoring Monitoring Closed Monitoring Monitoring Delivery Monitoring Delivery
Improving accuracy of	• Delays in entering handover pin to confirm handover has been completed due to competing	• Daily validation of ambulance handovers to re-commence with a monthly report to highlight	DDO for UEC	Monitoring

handover data between YAS / DBTH	other tasks • Previous 'double pinning' system stopped pre-Covid as automatic system was being trialed. This was never implemented due to Covid-19 pandemic • Internal daily validation was stood down as a result of the above	any difference in handover time recorded • 'Double pinning' system to be re-commenced to ensure crews pin out prior to leaving the department and DBTH staff also pin out to confirm handover time. Supporting Protocol to be developed • YAS to share data and investigate why the time stamp is no longer visible on the Electronic Patient Record Form (EPRF) • Monthly meetings to be held with YAS/DBTH operational teams • NHS England and Emergency Care Intensive Support Team to undertake site visits across South Yorkshire and Bassetlaw to ensure consistent approach	YAS/DDO DDO for UEC YAS DDO for UEC	Monitoring Monitoring Monitoring Closed

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	F1		
Report Title:	**True North, Breakthrough and Corporate Objectives 2022/2023**				
Sponsor:	Richard Parker, Chief Executive Officer				
Author:	Richard Parker, Chief Executive Officer				
Appendices:	Appendix 1				
Report Summary					
Purpose of report:	This report updates the Board of Directors on the progress made in quarter 1 on the delivery of the Breakthrough and Corporate Objectives for 2022/ 2023 through work being undertaken by Executive Directors. Progress to date reflects the challenges of the on-going pandemic and demands of the elective recovery programme.				
Summary of key issues/positive highlights	The updates identify that there have been challenges with accelerating the pace of recovery from the pandemic due to the ongoing operational pressures but that work towards the delivery of the Trusts Strategic Objectives and True North is being maintained.				
Recommendation:	The Board of Directors is asked to note the contents of the updates and advise on any changes and amendments to the suggested objectives to ensure that actions through 2022/2023 continue to mitigate risks to the delivery of the Strategic Vision.				
Action Required:	**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:	The Corporate objectives reflect the work needed to deliver the Board of Directors strategic direction and mitigate known and reasonably foreseeable risks.
Corporate risk register:	Delivery of the Corporate Objectives for 2022/2023 will support the reduction in known and reasonably foreseeable risks.
Regulation:	The Corporate Objectives for 2022/2023 identify actions which will be taken to maintain and ideally improve, the Trusts CQC Good rating at the next assessment. Demonstrating compliance with the standards expected

	to be achieved for a Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.
Legal:	The Corporate Objectives for 2022/2023 aim to maintain the Trusts progress and compliance with statutory responsibilities.
Resources:	The resources required to deliver the Corporate Objectives for 2021/2022 are identified as part of the planning processes for 2022/2023.

Assurance Route			
Previously considered by:		Executive Team	
Date:		**Decision:**	To be presented to the Board of Directors on 26 July 2022

Next Steps:	Specific Objectives will be reviewed at Board Sub Committees with overall progress reported to the Board of Directors in: • July 2022 • October 2022 • January 2023 • April 2023
Previously circulated reports to supplement this paper:	2022/2023 Corporate Objectives, True North and Breakthrough Objectives, Board of Directors Papers and Performance Reports.

1. INTRODUCTION

This paper updates the Board of Directors (BoD) on the progress which has been made by the Executive Team towards the delivery of the Corporate Objectives. The impact of the Covid pandemic on the Trusts patients and staff continues to result in significant pressure on the emergency and elective pathways. As a result, the Trusts performance in Q1, and the ability to deliver the Strategic aims and objectives has been slower than originally anticipated.

Measures and actions to mitigate the risks and restore the Trust progress towards the 'True North' were taken with the creation of the Directorate of Recovery, Innovation and Transformation. However, due to the continuing pressures and workforce gaps across the Trust the benefits of concentrating dedicated time and resources on the key elements of recovery; quality, safety, efficiency, and effectiveness are still to be fully realised.

2. BACKGROUND

Prior to the Covid pandemic the Trust had established a framework by which the Strategic Aims and Objectives were reflected from Ward to Board so that every member of staff could visualise and describe how they could contribute to the delivery of the Trusts Vision; The True North. The True North being the 'Golden Thread,' with progress towards the vision supported, and measured through the delivery of the Breakthrough, Corporate, Divisional, Directorate, Team, and Individual Objectives.

During 2021/ 2022 progress on the revitalisation of previous programmes of work and delivery continued to be affected by the sustained pressures within the South Yorkshire and Bassetlaw system related to the ongoing Covid pandemic. In 2022/ 2023 the full impact of the pandemic on planned care is now visible creating significant challenges in recovery with extended waits for diagnostic and elective services.

Therefore, the focus of the 2022/ 2023 objectives is related to the ongoing management of pandemic pressures, the recovery of waiting list and waiting time performance, and the delivery of safe, sustainable, effective, and efficient care.

As the gaps in the Executive Team are now reducing it is expected that enhanced support will be available to the Trusts Operational Teams to allow a renewed focus on the delivery of the Trusts operational and winter plans and on additional steps which can be taken to better support staff to recover previous performance levels and restore services.

Lessons learnt during the pandemic are being embedded as we seek to further innovate and transform services in and out of hospital care.

3. CORPORATE OBJECTIVES

The contribution each Director has made towards the delivery of the agreed objectives at the end of quarter 1 are identified in appendix 1.

Board sub-committees have agreed the specific objectives and undertake assurance on the delivery of the specific elements to assure the delivery of the Trusts performance.

4. RECOMMENDATIONS

The BOD is asked to discuss the contents of this paper, advise upon any necessary amendments to improve the Trust delivery of the True North.

True North Objective	Senior Responsible Officer	Strategic Objectives for 2022/ 2023	Oversight and Assurance	Expected Outcome
To be the Safest Trust in England Outstanding in all that we do.	**Chief Executive Officer (CEO) Deputy Chief Executive/ Director of Recovery, Innovation and Transformation**	Accelerate progress towards the delivery of the Trusts Strategic aims and objectives Complete and Implement the Trusts Recovery, Innovation and Transforamtion Plans Re invigorate the Trust Quality Improvement Programme to drive innovation, efficiency, transformation and service delivery Work with partners at a local, ICS and national level to identify opportunities and maximise the benefits and impact of enhanced health and social care collaboration and partnership in our communities and workforce. Work with partners across Place, ICS and the Acute Federation to reduce inequality and deliver safer and more sustainable services	Board of Directors (BOD) Audit and Risk Committee (ARC)	Quantitative and Qualitative Evidence will be available to assure the BOD that the Trust has delivered improvements across the full range of strategic aims and objectives
BREAKTHROUGH OBJECTIVE				
Achieve measurable improvement in our quality standards and patient experience	**Chief Nurse Executive Medical Director Chief Operating Officer**	Develop and Implement a DBTH Quality Framework which describes how 'Outstanding' is defined and achieved.	BOD	A DBTH Quality Framework will be in place
		Implement the outcome of the Governance and Risk reviews and demonstrate evidence which supports the delivery of the standards which would allow the CQC to rate all Divisions as Good for Services Safe	Quality and Effectiveness Committee (QEC)	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards
		Demonstrate evidence which supports the delivery of the standards which would allow the CQC to rate the Trust as Outstanding for Caring	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards
		Achieve National, agreed ICS, and local access and performance standards	QEC	The 2022/ 2023 Assurance Framework will confirm that the Trusts plans are being delivered.
		Ensure that the Patient and Carer voice is listened to by delivering co-produced outcomes	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards
		Celebrate, share and promote good practice and successes	BOD	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards
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.	**Director of People and Organisational Development**	At least 90% of colleagues have an appraisal linked to the Trust's objectives and values	People Committee (PC)	The 2022/ 2023 Assurance Framework will confirm that the Trusts plans are being delivered.
		5% improvement in colleagues reporting they are able to make suggestions to improve the work of their team/department	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
		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.	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
		90% of the Divisional and Directorate leaders will have undertaken leadership development programmes.	PC	Quantitative and Qualitative Evidence will be available to confirm that services meet or exceed the CQC standards
The Trust is within the top 25% for people and learner feedback	**Chief People Officer Chief Nurse Executive Medical Director**	Delivery of a 5% improvement in colleagues and learners recommending the Trust as a place to work and learn in the 2022/ 2023 staff survey results	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
		Delivery of a 5% improvement in how valued colleagues feel by managers and the Trust in the 2022/ 2023 staff survey results	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
		Delivery of 5% improvement in health and wellbeing feedback in the 2022/ 2023 staff survey results	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
		Delivery of 5% improvement in WRES and WDES feedback in the 2022/ 2023 staff survey results	PC	Local monitoring and the 2022/ 2023 Staff Survey will confirm the improvement
The Trust is in recurrent surplus to invest in improving patient care	**Director of Recovery, Innovation and Transformation Director of Finance Chief Operating Officer**	Delivery of the agreed Corporate, Divisional and Directorate Budgets and Perforamcne Standards.	Finance and Performance Committee (F&P)	The 2022/ 2023 Assurance Framework will confirm that the Trusts plans are being delivered.
		Deliver specified improvements in efficiency and effectiveness to return the Trust, as much as is possible to at least pre pandemic levels	F&P	The 2022/ 2023 Assurance Framework will confirm that the Trusts plans are being delivered.
		Demonstrate Improvements in Governance through improved management information, systems and processes.	F&P ARC	The 2022/ 2023 Assurance Framework will be in place with high quality information on performance and delivery which reflects the Trusts aims and objectives and allows

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	BOARD OF DIRECTORS UPDATE AND LEAD BOARD SUB COMMITTEE (S)	Expected Outcomes	Q1 Update - July 2022	Q2 Update - Sept 2022	Q3 Update - July Dec	Q4 Update - March 2022
Deputy Chief Executive/ Director of Recovery, Innovation and Transformation	Take a lead role in working with Partners in Bassetlaw Place and the Nottingham Integrated Care System to achieve the Place and Systems Objectives and Outcomes objectives for 2022/ 23.	Board of Directors (BOD)	DBTH to be an active partner in Nottinghamshire Care System and for any elements of the Nottinghamshire ICS system plan to be delivered as necessary. Monitored through Board report updates and via regular report into Finance and Performance Committee (F&P).	Attending meetings with the provider alliance, last report to board being the nominations paper re the Notts ICB. Taking part, with other Executive Directors, in a KPMG review on behalf of Notts Provider Alliance regarding direction of travel.			
	Engage at Place and ICS to identify transformation and development opportunities which enhance the services for our communities and staff	BOD	Plans will be in place for services which reduce inequalities and improve outcomes.	Work ongoing			
	Establish a Trust Wide plan to drive Recovery, Transformation and Improvement opportunities across the Trust to improve quality and safety, reduce inequality and improve efficiency and effectiveness.	Finance and Performance (F&P) Audit and Risk (A&R) People Committee (PC) Quality and Effectiveness (QEC)	Plan for recovery of elective and emergency performance has been developed, and amended to reflect higher than expected Covid 19 and emergency activity. Wider plan to be produced by October 2022.	Work ongoing			
	Complete the Service Line reporting work utilising the results to drive the Trusts Strategic Direction	F&P	Plan to be presented to TEG, F&P, Quality and Effectiveness Committee (QEC) and onto Board in October 2022	Specialty reports largely completed, additional workshops held with Trust Executive Group(TEG) and Executive Team. Regular report made to F+P			
	Support the delivery of a robust learning and development programme to maximise the capacity and capability for improvement	People Committee (PC)	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	Work ongoing			
	Support the Board of Directors to champion Quality Improvement as the vehicle for transformation	BOD	Plan to be presented to TEG, F&P, QEC and onto Board in October 2022	Work ongoing			
	Lead the development of the New Hospital Business Case and once funding has been approved ensure the deliver of the Trust major capital programmes; Bassetlaw Emergency Care Village (BEV), Mexborough Surgical Care Hub, Mexborough Community Diagnostic Centre (CDC)	BOD F&P	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	BEV case to be presented to F&P and Trust Board in July, CDC case completed and submitted, work on going on other schemes			
	Ensure the delivery of the Trust Information and Technology Strategy maximising the benefits of Information Technology to safety, efficiency and effectiveness	F&P QEC Audit and Risk Committee (ARC)	Monitored through project plans, and agreed budgets into F&P and onwards to the BOD as required.	EPR case presented to the FP and Trust board and submitted to NHSE			
	Maximise the benefits and opportunities of the Wholly Owned Subsidiary (WOS)	F&P A&R	The WOS is making an increasing contribution to the Trusts plans	Good progress made with Quality Medical Education and Training (QMET), and the WOS is looking at feasibility of putting a small pharmacy on BDGH site			
	Ensure that the Board of Directors, Board Sub Committees and Trust Operational Management Groups have quality assured information by which to assess and assure that delivery of the Trusts Strategic and Operations Objectives.	ALL	Monitored against project plan for data improvement, and the introduction of data quality kitemarks. Reporting into F&P and other BOD sub-committees as required.	Derrick Scorecard system now live and Project Management processes via Monday.com software being implemented			
Executive Medical Director	Fully implement the job planning process. Ensuring that job plans support the delivery of safe, sustainable, efficient and effective services Ensure that the internal audit recommendations are completed	F&P QEC	100% of senior medical staff job plans reviewed, agreed and signed off on the Allocate system Ensure the job planning review process is established to have an annual job plan cycle Job Plan Audit Recommendations Action Progress Meeting established to progress and monitor actions against internal audit recommendations through to completion	Job Plan Action Progress Meeting established. 14 out of 20 actions and sub-actions now complete and closed by internal auditors The first of a series of job planning workshops for clinical directors held 05/07/2022			
	Support specialties and Divisions to optimise recruitment and retention processes with a specific focus on smaller services and difficult to recruit to areas.	QEC	Targeted workforce meetings with specialties/divisions to be established to optimise recruitment and retention processes, with Medical Director, Medical HR, Divisional Director, Divisional Director of Operations, Clinical Directors, Education Department Share good practice and learning across specialties	MD with responsibility for workforce, working with Medical HR, Education Department and Divisional/Specialty leads to identify specialties with difficulty in recruitment			
	Following the completion of the reviews of Corporate, Divisional and Directorate Governance arrangements embed the clinical governance and risk management process changes	QEC	In line with the recommendations from the external review, ensure governance arrangements and risk management processes are revised and a change management plan developed Communication and engagement with divisional and corporate areas to embed recommended changes through the robust governance framework	External review complete and report awaited.			
	In conjunction with the Chief Nurse ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards.	Working with Chief Nurse to complete the development and implementation of the Trust's Quality Strategy			
	Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports	BOD QEC	Work closely with Chief Nurse and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Chief Nurse and Director of Midwifery to review findings, agree recommendations and develop action plans. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered. Milestone outcomes to be jointly agreed with Chief Nurse and Director of Midwifery.	Working closely with Chief Nurse and Director of Midwifery to jointly agree action plans in line with national recommendation from the Ockenden report.			
	Ensure that learning from incidents, complaints, claims and the Learning from Death Reviews are used to improve the quality and sustainability of services; maintaining and improving outcomes and a reduction in Hospital Standardised Mortality (HSMR) and Standardised Hospital Mortality Index (SHMI)	BOD QEC	Medical Examiner Learning from Death Reviews and lessons learnt will be used to maintain and improve outcomes and reduce HSMR and SHMI Learning from incidents, complaints, claims demonstrated in the integrated quality and performance report, with targeted interventions as needed	Medical Examiner Team scrutinising non-coronial deaths in acute Trust Trust Board reports produced to provide assurance of recommendations and implemented actions. Trust Mortality Group reviewing HSMR performance and trends.			

DIRECTOR	OBJECTVIES IN SUPPORT OF THE DELIVERY OF THE TRUSTS TRUE NORTH AND BREAKTHORUGH OBJECTIVES	BOARD OF DIRECTORS UPDATE AND LEAD BOARD SUB COMMITTEE (S)	Expected Outcomes	Q1 Update - July 2022	Q2 Update - Sept 2022	Q3 Update - July Dec	Q4 Update - March 2022
	Work with the Chief People Officer to maximise the benefit of the Senior Doctor Leadership Development Programme to develop senior leaders across the Trust.	PC	Senior doctor leadership development programme in place Proactively encourage senior medical workforce to engage with the programme Encourage the use of study leave to allow protected time for leadership development	Senior doctor leadership development programme planned for 2022/23			
	Fully embed the Medical Advisory Committee (MAC) as the vehicle for engagement and communication with the wider senior medical workforce.	PC	Establish bi-monthly Medical Advisory Committee meetings with agreed Terms of Reference Establish bi-monthly MAC planning meetings to cover a range of subject matter as requested by the senior medical workforce Invite Executive Directors and Non-Executive Directors to attend each meeting as a means of engaging and having two-way communication between the senior medical workforce and Trust Board members	Medical Advisory Committee meetings established monthly Senior medical staff surveyed for input into topics and themes for discussion Process in place to forward plan agenda			
	Support the delivery of the Trust Strategic Direction through the delivery of safe, resilient, efficient clinical pathways which are compliant with NICE guidance and evidence based practice and aligned to the Place, Integrated Care System and Acute Federation clinical networks.	ALL	Engage with divisions and specialties through Service Strategy Reviews, incorporating GIRFT recommendations, in line with Trust Strategy Oversight of priorities in terms of short, medium and longer term strategic plans Support pathway redesign to ensure services are delivering efficient clinical pathways that are evidence based and aligned to wider clinical networks	GIRFT review in specialities to produce up-to-date position re: GIRFT recommendations.			
Director of Finance	Work with the Corporate and Divisional Directors to ensure the delivery of the Trust revenue plan	F&P A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported monthly to F&P, with the year end accounts presented to ARC.	Year end accounts signed off at the end of June with unqualified audit opinion for 21/22. Currently off track against financial plan by £1.1m. Financial assurance framework in place for 22/23 with escalation and support offer through POSM meetings with Divisions to improve financial position.			
	Work with the Corporate and Divisional Directors to ensure the delivery of the Trusts Capital Plan	F&P A&R	Improved support to Divisions to support delivery of the Trust's financial plan. This will be reported	Corporate Investment Group (CIG) re-introduced from beginning of financial year, with significant number of capital cases now approved, especially in Estates. Capital plan currently on track to be delivered by year end.			
	Support the work on the large scale business cases; the New Hospital Strategic Outline Business Case, Bassetlaw Emergency Care Village, Community Diagnostic Centre and the Elective Surgical Hub.	F&P A&R	Approval of business cases. The development of cases will be monitored through business cases to F&P and onwards to the BOD as required.	Finance team continued to support all significant business cases. EPRR approved at Board in Q1. CDC Phase 2 now approved by national team. Currently working on BECV ahead of presentation to Board in July.			
	Ensure the delivery of the Estates Strategy and Plans	F&P A&R	Annual objectives for Estates will be delivered in line with plan (e.g. Granger Report). This will be monitored through project plans and reported through to F&P and ARC.	Estates plans and objectives are all currently on plan to be delivered including good progress on the Granger report actions which was reported on at the July F&P Committee.			
	Deliver an improved management accounts function including systems and training	F&P A&R	Roll out of training programme to Divisions, development of systems (including finance dashboard as part of data warehouse project), development programme for the team and review of structure including roles and responsibilities. This will be monitored through project plans.	Training Programme videos are in the last stages of completion, ledger information now linked into Datawarehouse and finance dashboards are developed in draft and are in the process of being signed off over the next month, FBP development programme being reviewed, and roles and responsibilities work has now started.			
Chief People Officer	Develop and launch revised People Strategy aligned with national NHS People Plan, People Promise and priorities.	BOD PC	Engagement with colleagues to author the revised People Strategy, which will demonstrate the DBTH interpretation and delivery against the national plan and priorities. Work to begin in Q2/Q3, to launch Q4.	Planned for work to begin Q2			
	Design and implement a Trust wide approach to engagement in the national staff survey, including developing plans to improve participation, feedback on the results and corporate/ local action planning to improve results.	BOD PC	Approach defined for the 2022 staff survey defined and communicated in Q2 prior to survey launch. Engagement sessions booked ready for lifting of embargo in Q4, with consistent approach to action planning at Trust-wide and local level. 63% response rate or better in the survey (Q3).	Tender for provider for 2022 survey underway and approach to engagement in the survey results being communicated. Update at July PC.			
	Actively support and further develop the Trust Leadership and Organisational Development opportunities Consolidate and strengthen links with Education and Research Team to support the delivery of learning and development Support focused Organisational Development interventions to improve staff survey feedback and local improvements.	PC	Leadership development prospectus in place and offer expanded throughout the year. Roll-out of the Team Engagement and Development (TED) tool to support teams, as part of the national pilot. Improvements in leadership questions in staff survey. Embed role as new Exec lead for Education and Research, maximising opportunities for working with the People and Organisational Development (P&OD) team.	Leadership prospectus launched. TED tool workshop held in June with c80 participants, first teams using the tool. Exec lead for Education and Research confirmed in June.			
	Build on the Health and wellbeing offer to ensure a sustainable and holistic offer for our people making best use of system opportunities.	BOD PC	Comprehensive, proactive and holistic health and wellbeing (H&W) offer in place which is well understood and accessible by our people. Improvements in H&W questions in staff survey. Increase in number of H&W Champions. Increase in preventative aspects of the overall offer. Positive impact on sickness absence (recognising impact of other factors). Review of Occupational Health capacity undertaken and decisions made on resource requirements.	Wellbeing offer continues to be expanded e.g. smear clinics. OH business case previously submitted. H&W update at July PC.			
	Working with the Executive Team and other colleagues, develop and implement a leadership behaviours framework building upon the Develop, Belong, Thrive Here at DBTH.	PC	Engagement with colleagues to develop the framework, linked to existing DBTH ethos and national resources (Q3). Plan in place for launch, implementation and future embedding of the framework linked to all aspects of the employee life cycle. Staff survey impact in future years.	Plan for engagement to begin in Q3 after the summer period.			
	Review recruitment and retention processes to maximise efficiencies, improve timescales and enhance applicants' experience. Developing and strengthening the recruitment and retention team, and the use of technology.	PC	Completion of Quality and Improvement (QI) project on end to end recruitment process, from vacancy approval to 'first day ready'. Improvement action plan developed and delivered with PMO support. Improvements seen in length of process and candidate experience. Recruitment team capacity explored and decisions made on resource requirements. Automation options explored.	QI project scoped and workshop arranged for 19 July with stakeholders. Recruitment business case previously submitted. Update on recruitment KPIs and plans at July PC.			
	Review the approach to casework including the implementation of technology to improve experiences.	PC	Casework database implemented. Improvement in length of time taken on individual casework. Further roll-out of 'just culture' approach to managing casework, working with Staff Side colleagues.	Casework database implemented. Update at July PC.			

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Chief Operating Officer	Ensure that Emergency Preparedness, Resilience and Response (EPRR) plans and assurances are in place to respond to all reasonably foreseeable incidents	ARC	Plans being updated post Covid business continuity and emergency plans. Training offer has been updated and is being rolled out across on call teams.	Training being booked. Monthly EPRR updates booked with COO			
	Ensure the delivery of the National, ICS and Local standards for Urgent and Emergency Care, Elective Care and cancer care, and diagnostics ensuring that wherever possible reduce inequalities in access.	F&P	Business as usual plans in place and emergency recovery board set up July 22 Elective recovery board set up August 22	Monthly review and weekly updates agreed			
	Ensure wherever possible that the delivery of the recovery and restoration plans reduce inequality	QEC	Emergency recovery and Elective recovery boards setup with review monthly	ICB monthly review			
	Ensure arrangement are in place to maintain and improve patient flow to maximise efficiency and effectiveness	F&P	Performance which related to patient flow will be at 2019/ 2020 levels.	Plan to be updated			
	Ensure that services deliver the required levels of transformation to allow access to enhanced funding	F&P	Services will be linked into QI program and transformation board. Transformation board will meet monthly with feed in from elective and emergency programs	First boards to be held in Q2			
	Develop, agree and implement robust plans to manage winter pressures and enhanced IPC measures	F&P PC	Winter plans will be in place by Q3 to reflect divisional plans Winter plans linked to the Integrated Care System and PLACE plans.	Initial plan shows bed reduction latest version to include ward 22 beds			
Chief Nurse	Working with the Executive Medical Director to embed a 'Quality Framework' define the characteristics and evidence that will define and support the Trust to be 'Outstanding in all that we do.'	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Implementation now commenced, project team working question set on trial areas , this will feed into newly formed quality steering group then Transformation board. 'Perfect Ward' audit and accreditation tool across all in patient areas to ensure we have a robust mechanism to measure quality metrics including, patient falls, hospital acquired pressure ulcers, medication incidents.			
	In conjunction with the Executive Medical Director ensure that the Trust is able to demonstrate evidence of compliance with the standards required to achieve a CQC Good rating in the Safe Domain and an Outstanding rating in the Caring Domain.	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Working with The Executive Medical Director to complete the development and implementation of the Trust's Quality Strategy Work underway to ensure the Trust and Division can demonstrate compliance with the CQC standards.			
	Jointly lead the maternity improvement plan in line with national recommendation from the Ockenden report, clinical Negligence Scheme for Trusts (CNST) year 3 and any further related reports	BOD QEC	Work closely with Medical Director and Director of Midwifery to deliver the action plans developed in line with national recommendation from the Ockenden report. Review of safety culture within maternity, work closely with Medical Director and Director of Midwifery to review findings, agree recommendations and develop action plan. The 2022/ 2023 Assurance Framework will ensure the Trusts plans are being delivered.	Ockenden action plan in place and reported to the BOD Additional resources being put in place to proactively collect and catalogue CNST evidence Birth rate plus review completed. Report to be provided to QEC Work underway to strengthen the midwifery management structure			
	Ensure the patient/carer voice is listened to by delivering increasing evidence of co-produced outcomes	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Work is underway to implement a revised patient experience service.			
	Ensure safe and benchmarked staffing levels through the Trust, Safer Nursing Care Tool (SNCT) undertaken n May 2022, full feedback will be presented at board in September 2022.	BOD QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Safe staffing assessments and recommendation will be presented to BOD in September			
	Implementation of the Patient Safety Incident Response Framework (PSIRF) and development of patient safety specialist roles across the organisation. Awaiting further national guidance on next steps , patients safety champions identified and in place	F&P QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Work is underway and will be finalised once the external reviews of risk and governance are completed.			
	Celebrate, share and promote good practice	QEC	Quantitative and Qualitative Evidence will be available to confirm that services meet and exceed the CQC standards	Individaul opportunities to celebrate good pratcice and patient care are reported through established communication channels and celebration events are being planned. Listening events with senior nurses are underway.			

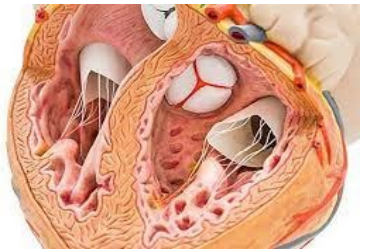
Trust Board: Research and Innovation Strategic Direction

Sam Debbage, Deputy Director of Education and Research
Jane Fearnside, Research Fellow

July 2022

Our Journey

- DBTH R&D Strategy 2017-2022 highlighting the strong foundation of Portfolio (including commercial) research activity
- Formation of the new Education and Research Directorate: January 2020
- Enhanced governance and assurance
- Investment and ongoing consideration in clinical academic pathways/ academic posts including research education lead
- Future developments and alignment:
  - Internally: Quality strategy, People strategy
  - Externally: Nursing, Midwifery and Allied Health Professional national strategies



Reduced life expectancy

Drivers for research and innovation strategic priorities

Starting well:

- Low birth weight
- 4% & 3% above national average for obesity in 5 and 11 year olds respectively
- More that the national average of children are in care (364 per 10,000)

Living well:

- Increase in hospital admissions due to alcohol-related conditions
- Cancer mortality rates improving but still significantly worse than national average
- Under 75s more likely to die from cardiovascular disease (although improving)
- 69% of adults are overweight or obese

Ageing well:

- More people at risk of falling
- More request social care support
- Fewer people able to remain at home 91 days after discharge from hospital than in other areas

A life course approach; whole life: whole systems

Our vision:

To establish DBTH as a leading centre of research excellence through a talented and diverse workforce, united in its core mission to deliver outstanding research that drives improvement in the health and well being of the people we serve.

Our mission:

To embed a progressive research and innovation culture by developing infrastructure, staff capability and prioritisation of areas of excellence in collaboration with our academic, commercial and wider care partners.

Improving the HWB of our patients and workforce through research and innovation

Our challenges

- Reducing the gap in health inequalities for the population
- Developing a financially sustainable R&D infrastructure and governance to support growing research and innovation within the Trust
- Growing research capability and capacity through appropriate career pathways, joint appointments and workforce wellbeing
- Using data and digital transformation to drive areas of strategic priority that addresses the greatest areas of unmet health need
- Growing and leading inclusive research, developed with our local communities, especially those that are under represented
- Improving maternal and child health
- Working together with our partners to tackle poor health and well being and the factors responsible (obesity, deprivation, poor mental health, alcohol and drug misuse)
- Continue to optimise safety and performance through undertaking and implementing meaningful research
- Tackling the health and wellbeing challenges facing our already significant and growing ageing population
- Improving patient outcomes through prevention, early diagnosis and better management of cardiovascular and respiratory diseases and cancer.

The University Of Sheffield.

- **Strategic focus:**
- Further develop strengths in maternal and foetal health
- Health informatics
- Digital technologies (AI, big data, routinely collected data)

- **Current strength:**
- New-born screening strategies
- Global preterm birth research
- Early Years work
- Dept. of Psychology – autism and learning disabilities as well as mental health.

Clinical academic pathway

- **Strategic focus:**
- BaBiD – set up and exploitation of data to inform targeted research to improve outcomes
- Grow research capacity in NMAHPs – e.g. NIHR PCAF, NIHR DRF
- Reduce childhood poor health in obesity induced disease
- Work with partners to reduce childhood obesity
- Improve maternal outcomes in BAME communities
- **Current strength:**
- Existing R&D capability for paediatric research,
- Dedicated Research Lead
- Professor of Nursing (Prof. Ali)
- Dedicated, agile and strategic senior leadership to support growth in this priority area

Sustainability

Reducing health inequalities

Sheffield Hallam University

- **Strategic focus:**
- Maternal and Child health
- Reducing childhood obesity & poor physical activity
- Innovation to address unmet needs in service delivery e.g. robot delivery in autism assessment
- Delivery of clinical services
- **Current strength:**
- Delivery of paediatric services through AWRC
- Existing research reputation in this field.

Starting well: Improving maternal and child health

The University Of Sheffield.

- **Strategic focus:**
- Personalisation of prevention strategies
- Remote monitoring with smart devices & sensors
- Digital technologies (AI, big data), health informatics
- Imaging (POLARIS)
- *In Signeo* institute
- EPSRC "Digital hub"
- **Current strength:**
- Screening programmes (bowel screening)
- Trials of complex interventions
- U&E (CURE) research
- Dept. of Psychology research – workforce wellbeing

Clinical academic pathway

- **Strategic focus:**
- Surgery (oncology, general and orthopaedic)
- Improving cancer outcomes through prevention, early detection and optimised management
- Prehabilitation and rehabilitation
- Improving cardiology services to support and reduce CVD
- Exploit and optimise data and digital transformation expertise
- **Current strength:**
- Surgery, Rheumatology, Renal
- R&D expertise in delivery of studies including commercial studies

Sustainability

Reducing health inequalities

Sheffield Hallam University

- **Strategic focus:**
- Advanced Wellbeing Research Centre (AWRC)
- Lab4Living – design for healthy lifestyles
- Prehospital emergency and urgent care
- Health/MedTech, data & digital innovation
- Loneliness and mental health (Prof Whigfield)
- **Current strength:**
- Increasing physical activity through AWRC projects
- Living well with cancer/prehab
- Moving well @100
- Workplace wellbeing
- Programme evaluation (Move More)

Living well : Improving patient outcomes in areas of greatest need

The University Of Sheffield.

- **Strategic focus:**
- Healthy LifeSpan Institute (HELSI) – Prevention & delay, understanding ageing, sharing knowledge & AI
- Remote monitoring with smart devices & sensors
- Digital technologies (AI, big data), health informatics
- Multimorbidity
- Improving cancer outcomes

- **Current strength:**
- Screening programmes (bowel screening)
- Trials of complex interventions
- HELSI

Clinical academic pathway

- **Strategic focus:**
- Surgery – building on "Bridging the age gap" study (Prof Wyld), Oncology/Orthopaedic (Prof Wyld/Dr Wilson)
- Prehab/rehab – improving fitness to treat & recovery
- NMAHP expertise within Falls team, service optimisation
- Elderly medicine

- **Current strength:**
- Surgery (including resources and training)
- R&D expertise in delivery of studies including commercial

Sustainability

Reducing health inequalities

Sheffield Hallam University

- **Strategic focus:**
- Ageing & long term conditions
- Research Centre for Applied health and social care
- Cancer management

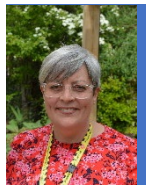
- **Current strength:**
- AWRC
- LabforLiving
- Cancer – prehabilitation and rehabilitation
- Lifelong conditions
- Neuro rehabilitation research programme

Ageing well: Improving the health and wellbeing of our ageing population

Dr Alasdair Strachan
Director of Education & Research

Professor Parveen Ali
Professor of Nursing
Academic partner:
University of Sheffield

Jane Fearnside
Senior Fellow



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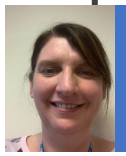

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Education & Research Senior Leadership Team

www.dbth.nhs.uk

Strategy development:

Public consultation
(Sept 2022)

Stakeholder engagement
(Sept/Oct 2022)

Final report and strategy
(Nov 2022)

Final R&I QEC sign off: **6th December 2022**

Steps to growing research in DBTH:

Leading:

NIHR application to secure grant capture as the lead

BORN & BRED IN Doncaster

Cohort data to improve maternal and child health

Partnership:

UKRI Engineering and Physical Sciences Research Council

EPSRC Digital hub: Lead The University of Sheffield

Leadership:

Maximising opportunities to collaborate and lead

Timelines and outputs

www.dbth.nhs.uk

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	F3		
Report Title:	**Bassetlaw Emergency Village Outline Business Case**				
Sponsor:	Dr Kirsty Edmondson Jones, Director of Innovation & Infrastructure				
Author:	Archus				
Appendices:	Bassetlaw Emergency Village Outline Business Case - full suite of appendices available upon request				
Report Summary					
Purpose of report:	The purpose of this report is to seek approval of the Bassetlaw Emergency Village Outline Business Case.				
Summary of key issues/positive highlights:	◆ Delivery of the preferred option requires capital investment of £17.98m, delivered predominantly via £17.605m of Wave 4 STP funding, which needs to be utilised by March 2024. ◆ The draft Programme to support these timescales are ambitious but work is underway to ensure deliverability. ◆ Overall, the investment offers high value for money with the economic model demonstrating a Benefit Cost Ratio of 4.48 to 1. ◆ The LTFM demonstrates the scheme is affordable in the long term. ◆ However, this is dependent on the delivery of cash releasing benefits and work is required as part of the Full Business Case to develop a workforce model that supports this.				
Recommendation:	Receive the Finance & Performance Committee's recommendation to approve the BEV Outline Business Case for submission to NHSE/I by 29th July 2022.				
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 changes made to the relevant strategic aim on the Board Assurance Framework
Corporate risk register:	N/A
Regulation:	The purpose of the report is not linked to regulatory requirements.
Legal:	The purpose of the report is not linked to legal requirements.
Resources:	No impact on resources.
Assurance Route	

Previously considered by:		Bassetlaw Emergency Village Steering Group Bassetlaw Emergency Village Project Board Finance & Performance Committee	
Date:	21/07/2022	**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

1. Introduction

The Bassetlaw Emergency Village (BEV) Project is currently developing the Outline Business Case (OBC) to secure £17.605m to create a modern, fit-for-purpose emergency care facility at Bassetlaw Hospital. The new facilities will be appropriately configured and right sized to deliver high quality care and meet the rising demand for services.

2. Original STP Bid

In March 2020 an STP bid was submitted for £17.605m for the development; enabling the Trust to meet demand, patient safety, critical infrastructure, and Care Quality Commission (CQC) concerns with emergency pathways at Bassetlaw Hospital (BH). In particular it made the case for the following:

- Upgraded emergency care service at BH, appropriately configured and right-sized to deliver the highest standards in emergency care
- Full integration of urgent care services with the emergency department, with single ambulant points of access to UTC and ED facilities
- Enhanced co-located diagnostic imaging facilities to support the transformation of the emergency pathways
- An environment that maximises efficient and effective use of the workforce to deliver high quality emergency care and sustain the care quality improvement trajectory
- Backlog maintenance and estates infrastructure

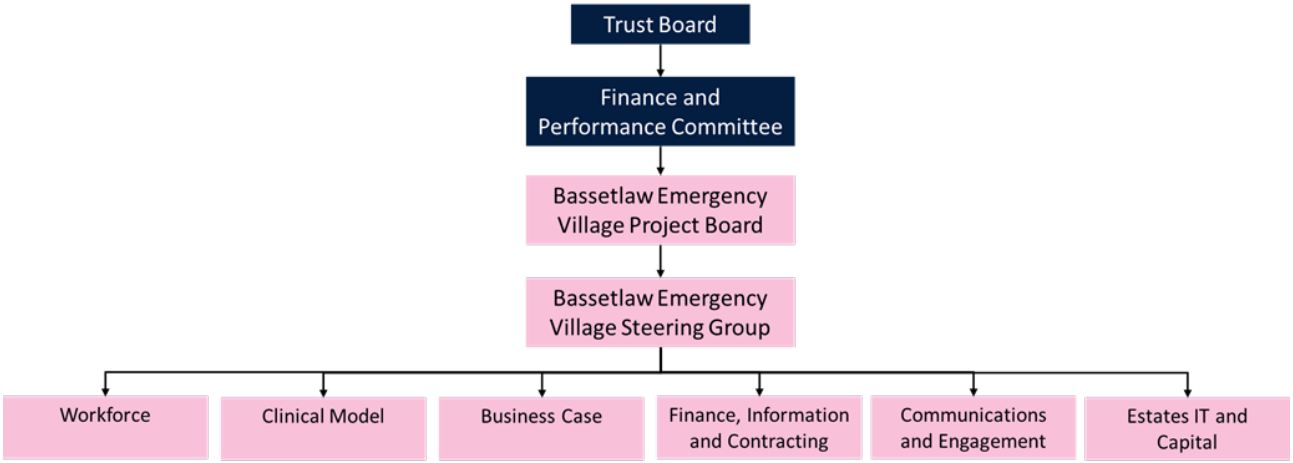
The successful STP bid allocated £17.605m to the project.

3. Project Structure & Governance

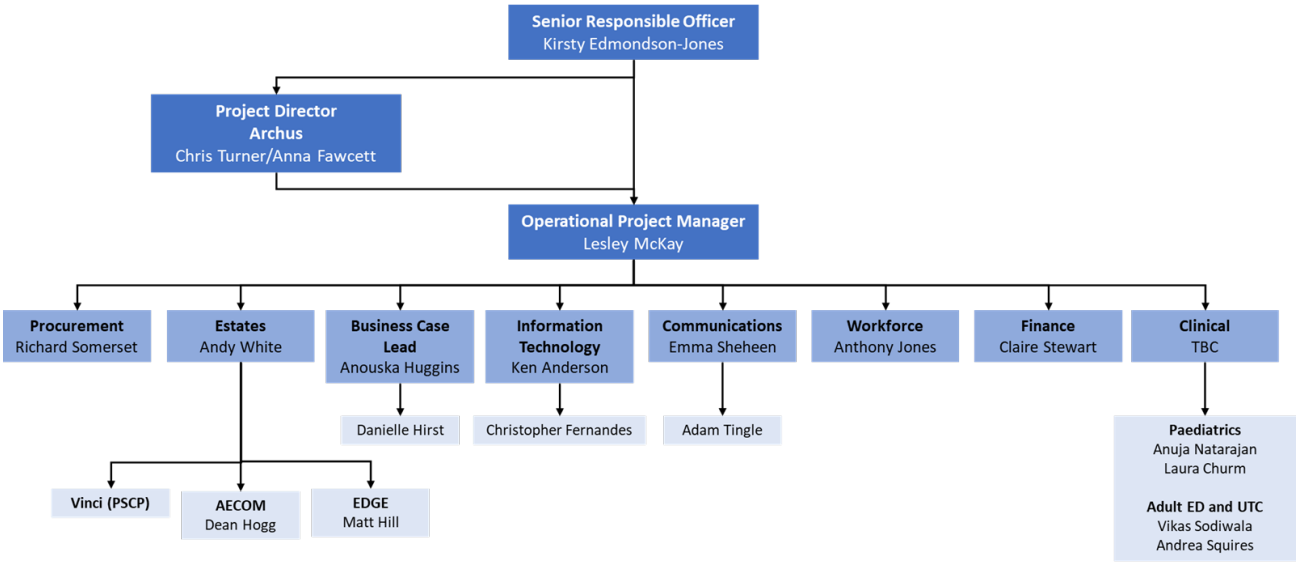
In December 2021, the Trust procured the services of Archus to provide Project Director and Strategic Healthcare Planning support to the project, and to alleviate some of the project related pressure from the (then) SRO Marie Perdue. It was agreed to undertake the following as part of the initial stages of the commission:

- Review governance & meeting arrangements - produce Project Implementation Document (PID) and confirm roles, responsibilities, project structure and governance and reporting arrangements
- Detailed review of project programme and risk register
- Update the Schedule of Accommodation (SOA) by remodelling patient activity with associated coding issues and impact of covid to be thoroughly understood
- Confirm Model of Care and produce Clinical Brief document for approval
- Work with the Trust capital PM (AECOM) and provide operational PM support whilst internal support was sought (internal resource now in post)

The project governance structure has been established to reflect the principles and themes of controlled project delivery. The following governance structure has been approved by the Project Board:



Post Marie Perdue leaving the Trust it was confirmed in May 2022 that Kirsty Edmondson-Jones would take up the role of Project SRO in the following Project Management structure.



4. Structure and content of the document

The OBC has been prepared using the agreed standards and format for business cases, as set out in NHS Improvement Capital regime investment and property business case approval guidance for NHS trusts and foundation trusts (NHS Improvement 2016).

The approved format is the Five Case Model, which comprises the following key components:

Strategic Case	This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
Economic Case	This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM).
Commercial Case	This outlines the content and structure of the proposed deal.
Financial Case	This confirms funding arrangements and affordability and explains any impact on the statement of financial position of the organisation.
Management Case	This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

5. Existing Arrangements & Rationale for Investment

Urgent and emergency care services at BH are currently provided in a number of locations across the site:

Service	Role
Emergency Department (ED)	Minors (UTC)/Majors/Resus for adults and children. Open 24/7
Assessment and Treatment Centre (ATC)	For medical, surgical or frailty assessment. LoS 24-72 hours
Children's Assessment Unit	10 spaces for assessment and treatment of children and young people. Open until 9pm, last referral 7pm. Children needing overnight care/observation transferred to DRI.
Fracture Clinic	Open 9 hours per day, 5 days per week.
Same Day Emergency Care (SDEC)	For medical, surgical, gynae or frailty non elective care. LoS up to 12 hours. Open 12 hours per day, 7 days per week

The current location of services is shown as follows:

The configuration of existing urgent and emergency care services at BH is no longer fit to deliver the Trust's preferred clinical model for emergency care. The main problems are:

ED capacity

- The department was originally designed and built to safely manage a maximum of 100 people a day. It currently sees an average of 153 patients a day, with the highest ever daily attendance at 236.

Patient flow

- The emergency care pathway is currently fragmented which results in inefficiency and lack of flexibility.
- Urgent, ambulatory and assessment services should be co-located.

- Streaming patients to the most appropriate care pathway will result in improved clinical outcomes, operational efficiencies and reduced admissions.

A review of U&EC services at BH (which formed part of a wider review across the ICS) made recommendations in the following areas:

- Streaming could be improved by moving from the current model of streaming at the ED front door to a model in which UTCs (staffed by a combination of primary care and acute staff) act as the front door of ED to enable emergency medicine specialists to focus on higher acuity need within the ED.
- Many 'minors' could be considered for alternative care settings. Earlier signposting of patients by community-based teams/ambulance services could avoid ED attendances and admissions.
- Direct access into SDEC facilities avoiding inappropriate use of ED.
- SDEC facilities should be developed to accommodate an enhanced frailty pathway to help older patients access the care they need without having to go through the ED, and other high-volume pathways such as respiratory, abrasions/contusions etc.

Paediatric urgent and emergency services

In previous inspections, the CQC found that paediatric nursing ratios were inadequate due to Children's services being located in different parts of the site. Patient pathways within ED were specifically highlighted due to the front door streaming process and the number of paediatric nurses available within the department.

Backlog maintenance and estates issues

The condition of the building is currently too poor to make it suitable for its role in the future as part of the ICS emergency services provision. Backlog maintenance costs are high, and the BH site also has RAAC roofing on a number of buildings which are due to be replaced as part of the national RAAC eradication programme.

Recruitment and Retention

One of the longstanding key challenges for services is the recruitment and retention of staff. This is not unique to the local area and workforce shortages have been exacerbated by the pandemic.

6. Model of Care & Clinical Brief

The Emergency Village will contain all facilities required for the resuscitation, assessment and initial management of patients who have been injured or are acutely ill. The department will also treat patients who cannot be appropriately dealt with by primary care services. Patients may be referred from the following sources:

- Self-referral
- GP emergency referrals
- Ambulance Service
- Walk in centre
- NHS Direct
- 111 First

The front end 'Emergency Department' is pivotal in the delivery of healthcare to the public. Ultimately how the new facility manages emergencies will reflect how it achieves the high-quality care it aims to deliver. The service will provide a single point of access for all adult and paediatric emergencies at Bassetlaw Hospital.

The Emergency Village will accept adult and paediatric patients 24 hours a day, 7 days per week, 365 days per year. Care will be provided, following triage/streaming, within one department divided into sub-units:

Emergency Department (ED):

- Resuscitation;
- Rapid Assessment & Treatment (RAT);
- Integrated Adult Assessment & Treatment (combined Majors & Minors);

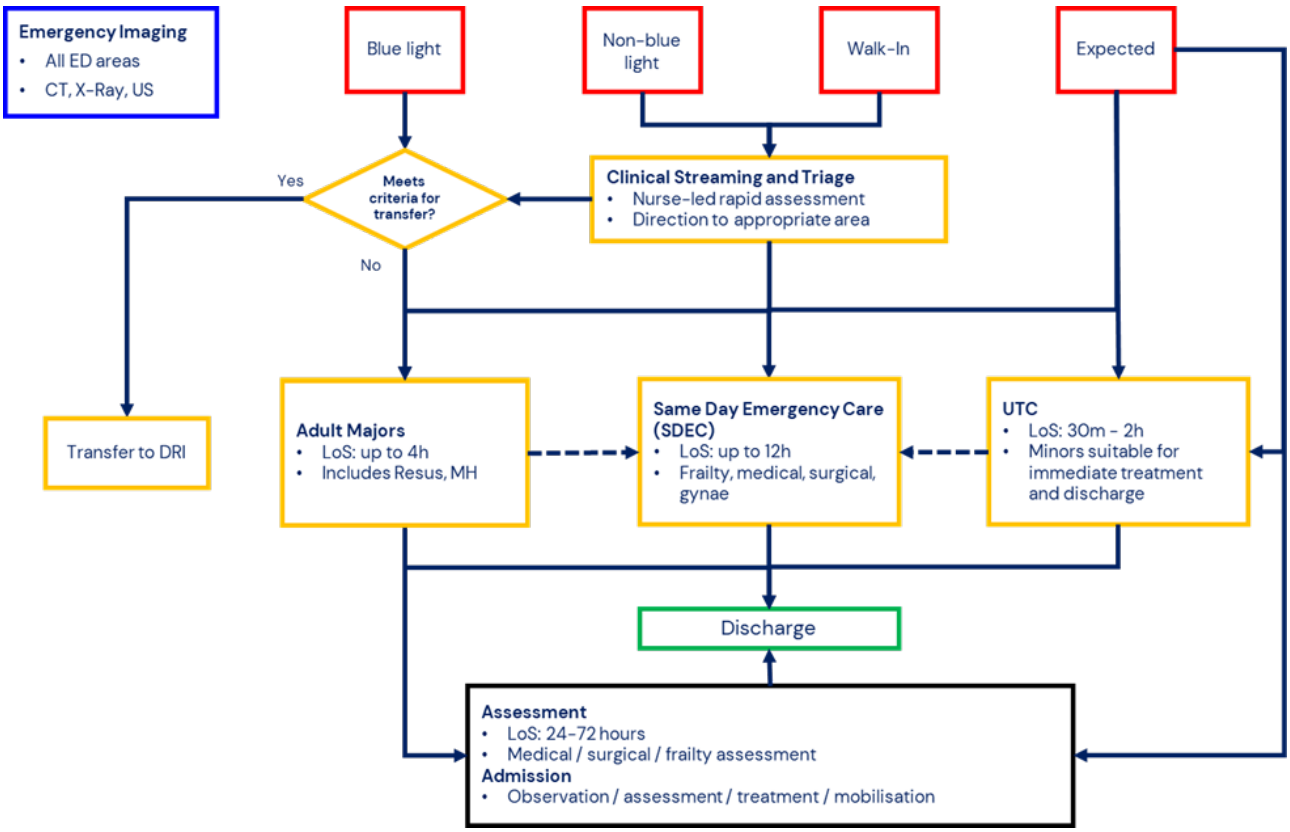
Social Care & Mental Health Facilities;

- GP Out of Hours Service;
- Same Day Emergency Care (SDEC);
- Assessment and Treatment Centre (ATC);
- Children's Emergency Department (CED);
- Children's Assessment Unit (CAU);
- Fracture Clinic;
- Central Staff Support Zone.

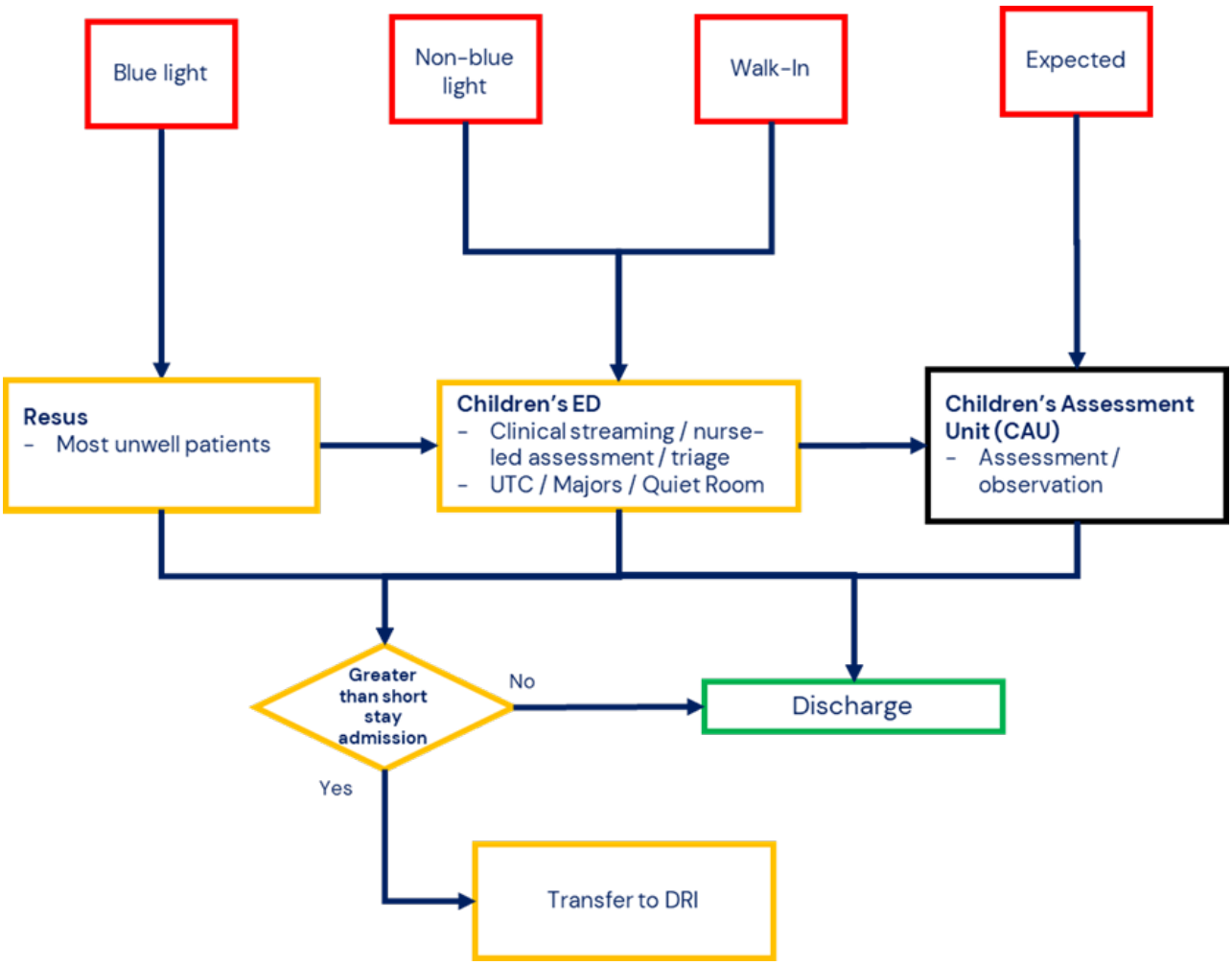
The model of care and clinical brief has been developed with all relevant specialty service providers as part of an extensive engagement programme of workshops. The model reflects the discussions and has gained the support of relevant services involved in its development. The model will inform the simplified development of the facilities which will facilitate delivery of integrated front door emergency care for adults.

The clinical brief has been appended to this report as Appendix 1.

The below diagram presents the ED pathway for Adults:



The below diagram presents the ED pathway for Children:



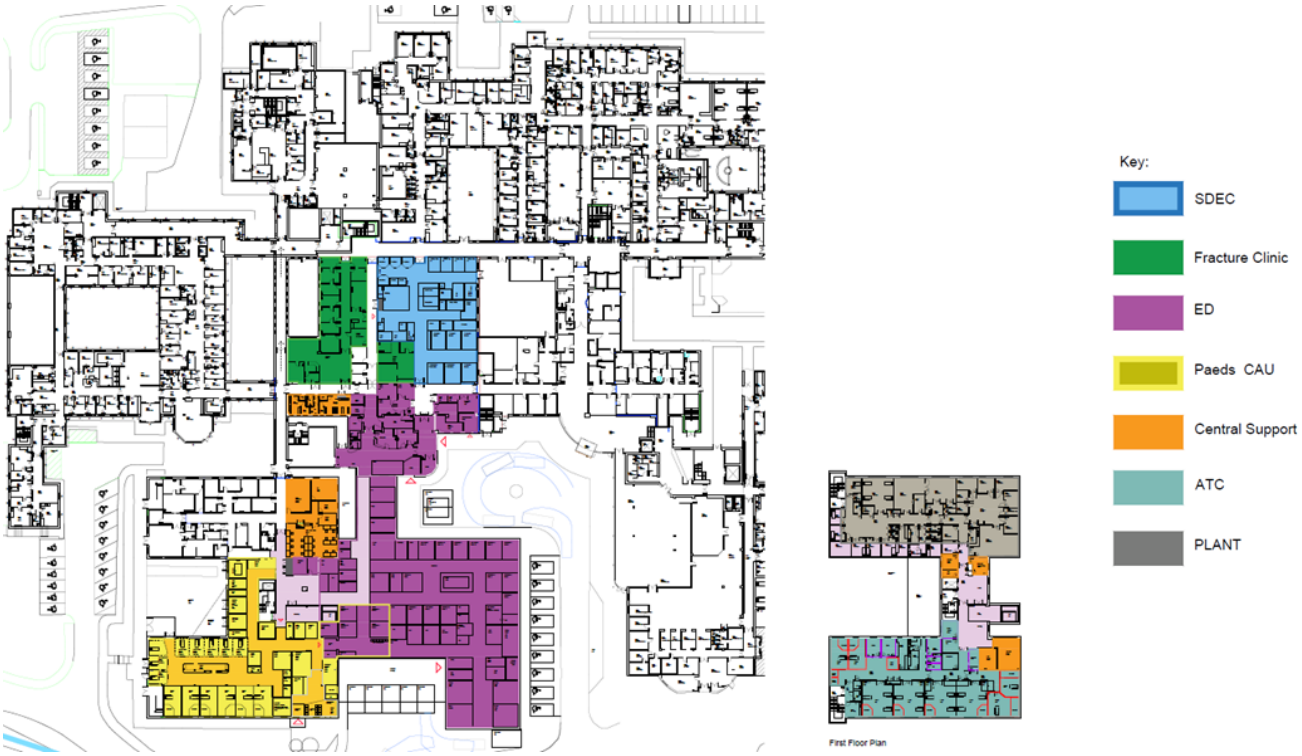
7. Schedule of Accommodation

Appendix 2 presents the history of the Schedule of Accommodation (SOA) with versions 1 to 8 being developed with limited clinical input and focus on a producing a financially suitable SOA. Versions 9 to 15 have considered the clinical desires, activity and capacity modelling and financial suitability. Version 9 has been produced as an HTM/HBN compliant schedule of accommodation and later versions have derogated from this version based on Trust and design requirements.

The Schedule of Accommodation (SOA) has been appended to this report as Appendix 2.

8. Preferred Option & Design

The design of preferred option, which involves refurbishing and extending the Mental Health building to create the Bassetlaw Emergency Village, is a direct output from the SOA V.12 and has been further defined through stakeholder engagement with clinical leads and key members of the project team. This has generated further iterations of the SOA and it was V.15 (as drawn by the architect) that has been costed for the purposes of informing the Economic Appraisal.



9. Capital Cost

It is anticipated that delivery of the preferred option will require capital investment of £17.89m which will be funded as follows:

- £17.605m provided through Wave 4 STP funding as outlined in the original SOC.
- £0.393m self-financed by the Trust including:
  - £0.186m funded as part of the Trust's wider Mental Health scheme, specifically in this case to provide appropriate Mental Health spaces in ED.

- Work is underway to explore options to fund the remaining £0.207m, such as value engineering to reduce costs as the design of the scheme matures.

10. Economic & Financial Review

In line with best practice, a rigorous options appraisal was conducted which considered a wide range of options using the HM Green Book Options Framework. This identified a shortlist of four options and the subsequent economic appraisal demonstrated that the preferred option offers best value for money with the best incremental Net Present Social Value (NPSV) and a Benefit Cost Ratio (BCR) of 4.48.

This is because the £17.98m investment generates a range of benefits including:

- Providing CAU facilities overnight will result in fewer children being transferred to DRI reducing associated costs.
- Improved adjacencies between ED and ATC will enable more integrated ways of working and deliver rota efficiencies.
- The integrated front door and improved clinical flows will enable ED to achieve national targets and reduce patients' time spent in the department.
- Providing a better working environment and clinical model that will provide opportunities to improve recruitment and retention, reduce sickness absence, and reduce reliance on agency usage.
- Providing modern efficient facilities that will improve energy consumption.
- Delivering social value through local investment including creation of apprenticeship and new construction job opportunities.

The revenue consequences of this investment include £143k of incremental operating costs, £196k of annual depreciation charges and Public Dividend (PDC) dividend payments calculated at 3.5% of net relevant asset value each year.

Revenue affordability is dependent on the delivery of the cash releasing benefits of £683k p.a. to mitigate these costs and, it should be noted, that

- Further work is required to develop the workforce model behind this at FBC stage.
- The workforce model is dependent on delivery of the RAAC scheme to unlock the benefits of adjacencies with ATC.

11. Project Programme

To date the project team has been working well to keep to the current project programme, with anticipated OBC submission to NHSE&I at the end of June 2022. The current programme also denotes a build start date of June 2023 with an approximate 2-year build.

It was confirmed at the last Project Board (16th May) that funding from the centre (£17.6M) has to be spent by end of March 2024. This was the first time this information had been shared with the Trust by NHSE&I and the current Preferred Way Forward and associated programme cannot meet such timescales.

In addition, the capital cost challenges outlined in section 8 have resulted in the June 2022 OBC submission date to NHSE&I being unachievable, and rescheduled for July 2022. NHSE&I have confirmed that the OBC will go to either the October or November 2022 Recommendation Board for approval depending on demand in the system. However, they are mindful of the FBC related dates for delivery and have committed to working with the Trust to ensure timescales are adhered to.

Activity	Start Date	End Date
OBC Production	05/05/2022	26/07/2022
NHSE&I OBC Approval	30/07/2022	21/10/2022
Design Development (RIBA stage 3)	18/07/2022	31/10/2022
Design Completion (RIBA Stage 4 Co-ordinated Design)	11/10/2022	17/01/2023
Market Testing	27/09/2022	28/11/2022
Receipt of GMP	13/12/2022	13/12/2022
Finalisation of FBC	14/12/2022	13/01/2023
Trust Approval	16/01/2023	20/01/2023
Submit FBC to NHSE&I	23/01/2023	23/01/2023
NHSE&I FBC Approval	23/01/2023	14/04/2023
Stage 4 Enabling works	20/02/2023	31/03/2023
Stage 4 Construction Works	03/04/2023	05/04/2024
Handover and Completion	05/04/2024	19/06/2024

12. Recommendation

The Finance & Performance Committee are asked to:

- Note and accept the BEV Project OBC Executive Summary agreeing the detailed economic business case and the associated, highlighted capital and revenue costs/risks/benefits.
- Receive, review and recommend approval of the BEV Outline Business Case to Board of Directors for submission to NHSE/I on 29th July 2022.

Archus

The healthcare infrastructure specialist

Bassetlaw Emergency Village Clinical Brief

Draft for sign off - May 2022

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Document Control

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1.2 Purpose of the ED

2 Emergency Department

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2.3 Adult Emergency Department

2.4 Fracture Clinic

2.5 GP Out of Hours Service

2.6 Same Day Emergency Care (SDEC)

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3.1 Peak period modelling approach

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3.3 Growth

4 Functional Content

4.1 Model of Care

5 Facility Requirements

5.1 Schedules of Accommodation

6 National Standards

7 FM Service Requirements

8 Environmental Requirements

Appendices

Appendix A – Schedule of Accommodation V12

Document Control

Report for	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
File ref	https://archusuk.sharepoint.com/sites/Midlands/Shared Documents/Clients/Doncaster and Bassetlaw NHS Trust/03 Bassetlaw Emergency Village HCP/01 Clinical Brief/02 Bassetlaw CB/01 Bassetlaw Clincial Brief.docx
Prepared by	Paul Sheldon
Date	May 2022
Checked by	
Date	

Version Control

Version	Date	Version	Person
V1	16/03/22	Development of template and population of content.	Monique Chavda
V2	25/03/22	First draft document for issue	Paul Sheldon
V3	16/05/22	Final draft document for sign off	Paul Sheldon
V4	20/05/22	Updated existing functional content on SOA summary	Paul Sheldon

1 Introduction and Purpose

1.1 Overview

The Emergency Village will contain all facilities required for the resuscitation, assessment and initial management of patients who have been injured or are acutely ill. The department will also treat patients who cannot be appropriately dealt with by primary care services. Patients may be referred from the following sources:

- Self-referral
- GP emergency referrals
- Ambulance Service
- Walk in centre
- NHS Direct
- 111 First

The front end 'Emergency Department' is pivotal in the delivery of healthcare to the public. Ultimately how the new facility manages emergencies will reflect how it achieves the high-quality care it aims to deliver. The service will provide a single point of access for all adult and paediatric emergencies at Bassetlaw District General Hospital (BDGH).

The Emergency Village will accept adult and paediatric patients 24 hours a day, 7 days per week, 365 days per year. Care will be provided, following triage/streaming, within one department divided into sub-units:

- Emergency Department (ED):
  - Resuscitation;
  - Rapid Assessment & Treatment (RAT);
  - Integrated Adult Assessment & Treatment (combined Majors & Minors);
- Social Care & Mental Health Facilities;
- GP Out of Hours Service
- Same Day Emergency Care (SDEC);
- Assessment and Treatment Centre (ATC);
- Children's Emergency Department;
- Children's Assessment Unit (CAU);
- Fracture Clinic;
- Central Staff Support Zone.

1.2 Purpose of the ED

The ED will provide services to adults and children.

- The ED provides a twenty-four-hour emergency service of resuscitation, stabilisation, investigations, early treatment and appropriate referral for critically ill adult patients including the initial management of patients involved in a Major Incident.
- Children under sixteen years will be seen in the separate Paediatrics area. This will require good and immediate routes through to the Paediatric Department.
- The department provides a designated covered area external to the building for the parking of ambulances and the protection of patients from the weather whilst transferring them into the ED. In the event of a major incident there will be a requirement to be able to secure and isolate part of this area.
- External space is required immediately outside of the ED for erecting inflatable chemical decontamination tents supplied via the Ambulance service. The ED require storage for their own unit. The unit may need to be secured to an external wall. Hot and cold water supplies are required along with an electric compressor to inflate the tents. External planning must facilitate a space which would enable a considerable amount of activity.
- The ED will provide Mental Health rooms within the adult and paediatric departments offering assessment, screening and onward referrals.
- All the areas within the Emergency department work closely as a unit to manage the flow of non-elective patients attending the hospital. It is imperative that the flow from the ED and the corresponding assessment areas is direct and seamless allowing the smooth transfer of patients into an appropriate assessment bed without delay.

2 Emergency Department

The emergency care entrance provides access to the ED for all patients and visitors attending the department. It is the focal point to receive critically ill unplanned patients & provide rapid assessment of all patients who access emergency care.

2.1 Emergency Department (ED)

Self-presenting Patients

All patients requiring emergency care arriving by private and public transport will use the ED Entrance & Waiting. On arrival patients will report to reception where they will be; booked in if required; triaged and streamed to the appropriate zone by a member of the nursing team; directed to waiting for assessment. Patients will then be directed by a member of clinical staff to a patient room where their details & medical history will be taken & any examination to assess the injury undertaken. Following assessment patients will either be:

- Treated in the ED and discharged home, via main entrance;
- Referred on to the ATC, Fracture Clinic or SDEC;
- Referred on to a specialty department (eg. Theatres, Critical Care, Cardiology etc);
- Admitted to the hospital as an inpatient,

All self-presenting patients, triaged by reception as needing immediate attention, will be taken directly to Assessment or appropriate department (e.g. resuscitation).

Children will be seen in the paediatric department for both waiting & assessment, not here.

Ambulance Patients

Patients brought in by ambulance will enter the department by a separate dedicated entrance. All patients arriving by ambulance will be triaged immediately by a senior nurse, within a “handover area” easily accessible from the ambulance entrance. Patients requiring urgent attention will usually be met at the ambulance entrance by department clinical staff and either be treated in RAT or taken directly to the appropriate department (most will be expected as the ambulance crews will call ahead to inform the department). The Ambulance crew will inform reception of any patient details for registration.

Patients arriving by ambulance will be treated in either RAT, a majors room, a resuscitation room, or in the “handover area”, and will not use the main entrance waiting area.

Relatives/friends

Most patients will be accompanied by at least 1 person. Most of the time although the relatives/friends will spend some time in the main entrance area waiting as well as time with the patient in the treatment area. They may also wish to make phone calls/using vending facilities etc. Where patients are accompanied by more than 2 relatives/friends they will be asked to wait in The ED Entrance & Waiting area, or be directed to appropriate café or public facilities on site.

2.2 Integrated Front Door (IFD)

The Integrated Front Door (IFD) provides the initial point of contact for all self-presenting patients, whether they are walk-in patients or are referred by their GP, 111, or NHS Direct. Patients are greeted at reception, booked in if required and streamed to the relevant sub-department.

The IFD comprises reception, a small local waiting area, sanitary facilities, parking for prams, pushchairs, shopping and wheelchairs, and Triage / Streaming rooms.

Social Care & Mental Health Facilities

Adjacent to the IFD, social care and mental health facilities are provided for those patients that are distressed, confused or in some way mentally impaired. Facilities include a multi-use room for de-escalation, counselling, examination and minor treatment, along with dedicated sanitary provision.

2.3 Adult Emergency Department (ED)

There are three groups of patients attending the Adult ED department:

- Patients requiring immediate resuscitation
- Non-ambulatory (needing a trolley)
- Ambulatory or Independent Wheelchair users

Purpose

To assess and treat all patients with a significant recent injury or acute illness and where appropriate fast track them to a specific clinical centre.

To set up and maintain telemedicine links between ED, ambulances and other health settings.

Scope

This department will provide an emergency service for adults within the Bassetlaw area.

The department receives life-threatening emergencies as well patients suffering from traumatic injury, psychiatric problem, or those of a more minor nature.

The department is the focal point in any major incident as described in the Trust's major incident policy.

To provide an assessment service to those patients, between the ages of 16 + who present with a mental health problem.

Service Trends

The development of the Urgent care/111 services will allow the streaming of minor illness to Primary Care and Urgent Treatment Centres

People attending the department are becoming sicker, attending with higher acuity illness.

The likely outcome of the above is that this department will see an increasing number of more seriously ill patients, who will require more treatment.

Adults requiring resuscitation

Most of these patients will be brought in by ambulance and they will be known about in advance and pre-registered through radio contact with ambulance service. However, some patients will collapse in the department or be assessed as definitely or possibly requiring resuscitation at assessment. Patients in the ED areas whose condition deteriorates sufficiently may also be transferred to the resuscitation area if clinical circumstances require.

Patients needing resuscitation will be transferred directly from the ambulance to a resuscitation bay. This includes paediatric resuscitation.

Patients requiring resuscitation/stabilisation may be accompanied by 2 adults on average who will wish to stay at the bedside or within the relatives room adjacent to Resus.

Patients requiring plain X-ray may have these taken in the resuscitation room, via the use of a mobile X-ray machine. The ability to image patients from head to foot is essential with 360° access and at least 1 metre clearance beyond either end of the trolley is required.

Some patients will need to be moved out of the area for CT and/or MRI scanning. They will return to Resus afterwards.

Resus patients may be transferred to theatre, to adult critical care or to an in-patient ward. Some patients will need to be transferred to other hospitals by ambulance; some patients will die and need to be transferred to the mortuary.

Non-ambulatory patients

These patients will typically arrive by ambulance although some may self-present.

- All patients are registered, and then are assessed. If they require treatment they will be treated and if not, then they will be discharged. In the event of patients arriving who have been contaminated with chemical or biological materials these patients will first go to the decontamination area, this will be erected for this purpose outside the department in a dedicated area.
- Most patients are accompanied by an average of 2 adults who will stay with them during their time on the unit.
- Investigations may be requested that require the patient to be transferred by a porter & a nurse escort to other areas, such as Imaging.
- The majority of treatment is undertaken in the patient examination / assessment room into which they were streamed, thus the treatment comes to the patient. Exceptions to this are non-mobile imaging as mentioned above.
- Following treatment, patients will leave the department & either be admitted to an in-patient facility, discharged home or transferred to another hospital. Patients whose condition deteriorates sufficiently may also be transferred to the resuscitation area if clinical circumstances require.

Ambulatory patients

These patients may arrive by ambulance or by other means of transport.

- All patients are registered, triaged and assessed and then based on the assessment are treated or not treated. Patients not requiring treatment are sent home following registration.
- Most patients may be accompanied by an average of 2 adults who will stay with them during their time on the unit.
- Investigations may be requested that require the patient to be transferred by a porter & a nurse escort to other departments such as Imaging.
- The majority of treatment is undertaken in the Patient Room into which they were streamed, thus the treatment comes to the patient. Exceptions to this are imaging as mentioned above and patients with fractures requiring a plaster cast. These patients are transferred to the Fracture Clinic after which they might return to the examination room and given aids such as crutches or be discharged directly from the Fracture Clinic. Some patients will require counselling or an interview with another health professional, e.g. a psychiatrist, or social worker. Following these discussions patients will leave the department & either be admitted to an in-patient facility, discharged home or transferred to another hospital. Patients whose condition deteriorates sufficiently may also be transferred to the resuscitation area if clinical circumstances require.
- A number of patients attending the unit will have complex discharge needs involving a range of agencies. Individual Patient Rooms will allow confidential discussions to take place.

Patients requiring emergency liaison psychiatry referral

These patients will be registered and assessed as per Ambulatory/Non-Ambulatory patients and a referral made to the liaison service as necessary to see them in the area appropriate to their care.

Any of these patients requiring a secure facility will be triaged to the Social Care and Mental Health facility. Where a patient is identified as a potential/definite admission, the patient should be transferred to the appropriate facility

Patients with suspected infection requiring isolation

These patients will be registered and assessed and then transferred direct, or as soon as isolation is deemed a requirement, to the isolation facility.

ED Accommodation Overview

The ED comprises:

- GP Out of Hours Service
    - 4 x clinic rooms to be shared with Bassetlaw Urgent Care Service (BUCS)
    - Patient WC
    - Support including Dirty Utility, resus trolley bay and linen store
- Ambulance Entrance & RAT

  - Entrance lobby
  - Handover area
  - 2 x Rapid Assessment and Treatment (RAT) rooms (part of Majors activity)
  - Staff WC
  - Storage for Major Incident equipment, Ambulance equipment, and trolley and wheelchair parking
- Resuscitation
  - 3 x adult resus rooms
  - 1 x child resus room
  - Staff Base
  - Clinical support zone
  - Dirty Utility
- Distressed and Bereaved Persons Facilities
  - Sitting room and associated beverage bay
  - Visitor WC
  - Body viewing / Bier room
  - Counselling room for breaking bad news and private discussions
- Adult Assessment and Treatment (combined Majors and Minors)
  - Sub-wait area
  - 13 x exam / treatment rooms + 4 Recliner chair bays
    - 1 room designated for infectious patients
  - 1 x treatment / procedure room
  - Staff base
  - Sanitary facilities
  - Support spaces including clean and dirty utility, satellite pharmacy, beverage bay, appropriate storage & FM facilities
  - Clinical administration workspaces

2.4 Fracture Clinic

Patients with fractures, musculoskeletal or orthopaedic conditions will be transferred to the Fracture Clinic, where they will be assessed and treated. If a cast is to be applied, this will be undertaken in the plaster room.

The Fracture Clinic is an existing facility on site that is to be retained.

2.5 GP Out of Hours Service

The GP Out of Hours Service is provided for patients that require GP care out of the normal working hours of their GP practice, and without an appointment. It is adjacent to the main ED and is accessed directly from the IFD.

This area will also be used by the Social Prescribing team, and the Bassetlaw Urgent Care Service (BUCS). The accommodation provided is described under the ED section of this document (Section 2.3)

2.6 Same Day Emergency Care (SDEC)

Same day emergency care (SDEC) is the provision of patient care with an investigation and/or treatment within the same day for non-elective patients who in the past would otherwise be admitted to a hospital bed. Under this care model, referred patients presenting at hospital with specific conditions can be rapidly assessed, diagnosed and treated without being admitted to an in-patient ward.

Patients can be referred to an SDEC through a number of different ways, including:

- triage on arrival at an emergency department (ED);
- direct referral from ED after some initial assessment;
- direct referral from GP or out-patient services;
- direct referral from the ambulance service;

Acuity, presenting condition and mobility of patients of any specialty will predict whether a trolley or reclining chair needs to be used, although this may change during their time in the unit. For this reason, a selection of patient spaces, included trolley bays, recliner chair bays and armchair bays is provided.

The nature of SDEC means that the patient pathway differs from that of the other sub-departments within the Emergency Village. Patients are often seen on multiple occasions during their time within the SDEC for different consultations, investigations, assessments, and observation. In between these contact points they are asked to return to the waiting area. For this reason, it is recommended that the waiting area is central within the facility, with the assessment and treatment spaces around the outside. A typical flow / adjacency diagram for SDEC is shown below:

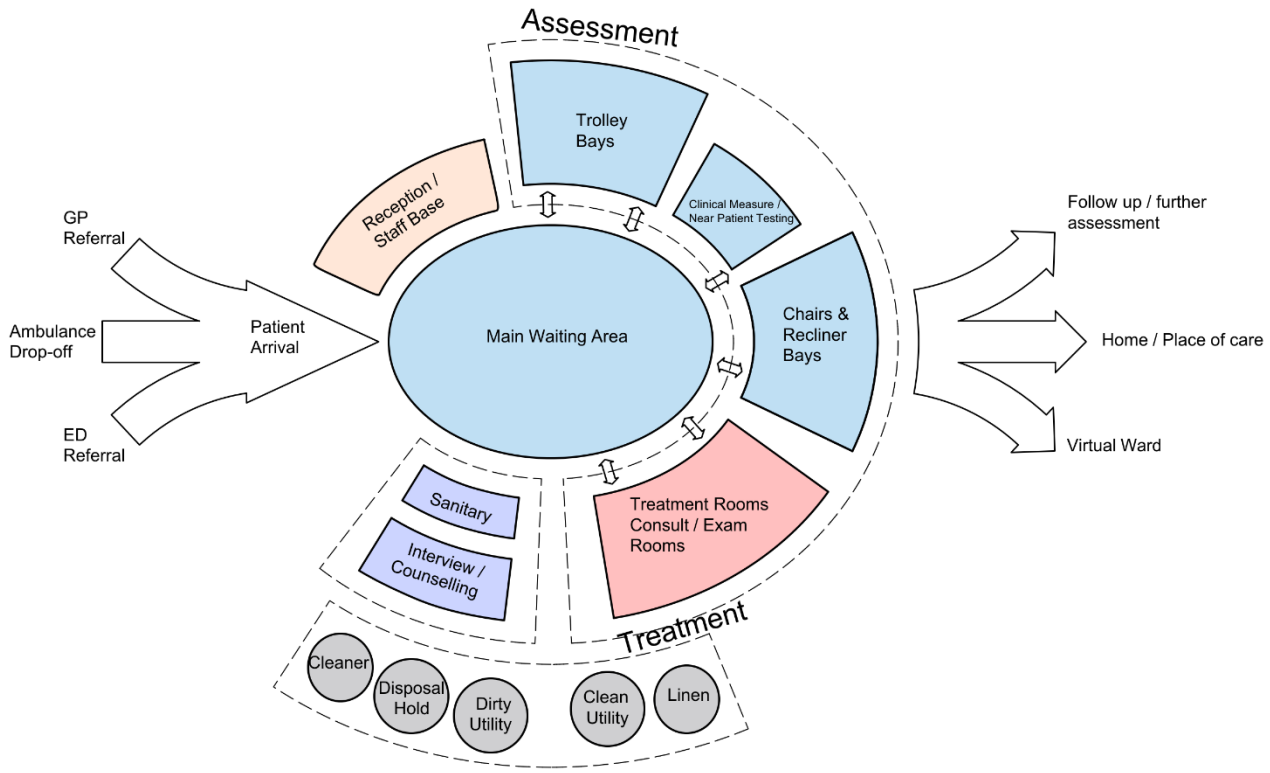


Figure 1 - Typical SDEC Arrangement

2.7 Emergency Assessment Unit (ATC)

The ATC is a bedded area provided for those emergency patients that require further monitoring, observation and assessment following initial examination / treatment but do not require full Inpatient admission.

The ATC allows patients to be observed on a short-term basis and permit patient monitoring and/or treatment for an initial period. This permits concentration of emergency activity and resources in one area, and so improves efficiency and minimises disruption to other hospital services.

The types of patient accepted into the ATC can be classified into high risk discharges, such as chest and abdominal pain; those requiring short-term treatment; patients with limited medical needs and clinical conditions needing only short-term observation.

The ATC is made up of a series of patient bedrooms that are smaller than those in a conventional Inpatient ward because the shorter length of stay removes the need for family space within the room.

Following their stay in the ATC, patients are either discharged or admitted to an appropriate Inpatient ward for further care.

2.8 Children's Emergency Department (Paediatric ED)

Purpose

- To assess and treat all unplanned children & adolescents with a significant recent injury or acute illness or any child who is brought to the department for review.
- To set up and maintain telemedicine links between ambulances and other health settings.

Scope

This department will provide an emergency service for Children & Adolescents in the Bassetlaw area.

Patient flow

There are three groups of patients attending the Paediatric ED department

- Patients requiring immediate resuscitation
- Non-ambulatory (needing a trolley)
- Ambulatory

Following access through the main ED entrance, children and adolescents with be triaged and, if requiring assessment or treatment, transferred to paediatric ED. They will either be seen straight away within an exam / treatment room or will wait in the dedicated sub-wait area.

All patients arriving by ambulance will be triaged immediately, at the ambulance handover station easily accessible from the ambulance entrance.

Children requiring resuscitation

Most of these patients will be brought in by ambulance and they will be known about in advance and pre-registered through radio contact with ambulance service. However rarely a child may collapse in the department or be assessed as definitely or possibly requiring resuscitation at assessment.

- Children needing resuscitation will be transferred direct from the ambulance to a resuscitation room or bay.
- Children requiring resuscitation/stabilisation are accompanied, on average, by 2 adults who will wish to stay at the bedside or within close proximity.
- Children requiring plain X-ray may have these taken in the resuscitation room, via the use of a mobile X-ray machine. The ability to image patients from head to foot is essential with 360° access and at least 1 metre clearance beyond either end of the trolley is required. This area must comply with Radiation Protection Legislation this will include protective shielding between each bay.
- Some patients will need to be moved out of the area for CT and/or MRI scanning they will return to the bay afterwards.

- Children may need to be transferred to theatre, or to an in-patient ward. Some Children may need to be transferred to other hospitals by ambulance; some Children will die and need to be transferred to the mortuary.

Non-ambulatory patients

These children may arrive by ambulance or by other means of transport.

- Following assessment children requiring treatment will be registered & will either be directed immediately to a treatment room or asked to wait in the dedicated Children's ED waiting area. Children with minor illness will be directed to Primary Care. Children not requiring treatment are sent home following initial assessment.
- Most children may be accompanied by an average of 2 adults who will stay with them during their time on the unit.
- Investigations may be requested that require the patient to be transferred by a porter & a nurse escort to other departments such as Imaging. On return to their room a second clinical assessment will be made.
- The majority of treatment is undertaken in the patient examination room into which they were streamed, thus the treatment comes to the patient. Exceptions to this are imaging and children requiring procedures under sedation, which will need to be transferred to a treatment room within the adjacent CAU.
- Some children will require counselling or an interview with another health professional, e.g. a psychiatrist, or social worker. This will take place either in the Assessment room, or the dedicated Safeguarding Suite. Following this discussion children will leave the department & either be admitted to the Paediatric In-Patient Ward, discharged home or transferred to another hospital. Children whose condition deteriorates sufficiently may also be transferred to the resuscitation area if clinical circumstances require.

A number of children attending the unit will have complex discharge needs involving a range of agencies.

Ambulatory patients

Children who present to the main reception will:

- Following assessment children requiring treatment will be registered & will either be directed immediately to a treatment room or asked to wait in the dedicated Children's ED waiting area.
- In the event of a child arriving who has been contaminated with chemical or biological materials these children will first go to the decontamination area, this will be erected for this purpose outside the department in a dedicated area shared with adults.
- Most children may be accompanied by an average of 2 adults who will stay with them during their time on the unit.
- Investigations may be requested that require the patient to be transferred by a porter & a nurse escort to other departments such as Imaging. On return to their room a second clinical assessment will be made.

- The majority of treatment is undertaken in the patient examination room into which they were streamed, thus the treatment comes to the patient. Exceptions to this are imaging and children requiring procedures under sedation, such as suturing, which will be done in the procedure room.
- Following treatment children will leave the department & either be admitted to an in-patient facility, discharged home or transferred to another hospital. Children whose condition deteriorates sufficiently may also be transferred to the resuscitation area if clinical circumstances require.

Patients requiring emergency liaison psychiatry referral

Children requiring emergency liaison psychiatry referral are seen by the appropriate team.

Children with suspected infection requiring isolation

These children will be registered and assessed as soon as isolation is deemed a requirement, will either be placed in an appropriate dedicated isolation room, or transferred to another facility.

Children who require an extended period of assessment before a definitive destination decision is made for them will either be admitted to the Children's Assessment Unit (CAU) or to a Paediatric Ward.

Paediatric ED Accommodation Overview

The Paediatric ED comprises:

- 4 x assessment rooms
    - 1 room to be designated for isolation
- 1 x Safeguarding Suite
- Sub-wait area
- Nurse base
- Patient WC
- Access to shared use of support spaces within the adjacent main ED department (staff access only)

2.9 Children's Assessment Unit (CAU)

The CAU is a bedded area provided for those emergency children that require further monitoring, observation and assessment following initial examination / treatment but do not require full Inpatient admission.

The CAU allows children to be observed on a short-term basis and permit patient monitoring and/or treatment for an initial period. This permits concentration of emergency activity and resources in one area, and so improves efficiency and minimises disruption to other hospital services.

The CAU is similar in function to the ATC, however is dedicated to the care of children under the age of 16. For this reason, a number of the bedrooms are sized to allow for parents' overnight stay. There is also an internal observed play area and an external play area included as part of the CAU. Welfare facilities for parents and families is provided in the form of a sitting room, beverage bay and sanitary facilities.

Following their stay in the CAU, children are either discharged or admitted to an appropriate Inpatient ward for further care.

CAU Accommodation Overview

The CAU comprises:

- 6 x single bedrooms with ensuite sanitary facilities
- 8 x assessment spaces
- 2 x treatment rooms
- Assisted bathroom and shower room
- Staff base
- Observed play area + secure external play area
- Relatives' support space
    - Sitting room with beverage bay / mini kitchen
    - Milk kitchen
- Clinical support space – utilities and storage
- Offices for Sister and Consultant on-call
- Staff support spaces
    - Staff rest
    - Sanitary facilities
    - MDT room
    - On-call room with associated ensuite
- FM Support spaces

2.10 Staff Support Zone

Staff support areas are provided in a centralised staff support zone that is shared by the whole facility. This area includes the following:

- Staff Changing including showers, sized for 45 people
- Staff Rest and mini kitchen, sized for 16 people
- Sanitary facilities
- Office desk-space (open-plan) for 18 people, including
    - 2 x CAU
    - 4 x SDEC
    - 2 x ATC
    - 10 x ED
- 2 x single bookable offices
- MDT Room
- Seminar Room
- Quiet room

3 Activity & Demand Management

3.1 Peak period modelling approach

The Peak period model approach acknowledges that ED demand is varied during the course of the day and capacity is required to sufficiently meet that demand with some assumptions to reflect that not all patients will be seen immediately. This is because to match supply to demand all the time would result in too much (and therefore under-utilised) capacity.

The busiest hours of the day are determined. The distribution of arrivals for that peak period is then set out and capacity is matched to that peak, offset by an assumption that not all activity will be possible to treat in the period of arrival

A time is assigned to each stream in ED and this directly influences the capacity required both at the time of arrival but also the activity that is in the department leading up to the peak period. This refines the logic and provides assurance that capacity will be sufficient to meet demand as it flows through the department.

3.2 Assumptions

The times in treatment rooms do not represent the total time in the department. The modelling is specifically set up to determine room requirements and therefore does not cover the time spent in ED including time spent in:

- Waiting Time
- Triage
- Fracture Clinic
- SDEC
- ATC

The times in the main treatment areas do assume that for those patients who require admission/onward continuous investigation, there will be sufficient downstream capacity to accommodate them. This is a critical assumption because without the downstream release valve for ED, ED will be a bottle neck for admission.

Table 1 - ED Assumption

ED Assumption	
Occupancy rate	Resus: 45.0% Majors: 70.0% Minors: 70.0% Paediatrics: 70.0%
Treatment times	Resus: 180 Majors: 120

ED Assumption	
	Minors: 30 Paediatrics: 60

Table 2 - Fracture Clinic Assumption

Fracture Clinic Assumption	
Operational parameters	Operating Hours: 9 Operating Days: 5 Operating Weeks: 48 Utilisation Rate: 85.0%
Appointment times (mins)	First: 30 Follow up: 20

Table 3 - SDEC and ATC Assumptions

SDEC and ATC Assumptions	
Operational parameters	SDEC Operating Hours: 12 ATC Operating Hours: 24 Operating Days: 7 Operating Weeks: 52 Utilisation Rate: 85%

3.3 Growth

Table 4 - Activity and growth assumptions

Activity and Growth Assumptions	
Baseline activity	Feb 2019 – Jan 2020
Growth	Age adjusted based on DBTH demand growth and market share
Projection Date	2034/35
ED modelling	80% peak period activity model applied

4 Functional Content

The facility will enable the integration at the front door of the following emergency services;

Table 5 - Functional Content - Adults

Stream - Adults	Spaces
[1]Majors	14
[2]Resus	3 + 1 Paediatric Resus place
[3]Minors	5
Mental Health	2 – [reduced to 1 during SOA development]
[4]Primary Care	4
SDEC	12
Fracture Clinic	5
[5]Assessment and Treatment Centre (ATC)	16

Table 6 - Functional Content - Children

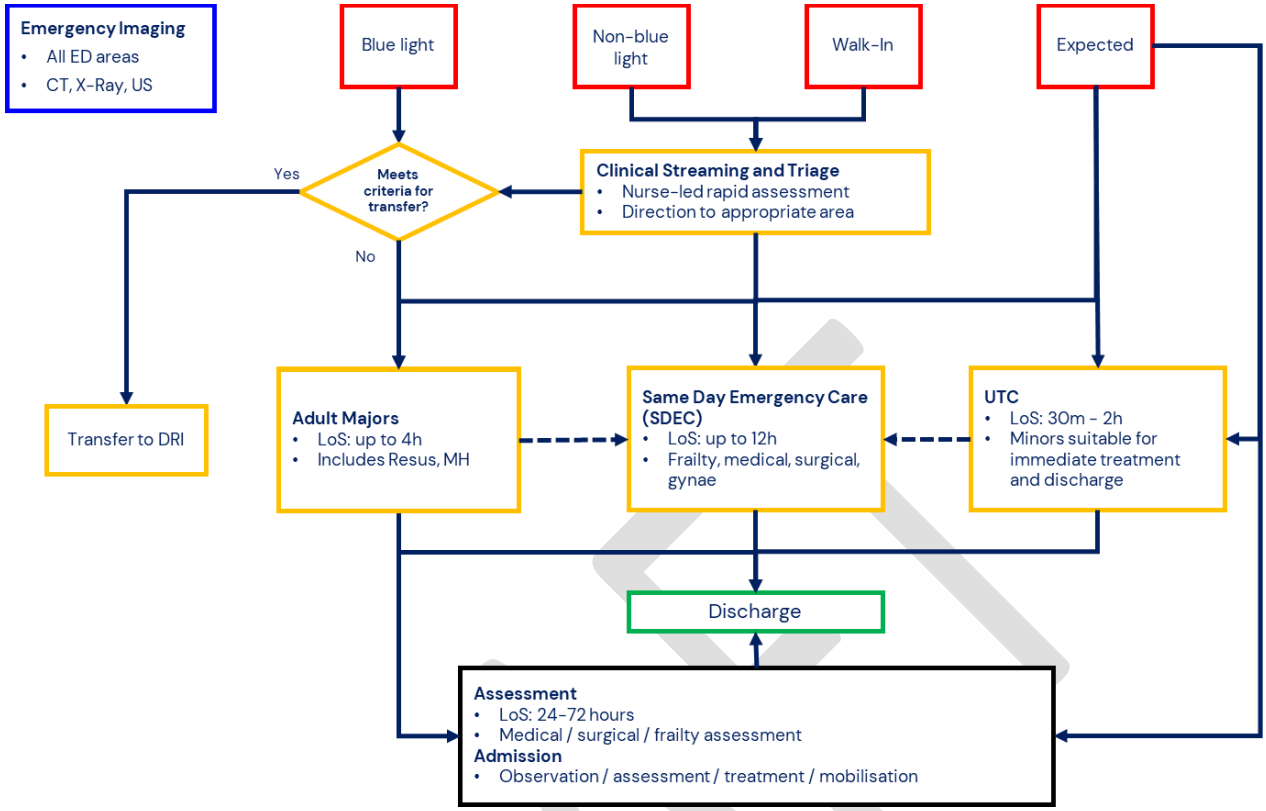
Stream - Children	Spaces
[1]Children's ED	4
[4]Children's Assessment Unit (CAU)	
Children's Assessment Beds	6
Children's Assessment Spaces	8
Children's Treatment Spaces	2

[1]Adult Majors and Children's ED ideally to include 1x each high acuity bays to enable step-down from resus
[2]Includes 1x children's resus space
[3]Minors and Primary Care spaces to be ideally co-located to maximise flexibility of use
[4]Trust instructed as per Option 3 of the Consultation
[5]Agreed in clinical workshop

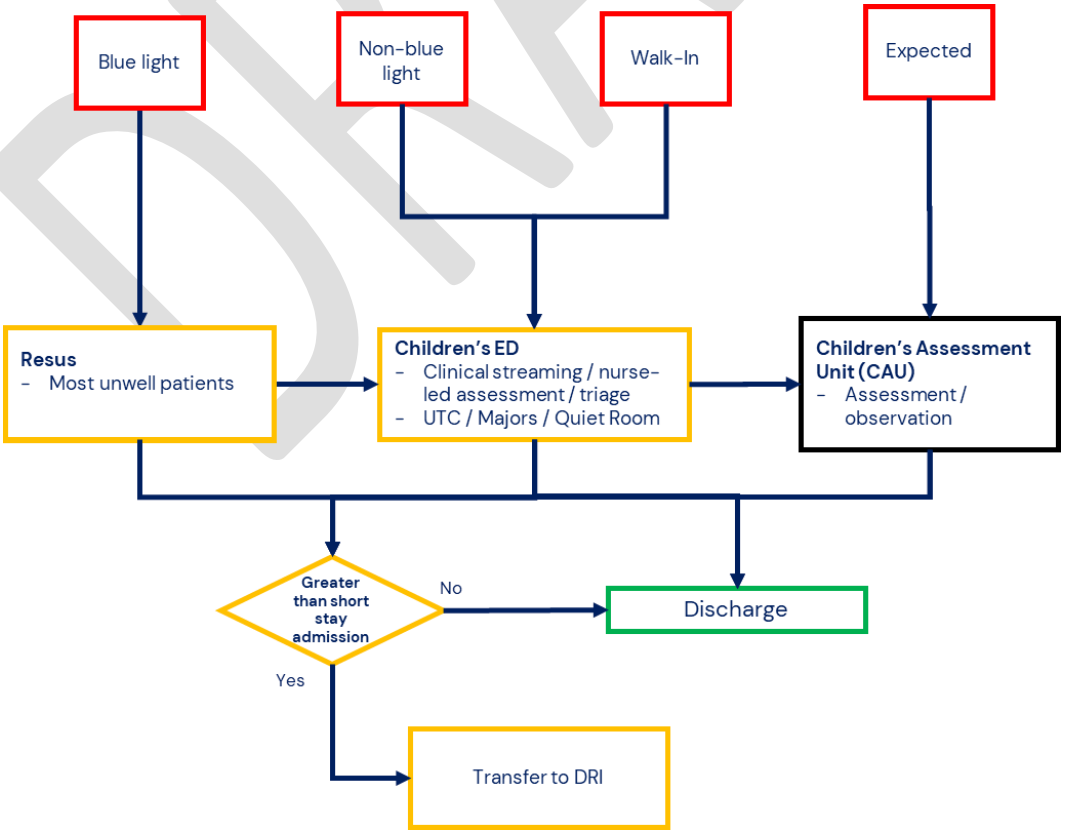
4.1 Model of Care

The model of care has been developed with all relevant specialty service providers as part of an extensive engagement programme of workshops. The model reflects the discussions and has gained the support of relevant services involved in its development. The model will inform the simplified development of the facilities which will facilitate delivery of integrated front door emergency care for adults.

The below diagram presents the ED pathway for Adults:



The below diagram presents the ED pathway for Children:



5 Facility Requirements

5.1 Schedules of Accommodation

The below table presents the history of the schedule of accommodation with versions 1 to 8 being developed with limited clinical input and focus on a producing a financially suitable Schedules of Accommodation. Versions 9 to 12 have considered the clinical desires, activity and capacity modelling and financial suitability. Version 9 has been produced as an HTM/HBN compliant schedule of accommodation and later versions have derogated from this version based on Trust and design requirements.

Table 7 - Schedules of Accommodation Versions

Summary Floor Areas		Previous Versions (pre-Archus)								Archus	Project Instruction					Project
Department		V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14	V15
Integrated Front Door		0.00	0.00	0.00	0.00	0.00	0.00	0.00	435.00	251.16	251.16	251.16	191.10	191.10	191.10	191.10
Emergency Department		1221.28	1623.16	1653.47	1307.25	1307.25	1077.00	997.50	800.00	1479.56	1192.17	1339.17	1005.48	1005.48	1005.48	1029.00
Primary Care		112.20	153.00	200.90	123.20	119.68	119.68	68.00	63.00	inc	inc	inc	inc	inc	inc	inc
Paediatric Emergency & Assessment		361.76	476.00	507.18	375.75	375.75	375.75	375.75	255.00	825.41	825.41	825.41	848.19	927.86	927.86	927.86
Shared Staff Zone		0.00	1025.44	301.50	239.40	232.56	232.56	218.96	406.00	413.82	413.82	413.82	399.57	399.57	386.13	386.13
Total GDA		1695.24	3277.60	2663.05	2045.60	2035.24	1804.99	1660.21	1959.00	2969.94	2682.56	2829.55	2444.34	2524.02	2510.58	2534.10
Whole Facility Allowances																
Communication (12%)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	356.39	321.91	339.55	293.32	302.88	301.27	304.09
Plant (20%)		339.05	655.52	532.61	409.12	407.05	361.00	332.04	0.00	593.99	536.51	565.91	488.87	504.80	502.12	506.82
Gross Internal area		**2034.29**	**3933.12**	**3195.66**	**2454.72**	**2442.29**	**2165.99**	**1992.25**	**1959.00**	**3920.32**	**3540.98**	**3735.01**	**3226.53**	**3331.70**	**3313.96**	**3345.01**
Not included in overall area																
Same Day Emergency Care (SDEC)	290.78	290.78	462.40	510.00	354.00	310.08	310.08	300.56	278.00	528.47	528.47	528.47	455.70	455.70	436.59	436.59
Assessment (ATC)	584.91	584.91	1085.28	0.00	0.00	806.48	806.48	596.36	635.00	734.27	683.55	683.55	644.60	644.60	644.60	644.60
Fracture Clinic	169.32	169.32	209.71	234.75	143.25	129.88	129.88	115.60	214.00	inc	0.00	inc	98.49	98.49	98.49	98.49

Functional Content	Existing	Previous Versions (pre-Archus)								Archus	Project Instruction					Project
Department		V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12	V13	V14	V15
Integrated Front Door	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health	1	1	1	1	1	1	1	1		2	2	2	1	1	1	1
Emergency Department																
Majors	9	11	19	16	12	12	12	12		14	19	19	19	19	19	19
Minors	7	0	0	0	0	0	0	0		5	0	0	0	0	0	0
Resus	3	3	5	5	3	3	3	3		3	4	4	4	4	4	4
Primary Care	4	2	4	5	3	3	3	3		4	4	4	4	4	4	4
Fracture Clinic	11	4	6	6	4	4	4	4		5	1	5	4	4	4	as existing
CDU	N/A	8	9	9	8	8	0	0		0	0	0	0	0	0	0
Paediatric Emergency & Assessment																
Emergency	3	3	5	4	3	3	3	3		4	4	4	4	4	4	4
Assessment	10	3	6	6	4	4	4	4		16	16	16	16	16	16	16
Same Day Emergency Care (SDEC)	0	10	20	20	11	12	12	12		12	12	12	12	12	12	12
Assessment (ATC)	21	17	38	0	0	25	25	18		16	16	16	16	16	16	16
Shared Staff Zone	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A

The full schedule of accommodation is provided at Appendix A.

6 National Standards

The new ED will meet the HBN – Health Building Note and equivalent standards with any derogations listed in the schedule of derogations. The fixtures and fittings will be determined when the RDS – Room Data Sheets are developed. They will also incorporate the following key standards.

The following is a useful guide to ensure Design Quality and development of the right facilities.

Table 8 - Key Standards

Strategic Aim	Response
Transforming Urgent and Emergency Care Safer, faster, better: good practice in delivering urgent and emergency care	A strategy to improve safety, quality, access and value in NHS Emergency Medicine in August 2015
The patient's right to confidentiality and privacy must be protected.	Individual rooms throughout the pathway. Secure EPR. Discrete treatment and consultation areas. Bereavement facilities and discrete exits for the recently bereaved.
Good design will promote efficient workflows and ensure an optimal environment for patients, carers and staff.	The design will demonstrate good patient flow uninterrupted by logistic, facilities or design impediments
There must be adequate space provided for direct patient care, clinical support areas and non-clinical ED activity.	The spaces will be equal to or larger than current NHS recommendation or where that is absent, international best practice. The Procure 22 Repeatable Rooms will be used.
Where adults and children are seen in the same ED, specific design requirements must be adhered to in relation to children, their parents and siblings. There should be clear separation of facilities between both groups.	The Adult ED and Paediatric ED will be separate entities and patient flows separated wherever possible. The only shared areas will be diagnostic and imaging facilities.
Emergency Medicine is constantly evolving and all EDs will need to be updated or replaced in time, to support the provision of the highest standards of contemporary emergency care.	The design of a new ED floor will be carried out with reference to learning from new schemes and by ensuring flexibility by the standardisation of space. Emphasis has been placed on creating adaptable and flexible rooms of identical size.

Strategic Aim	Response
There should be service user involvement in decisions made regarding the patient care environment.	As the design progresses use group involvement will occur.
All departments in an ED floor, regardless of configuration, should be DI enabled. Each floor will require a number of high-resolution monitors which provide diagnostic-quality images.	The Adult ED / Paediatric ED will have full IT functionality including access to related Trust software or similar.
The ED must have access to all other Imaging and diagnostic modalities 24 hours a day.	There are dedicated ED Imaging facilities. Additionally, accommodation is to be co-located with the main Imaging and proximate to the main Hospital building.
The College of Emergency Medicine recommends that a CT scanner should be available within, or immediately adjacent to, the ED and be available 24 hours a day.	The accommodation will have access to diagnostic imaging facilities on site
Access must be available for urgent MRI 24 hours a day for those conditions where immediate surgical intervention may be necessary (e.g. spinal cord compression).	The accommodation will have access to diagnostic imaging facilities on site
All EDs should have adequate infrastructure for infection control and prevention.	The design will demonstrate compliance with best practice for prevention of infection and control.
PHT require significant fast communication in the ED pathway.	ED floor will have access to central staff bases and a higher number of workstations to support faster patient turnaround and management.
Efficient design.	The design will demonstrate a patient centric approach, excellent facilities for training and learning, state of the art technology and spaces, and good use of natural light, colour, sound, feel. The overall design will demonstrate welcoming spaces where high quality people will want to work.
Social Work services should be established throughout ED for fast and immediate interaction.	The accommodation will include office support for the staff to work in a multidisciplinary way.
Patients waiting should meet the 4 hour standard and initial assessment via RAT	There will be a significant number of rooms throughout the departments, allowing

Strategic Aim	Response
should mean fast direction to the most appropriate clinical treatment area.	patients to access the most appropriate clinical areas for their condition, depending on demand at the relevant time. For both adults and paediatrics, the patient cubicles are identical, allowing for a variety of uses.
Paediatric treatment areas, sub-wait areas and waiting rooms must be completely separate from the equivalent adult areas in EDs that see adult and paediatric patients. There should be no audio-visual connection between adult and paediatric areas in such units.	The Adult ED and Paediatric ED will be separate entities. They have their own clinical functions and activities, plus clinical support areas.
Elderly patients should also ideally have audio-visual separation from other ED patients	Each clinical area will consist of individual rooms, allowing for audio-visual separation to an extent, although waiting areas will be shared.
Patients should have access to drinks and toilet facilities if waiting for ED treatment.	The design will include sanitary facilities in the waiting areas. Both the Adult ED and Paediatric ED will have beverage bays to allow staff to supply refreshments if necessary.
Disabled facilities should be available.	The design will demonstrate that the facilities throughout the departments will be NHS compliant.
The waiting room should be a safe and pleasant environment for patients or relatives who need to be there.	The design will demonstrate a welcoming and safe space while giving the prevention and control of infection its highest priority.
Security must be available to supervise the ED waiting room.	There will be a security CCTV at the main waiting areas in the Adult ED and Paediatric ED.
There must be regular and clear communication with patients in the waiting room about waiting times.	The design team should include IT related information boards in these locations.
Health promotion information should be made available to patients in ED waiting rooms	There will be a patient information board within or adjacent to the main waiting area in both the Adult ED and Paediatric ED.

Strategic Aim	Response
Patient registration should take place before or at the same time as triage.	The design will demonstrate how the natural flow within the entrance zone will encourage registration and then triage.
Patients should be able to access treatment cubicles on arrival and bedside triage and registration should be provided.	This is not the preferred model of care for the Adult ED and Paediatric ED.

7 FM Service Requirements

Provision has been made to support:

- Cleaning
- Linen Delivery
- Disposal Holds

8 Environmental Requirements

In addition to the general environmental requirements these are the specific requirements for this clinical space that should be taken into consideration.

- All facilities must be readily accessible to wheelchair users and sensory impaired people.
- All patient areas need to be designed to be secure, protecting patients and staff from intruders and equipment from theft.
- Number pad lockable doors for all areas containing equipment or patient records.
- A staff call and emergency call system is required.
- Good visibility to all patient areas.
- Appropriate lighting to all patient and staff areas.
- Provision of a security system.

Appendices

Appendix A – Schedule of Accommodation V15

Archus

The healthcare infrastructure specialist

UK Company Registration No. 6937095

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Bassetlaw Hospital Emergency Village
Schedule of Accommodation
Version 15

Archus
The healthcare infrastructure specialist

Summary Floor Areas		Project	
Department		**V15**	**Clarification Notes & Assumptions**
Integrated Front Door		191.10	
Emergency Department		1029.00	
Primary Care		inc	GP out of hours scheduled as part of ED
Paediatric Emergency & Assessment		927.86	
Shared Staff Zone		386.13	subject to workforce review
Total GDA		2534.10	
Whole Facility Allowances			
Communication (12%)		304.09	Communication allowance assumes single main corridor and 2 storey building
Plant (20%)		506.82	
Gross Internal area		**3345.01**	

Not included in overall area			
Same Day Emergency Care (SDEC)	290.78	436.59	
Assessment (ATC)	584.91	644.60	
Fracture Clinic	169.32	98.49	

Functional Content	Existing	Project	
Department		**V15**	**Clarification Notes & Assumptions**
Integrated Front Door	N/A	N/A	
Mental Health	1	1	
Emergency Department			
Majors	9	19	Majors and Minors combined to provide flexible integrated solution
Minors	7	0	
Resus	3	4	
Primary Care	4	4	
Fracture Clinic	11	as existing	
CDU	N/A	0	
Paediatric Emergency & Assessment			
Emergency	3	4	
Assessment	10	16	
Same Day Emergency Care (SDEC)	0	12	
Assessment (ATC)	21	16	
Shared Staff Zone	N/A	N/A	

Note: these are predetermined sizes as a result of the consultation document..

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Bassetlaw Hospital Emergency Village
Schedule of Accommodation
Version 15

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Integrated Front Door	Version 15			
	Size	No.	m2	Clarification Notes & Assumptions
Walk-in Entrance				
Lobby: entrance / draught	12	1	12.0	
Reception	5.5	2	11.0	5.5sqm per person
Office (1p)	8	1	8.0	Security satellite office
Waiting Area Allowance	1.5	8	12.0	Small local Waiting Zone only
WC - Semi Ambulant	2.5	2	5.0	
WC - Independent Wheelchair	4.5	1	4.5	
Infant Feed	6	1	6.0	
Nappy Change	6	1	6.0	
Changing Places	12	1	12.0	may not be required if provided elsewhere on site
Bay for shopping, prams & pushchairs	4	1	4.0	shopping, prams & pushchairs
Trolley / wheelchair parking	12	1	12.0	trolley / wheelchairs
Vending Machine	2	1	2.0	vending machine
Triage / Streaming	12	2	24.0	
Sub total			118.5	
Social Care & Mental Health				
Exam / Treatment	16	1	16.0	
Interview / Counselling / Consent: 7 people	12	0	0	
WC - Assisted	5.5	1	5.5	
De-escalation room	16	0	0	
Sub total			21.5	
Net Departmental area			**140.0**	
Departmental Allowances				
Planning	5%		7.00	
Sub total			147.0	
Circulation allowance	25%		36.75	Circulation allowance is department specific
Engineering	5%		7.35	
Gross Departmental area			**191.10**	

Emergency Department	Version 15			Change Control		
	Size	No.	m2	difference	reason for change	Clarification Notes & Assumptions
Minors 111 / UTC						
Donning / Doffing area	12	0	0.0	#REF!		
Staff Base (2p)	12	0	0.0	#REF!		5.5sqm per person. Rounded to standard room size
Exam / Treatment	16	0	0	#REF!		2 sided couch access
Treatment / Procedure Room	16	0	0	#REF!		
WC - Semi Ambulant	2.5	0	0	#REF!		
WC - Independent Wheelchair	4.5	0	0	#REF!		
Sub total			0	#REF!		
GP Out of Hours Service						
Sub-wait	1.5	8	12.0	#REF!		
Clinic Room	12	4	48.0	#REF!		
WC - Independent Wheelchair	4.5	1	4.5	#REF!		
Dirty Utility	8	1	8	#REF!		
Resus trolley bay	2	1	2	#REF!		
Linen Store	2	1	2	#REF!		
Sub total			76.5	#REF!		
Fracture Clinic						
Staff Base (2p)	12	0	0.0	#REF!		5.5sqm per person. Rounded to standard room size
Consult / Exam (dual sided)	12	0	0.0	#REF!		
Plaster room	16	0	0	#REF!		
Plaster store	4	0	0	#REF!		
Sub total			0	#REF!		
Shared Support - Minors, GP OOH & Fracture Clinic						
Clean Utility	12	0	0	#REF!		
Dirty Utility	8	0	0	#REF!		
Resus trolley bay	2	0	0	#REF!		
Linen Store	6	0	0	#REF!		
Store	12	0	0	#REF!		
Cleaner's Room	8	0	0	#REF!		
Disposal Hold	8	0	0	#REF!		
Sub total			0	#REF!		
Ambulance Entrance, Decontamination & RAT						
Lobby: entrance / draught	12	1	12	#REF!		
Ambulance Handover Area	12	1	12.0	#REF!		
Major Incident Store	8	1	8	#REF!		
Decontamination room	16	1	16	#REF!	Trust instruction to add back in - 16/05/22	
Trolley & Wheelchair Parking	12	1	12	#REF!		3 accident trolleys & 3 wheelchairs
Ambulance / Police Room	8	0	0	#REF!		
Ambulance Equipment Store	8	1	8.0	#REF!		
WC - semi ambulant	2.5	1	2.5	#REF!		Staff
Rapid Assessment & Treatment (RAT)	14	2	28	#REF!		taken from Majors activity
Sub total			98.5	#REF!		
Resuscitation						
Resuscitation Room: Adult	26	3	78	#REF!		
Resuscitation Room: Child	26	1	26	#REF!		
Staff Base (2p)	5.5	2	11	#REF!		
Clinical Support Zone	12	1	12	#REF!		Includes blood gas analiser
Dirty Utility	8	1	8	#REF!		
Sub total			135	#REF!		
Distressed & Bereaved Persons Facilities						
Sitting room	12	1	12	#REF!		
Beverage Bay / Mini Kitchen	5	1	5.0	#REF!		
WC - Independent Wheelchair	4.5	1	4.5	#REF!		
Body viewing/bier room	12	1	12.0	#REF!		
Interview / Counselling / Consent: 4 people	8	1	8	#REF!		
Sub total			41.5	#REF!		

Adult Assessment & Treatment					
Sub-waiting allowance	1.5	9	13.5	#REF!	
Exam / Treatment	14	13	182	#REF!	
Chair-centric Bay (recliner)	5	4	20	#REF!	fit to sit area
Treatment / Procedure Room	16	1	16	#REF!	
Lobby: Isolation	5	1	5	#REF!	
Plaster room	16	0	0	#REF!	Opportunity to remove if current pathways are appropriate.
Plaster store	4	0	0	#REF!	Opportunity to remove if current pathways are appropriate.
WC - Assisted	5.5	1	5.5	#REF!	
WC - Semi Ambulant	2.5	2	5.0	#REF!	
PPE Station	6	1	6	#REF!	
Donning / Doffing area	12	0	0.0	#REF!	
Clean Utility: with controlled drugs	16	1	16	#REF!	
Satellite Pharmacy	8	1	8	#REF!	
Dirty Utility	8	1	8	#REF!	
Staff Base (2p)	12	1	12	#REF!	
Office (1p)	8	1	8	#REF!	Sister / Charge nurse
Office (2p)	12	1	12	#REF!	Clinical workspace
WC - semi ambulant	2.5	1	2.5	#REF!	Staff
Cleaners Room	8	1	8.0	#REF!	
Pantry: Ward	12	0	0.0	#REF!	
Beverage Bay / Mini Kitchen	5	1	5.0	#REF!	
Disposal Hold: 1700 litres	8	1	8	#REF!	
Linen Trolley Bay	4	1	4	#REF!	
IT Hub	4	1	4	#REF!	
Sub total			348.5	#REF!	
Staff Welfare					Subject to workforce review
Interview / Counselling / Consent: 7 people	12	0	0	#REF!	
Staff Rest and Mini Kitchen Allowance	1.8	0	0	#REF!	
WC - semi ambulant	2.5	0	0	#REF!	Provided in shared staff zone
WC - Independent Wheelchair	4.5	0	0	#REF!	
Staff Changing Allowance	1.4	0	0	#REF!	
Sub total			0	#REF!	
Administration					Subject to workforce review
Office (1p)	8	0	0	#REF!	
Office (Open Plan)	5	0	0	#REF!	
MDT Room	16	0	0	#REF!	
Seminar Room	32	0	0	#REF!	Provided in shared staff zone
Cleaners room	8	0	0	#REF!	
Disposal Hold: 1700 litres	8	0	0	#REF!	
IT Hub	4	0	0	#REF!	
Sub total			0		
Net Departmental area			**700.0**	#REF!	
Departmental Allowances					
Planning	5%		35.00	#REF!	
Sub total			735.0	#REF!	
Circulation allowance	35%		257.25	#REF!	Circulation allowance is department specific
Engineering	5%		36.75	#REF!	
Gross Departmental area			**1029.00**	#REF!	

Paediatric Emergency & Assessment	Version 15			
	Size	No.	m2	Clarification Notes & Assumptions
Reception & Waiting				
Reception (2p)	5.5	2	11	
Waiting Area Allowance	1.5	6	9	3 per exam / treatment space, with 10% wheelchair spaces. May be split to provide separate adolescents waiting area
Wheelchair Waiting Space	3	2	6	
Children's Play & Wait	2	3	6	
WC - Semi Ambulant	2.5	2	5	
WC - Independent Wheelchair	4.5	1	4.5	
Sub total			41.5	
Paediatric Assessment & Treatment				
Staff Base (2p)	5.5	2	11	
Sub-waiting Allowance	1.5	4	6.0	
Exam / Treatment: Paediatric	14	4	56	
Lobby: Isolation	5	1	5	
Safeguarding Suite	16	1	16	
Sub total			94	
Children's Assessment Unit (CAU)				
Single Bedroom	19	6	114.0	Trust instruction for overnight stay facilities within room. Following consultation document.
Shower Room: Single Bedroom Ensuite	5	6	30.0	
Staff Base (2p)	5.5	2	11	
Assessment Space	16	8	128.0	
Assisted Bathroom	15	1	15.0	
Assisted Shower Room	6.5	1	6.5	
WC - Semi Ambulant	2.5	2	5	
Treatment room/ consult exam room	16	2	32.0	
Office (1p) - Sister	8	1	8	Sister / Charge nurse
Office (1p) - On-call consultant	8	1	8	On-call consultant
Sub total			357.5	
CAU Support Spaces				
Observed Play Area	12	1	12	
Sitting room	12	1	12	Relatives
Beverage Bay / Mini Kitchen	5	1	5	Relatives
Milk Kitchen	6	1	6	Relatives
WC - Specimen	4.5	1	4.5	
Clean Utility: with controlled drugs	16	1	16	
Dirty Utility	8	1	8	
Equipment Store	12	1	12	
Staff WC - semi ambulant	2.5	1	2.5	Staff
Disposal Hold: 1700 litres	8	1	8	
Cleaners Room	8	1	8	
Linen Trolley Bay	4	1	4	Linen trolley
Sub total			98	
CAU Staff Spaces				Subject to workforce review
Staff Rest and Mini Kitchen Allowance	1.8	4	7.2	
MDT Room	16	1	16.0	
On-call room	12	1	12.0	
Ensuite shower room - on-call	5	1	5.0	
Staff Changing Allowance	1.4	0	0	Provided in shared staff zone
Sub total			40.2	
Net Departmental area			**631.2**	
Departmental Allowances				
Planning	5%		31.56	
Sub total			662.8	
Circulation allowance	35%		231.97	Circulation allowance is department specific
Engineering	5%		33.14	
Gross Departmental area			**927.86**	

Same Day Emergency Care (SDEC)	Version 15			
	Size	No.	m2	Clarification Notes & Assumptions
Entrance, Reception & Waiting				
Reception	5.5	2	11.0	5.5sqm per person
Waiting Area Allowance	1.5	10	15.0	1 place per assessment place, with 10% wheelchair places
Wheelchair waiting place	3	2	6.0	
Children's play and wait	2	3	6.0	10% waiting places. Minimum 3
WC - Semi Ambulant	2.5	4	10.0	
WC - Independent Wheelchair	4.5	2	9.0	
Infant Feed	6	0	0.0	
Nappy Change	6	0	0.0	
Wheelchair parking	4	1	4.0	
Vending Machine	2	1	2.0	Vending machine
Sub total			63.0	
Triage & Assessment				
Triage room	12	0	0.0	Provide 1 room per 10 clinic spaces
Staff Base (2p)	11	1	11.0	
Consult / Exam (single sided)	12	2	24.0	
Trolley Bay (dual sided)	9	0	0.0	
Trolley Bay (single sided)	7	4	28	Mix of patient spaces TBC
Chair-centric Bay (recliner)	5	4	20	
Chair-centric Bay (armchair)	2.5	2	5	
Clinical WHB station	1.5	6	9	Minimum 1 between 2 patient bays
Clinical Measurement	8	1	8	1 per 20 assessment spaces
Donning / Doffing area	12	0	0.0	
Sub total			105	
Treatment & Consultation				
Consult / Exam	12	2	24.0	1 per 10 assessment spaces
Treatment / Procedure room	16	2	32	1 per 10 assessment spaces
Sub total			56	
Support Spaces				
Beverage Bay	5	1	5	
Clean Utility / Medicine Store	16	1	16.0	1 per 12 patient spaces. Includes blood gas analyser
Dirty Utility	8	1	8	1 per 12 patient spaces
Resus trolley bay	2	1	2	
Medium store	8	2	16	
Large store	12	1	12.0	
Linen store	6	1	6	
Cleaner's room	8	1	8	
Sub total			73	
Staff Welfare				Subject to workforce review
Interview / Counselling / Consent: 7 people	12	0	0	
Staff Rest and Mini Kitchen Allowance	1.8	0	0	
WC - semi ambulant	2.5	0	0	Provided in shared staff zone
WC - Independent Wheelchair	4.5	0	0	
Staff Changing Allowance	1.4	0	0	
Sub total			0	
Administration				Subject to workforce review
Office (1p)	8	0	0	
Office (Open Plan)	5	0	0	Provided in shared staff zone
MDT Room	16	0	0	
Sub total			0	
Net Departmental area			**297.0**	
Departmental Allowances				
Planning	5%		14.85	
Sub total			311.9	
Circulation allowance	35%		109.15	Circulation allowance is department specific
Engineering	5%		15.59	
Gross Departmental area			**436.59**	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Bassetlaw Hospital Emergency Village
Schedule of Accommodation
Version 15

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Shared Staff Zone	Version 15			
	Size	No.	m2	Clarification Notes & Assumptions
Staff Welfare				
Interview / Counselling / Consent: 7 people	12	1	12	Wobble room
Staff Rest and Mini Kitchen Allowance	1.8	16	28.8	Staff rest for approximately 1/3 staff, with contingency
WC - semi ambulant	2.5	2	5	
WC - Independent Wheelchair	4.5	1	4.5	
Staff Changing Allowance	1.4	45	63	1:2 male/female split
Sub total			113.3	
Administration				subject to workforce review
Office (1p)	8	2	16	Single person offices to be bookable for quiet / private working
Office (Open Plan)	5	18	90	Includes 2no. desks for CAU, 4no. desks for SDEC, 2no. desks for ATC, and 10no. desks for ED. May be split into smaller offices
MDT Room	16	1	16	
Seminar Room	32	1	32	Also used for multi-purpose training
Cleaners room	8	1	8	
Disposal Hold: 1700 litres	8	1	8	
IT Hub	4	1	4	
Sub total			174	
Net Departmental area			**287.3**	
Departmental Allowances				
Planning	5%		14.37	
Sub total			301.7	
Circulation allowance	25%		75.42	Circulation allowance is department specific
Engineering	3%		9.05	
Gross Departmental area			**386.13**	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Produced on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by

Archus
The healthcare infrastructure specialist

Outline Business Case for Bassetlaw Emergency Village

15/07/2022

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Document control

Report for	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
File ref	https://archusuk.sharepoint.com/sites/Midlands/Shared Documents/Clients/Doncaster and Bassetlaw NHS Trust/01 Bassetlaw Emergency Village OBC/04 Business Case/01 OBC/
Prepared by	Julie Harris, Tom Kiernan, Danielle Hirst
Date	
Checked by	Danielle Hirst, Anouska Huggins
Date	

Version control

V.	Date	Description of change/s	By
1.0	17/09/2021	Set up template and populated content	Tom Kiernan (TK)
1.1	28/09/2021	Adjusted template and populated with further content from SOC and internet searches	Julie Harris (JH)
1.2	22/12/21	Updated following comments from the Trust	JH
1.3	03/02/22	Updated following comments from the Trust. Case for change updated	JH
1.4	03/03/22	Activity and capacity modelling added	JH
1.5	30/03/22	Commercial Case content added.	JH
1.6	25/04/22	Commercial Case updated with latest procurement strategy draft (22.4.22)	JH
1.7	05/05/22	Options Framework updated. Strategic Case updated with latest information.	JH / Dani Hurst (DH)
1.8	05/05/22	Amended following Commercial Case peer review	Anna Fawcett (AF)
	11/05/22	Commercial Case updated with latest procurement strategy draft (10.5.22)	JH
1.9	16/05/2022	Management Case updated	TK
2.0	16/05/2022	Draft OBC issued to project board	DH
2.1	17/05/2022	Updated following Trust comments	JH
2.2	27/05/2022	Estates and FM Targets skeleton section added.	JH

V.	Date	Description of change/s	By
2.3	10/06/2022	Updates to the management case, issued for peer review	DH
2.4	23/06/2022	Updates following comments from Lesley McKay and Darren Francis	JH / TK
2.5	24/06/2022	Peer Review	Monique Chavda (MC)
2.6	29/06/2022	Updates to address Peer Review comments	DH / JH / TK
3.0	29/06/2022	Incorporate Economic Case	Anouska Huggins
3.1	08/07/2022	Insert final information throughout OBC	JH / TK / MC
3.2	15/07/2022	Final issue for F&P	JH / MC / AH

Glossary of Abbreviations and Acronyms

A&E	Accident & Emergency Department
ATC	Assessment and Treatment Centre
BAU	Business As Usual
BCR	Benefit Cost Ratio
BH	Bassetlaw Hospital
BIM	Building Information Modelling
BREEAM	Building Research Establishment Environmental Assessment Methodology
BUCS	Bassetlaw Urgent Care Service
CCG	Clinical Commissioning Group
CDM	Construction (Design and Management) Regulations
CE	Compensation Event
CIA	Capital Investment Appraisal
CAU	Children's Assessment Unit
CIC	Construction Industry Council
CQC	Care Quality Commission
CSF	Critical Success Factor/s
CT	Computed Tomography
DBFO	Design, Build, Funding, Operational
DBTH	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
DH	Department of Health
DQI	Design Quality Indicator
DRI	Doncaster Royal Infirmary
ED	Emergency Department
EOI	Expression of Interest
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
FBC	Full Business Case
FPC	Finance and Performance Committee
GCS	Government Construction Strategy
GMP	Guaranteed Maximum Price
HBN	Health Building Note
HLIP	High Level Information Pack
HMT	Her Majesty's Treasury
HTM	Health Technical Memoranda
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICT	Information Communication and Technology
IO	Investment Objective
IPA	Infrastructure Projects Authority
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LTP	NHS Long Term Plan
MMC	Modern Methods of Construction
NAO	National Audit Office
NEC	New Engineering Contract
NHSE/I	NHS England and Improvement
NN ICB	Nottingham and Nottinghamshire Integrated Care Board
NN ICS	Nottingham and Nottinghamshire Integrated Care System
NPSV	Net Present Social Value
OBC	Outline Business Case
OGC	Office of Government Commerce
P21+/22	ProCure 21+/22 National Framework
PAM	Premises Assurance Model
PCN	Primary Care Network
PCR	Project Completion Report
PDC	Public Dividend Capital
PEP	Project Execution Plan
PID	Project Initiation Document

PPE	Post Project Evaluation
PRINCE2	PRojects IN Controlled Environments: a structured project management method
PSCP	Principal Supply Chain Partner
PWF	Preferred Way Forward
Qii	Quality, Improvement and Innovation
QIPP	Quality, Innovation, Productivity and Prevention
RCPCH	Royal College of Paediatrics and Child Health
RDASH	Rotherham, Doncaster and South Humber NHS Foundation Trust
RAAC	Reinforced Autoclaved Aerated Concrete
RIBA	Royal Institute of British Architects
RPA	Risk Potential Assessment
SDEC	Same Day Emergency Care
SFI	Standing Financial Instruction
SOA	Schedule of Accommodation
SOC	Strategic Outline Case
SOF	Single Oversight Framework (NHSI)
SOFP	Statement of Financial Position
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plan / Partnership
SWOT	Strengths, Weaknesses, Opportunities, Threats
SY ICB	South Yorkshire Integrated Care Board
SY ICS	South Yorkshire Integrated Care System
TIP	Transforming Infrastructure Performance
ToR	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
VCS	Voluntary and Community Sector
VFM	Value for Money

1 Executive Summary

1.1 Introduction

This Outline Business Case (OBC) is for the investment of £17.98m to create a modern, fit-for-purpose emergency village at Bassetlaw Hospital which is part of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The new facilities will include a new emergency department for children and adults, which is adjacent to the assessment and treatment centre, same day emergency care services and the fracture clinic. A children's assessment unit will also be included. Facilities will be part new build and part refurbishment, and will be appropriately configured and right sized to deliver high quality care and meet the rising demand for services.

1.2 Approvals and Support

Drafting Note: This section assumes formal approval and support. Note to be remove following formal sign off of OBC

1.2.1 Trust Board of Directors

The Board of Directors formally approved this OBC at their meeting on 26 July 2022, which can be found at Appendix S1.

1.2.2 Integrated Care Board

A letter of support in principle for the OBC was received from Nottingham and Nottinghamshire Integrated Care Board and South Yorkshire Integrated Care Board, which can be found at Appendix S2.

1.3 Strategic Case

1.3.1 Organisational Overview

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is one of Yorkshire's leading acute trusts, serving a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas.

Hosting three main hospital sites and a number of additional services, the Trust is one of only six teaching hospitals in the region. It was awarded teaching hospital status in 2017. A modern and forward-facing Trust employing over 6,500 members of staff, it provides a full range of local hospital services across the following sites:

Doncaster Royal Infirmary (DRI)

DRI is a large acute hospital with 647 beds, a 24-hour Emergency Department (ED). In addition to a full range of hospital care, it also provides some specialist services including vascular surgery. It has inpatient, day case and outpatient facilities.

Bassetlaw Hospital in Worksop (BH)

BH is an acute hospital with 170 beds, a 24-hour ED and a full range of hospital services including a breast care unit and renal dialysis. It has inpatient, day case and outpatient facilities.

Montagu Hospital in Mexborough

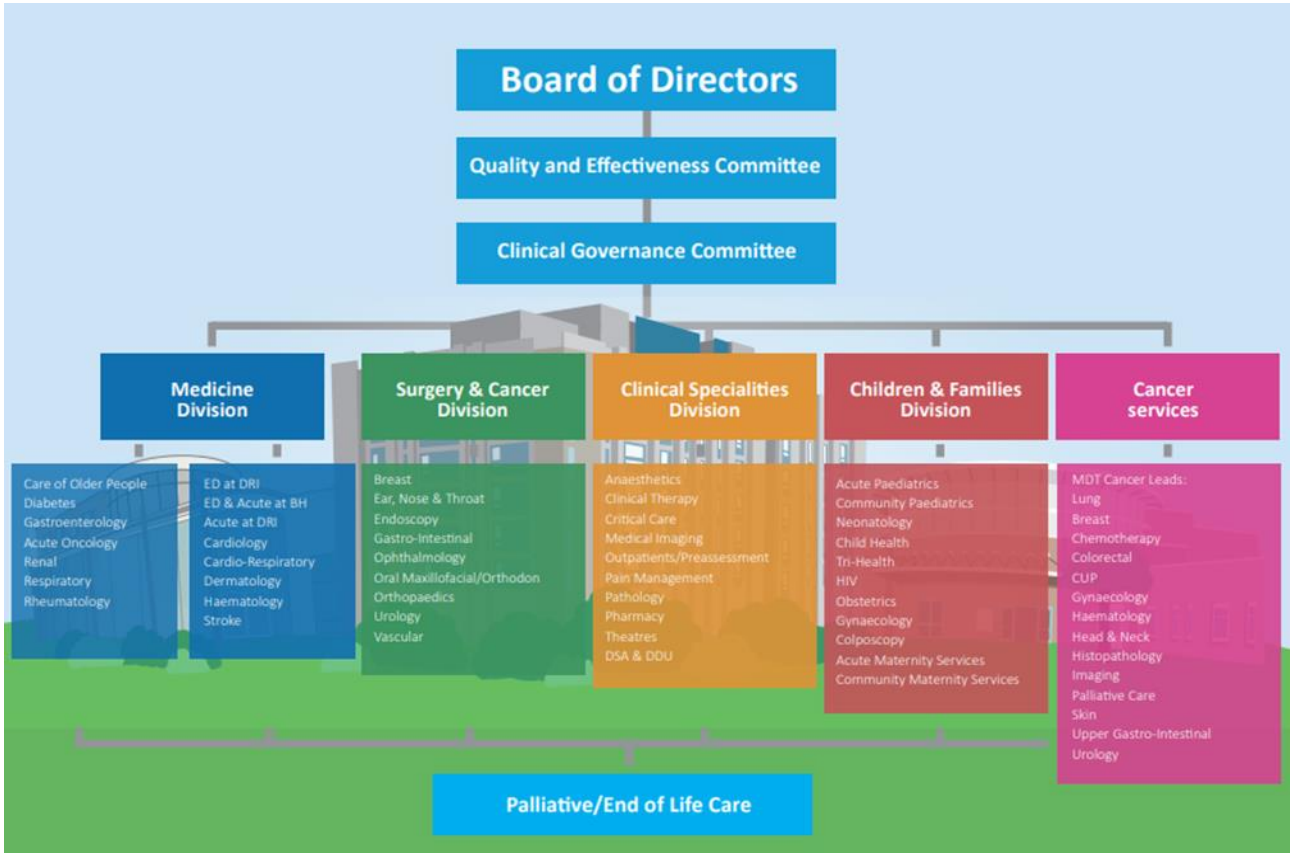
Montagu is a small non-acute hospital with 50 inpatient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am-9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of outpatient clinics. Montagu is the site of the Trust's Rehabilitation Centre, Clinical Simulation Centre and the base for the Abdominal Aortic Aneurysm screening programme. The Trust intend to develop a new CDC and Elective Orthopaedic Centre at this site which are currently subject to business case approval.

The Trust also provides outpatient and other health services at Retford Hospital, including clinical therapies and medical imaging.

1.3.2 Clinical Management Structure

The Trust's clinical services are organised into four divisions as illustrated below.

Figure 1: DBTH Clinical Services



1.3.3 CQC Inspection

A CQC inspection 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.

Specific areas of concern for urgent and emergency care services at Bassetlaw included:

- At peak times the department experiences crowding with patients waiting in the corridor. The escalation arrangements in place to mitigate crowding were unclear, particularly for specialty referral standards, ambulatory care, frailty pathways, or cancer care.
- Although paediatric nurse cover had improved it did not achieve the Royal College of Paediatrics and Child Health (RCPCH) (2018) guidance and night cover remained a challenge.

1.3.4 National Strategies

Key national strategic priorities most relevant to this OBC are contained within the following documents:

- NHS Long Term Plan;
- Government Construction Strategy;
- Lord Carter's Report: Operational Productivity & Performance in English NHS Acute Hospitals;
- Delivering a Net Zero National Health Service.

Other national strategies pertinent to the scheme are listed in section 2.5.2.

1.3.5 Regional and Local Strategies

Key regional strategic priorities most relevant to this OBC are those set out by:

- South Yorkshire Integrated Care Board;
- Nottingham and Nottinghamshire Integrated Care Board.

The ICBs' priorities are based on local Joint Strategic Needs Assessments.

1.3.6 Trust Strategies

Key DBTH strategic priorities most relevant to this OBC are contained within the following documents:

- Trust Values;
- Strategic Direction 2017-2022;
- Clinical Strategy;
- Patient and Engagement Strategy;
- People and Organisational Development Strategy 2017-2022;
- Workforce Plan 2019-2021;
- Digital Strategy 2017-2022;

- Quality and Improvement Strategy 2017-2022;
- Estates and Facilities Strategy 2017-2022;
- DBTH Green Plan 'Our Sustainable Path to Net Zero'.

1.4 The Case for Change

1.4.1 Existing Arrangements, Issues and Impact of Change

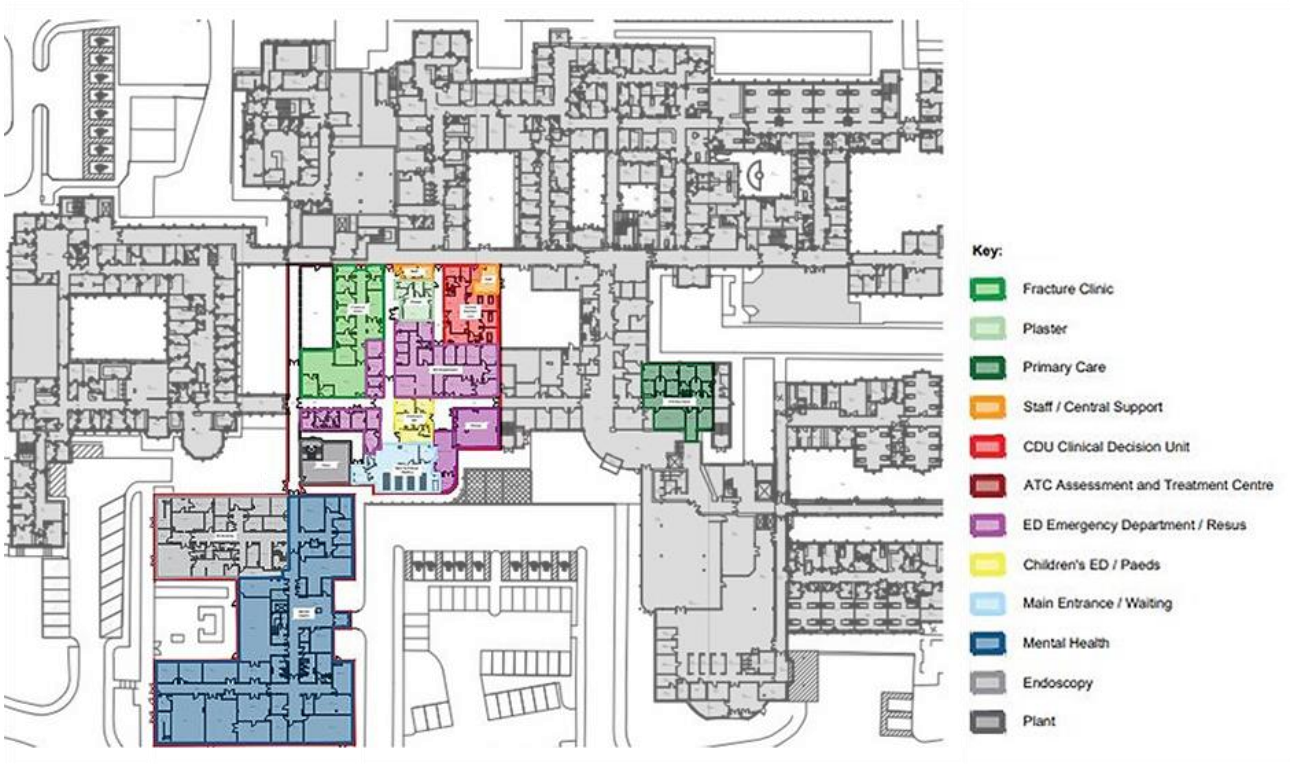
Urgent and emergency care services at BH are currently provided in a number of locations across the site:

Table 1: Current Arrangements

Service	Role
Emergency Department (ED)	Minors (UTC)/Majors/Resus for adults and children. Open 24/7
Assessment and Treatment Centre (ATC)	For medical, surgical or frailty assessment. LoS 24-72 hours
Children's Assessment Unit	10 spaces for assessment and treatment of children and young people. Open until 9pm, last referral 7pm. Children needing overnight care/observation transferred to DRI.
Fracture Clinic	Open 9 hours per day, 5 days per week.
Same Day Emergency Care (SDEC)	For medical, surgical, gynae or frailty non elective care. LoS up to 12 hours. Open 12 hours per day, 7 days per week
Primary Care	Primary care is an appointment-based system on site but not co-located. It is generally managed by advance nurse practitioners and limited GP input.

The current location of services is illustrated in the figure below.

Figure 2: Emergency Services - Existing Site Layout



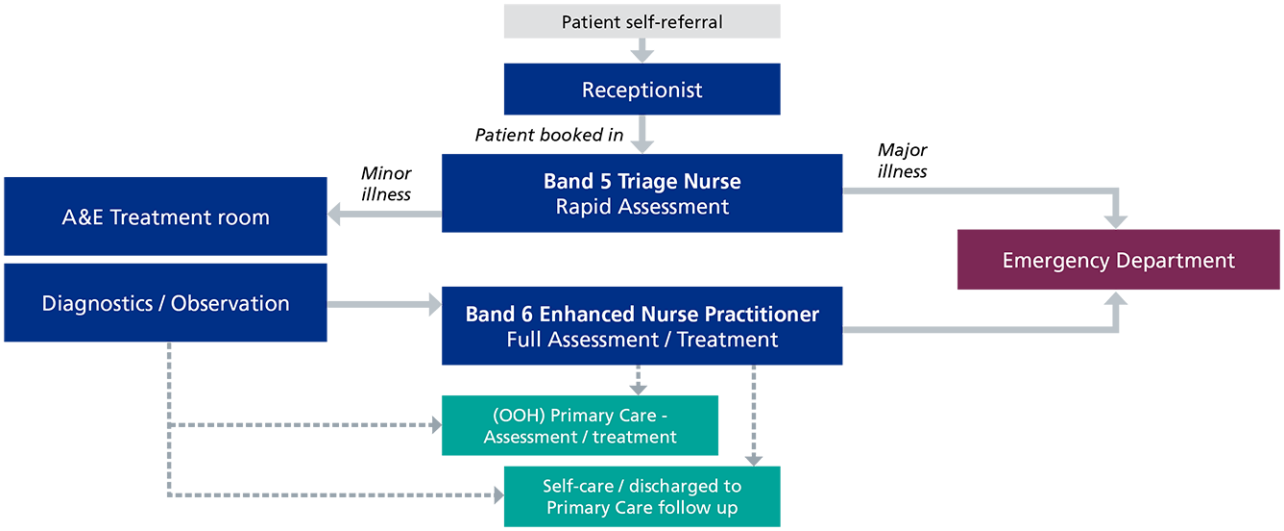
The figure illustrates how fragmented some of the current urgent and emergency care services are. For example, the paediatric spaces within the ED are not adjacent to the children's assessment unit (which is located elsewhere in the hospital), which means that staff cannot easily work across both areas. In addition, the location of SDEC away from the ED does not encourage same day care. The existing footprint for re-use is disjointed and would not allow for the required interdependency and co-location that the emergency care services require. Without additional accommodation the required schedule of accommodation to meet service demand cannot be met.

The figure below illustrates the current patient pathway for urgent and emergency care services at BH. The front door process is as follows:

- 24/7 Receptionist books patients in.
- 24/7 Band 5 Triage Nurse triage minor illness / injury patients in the A&E treatment rooms. Blood tests, ECGs, observations etc are initiated here.
- 24/7 Band 6 Enhanced Nurse Practitioner undertakes full assessment and treatment for minor illness.

The existing process is not as efficient as it could be. For example, patients suitable for SDEC often end up in ED first, and many minors could be directed away from ED to be treated elsewhere. Triage and clinical streaming could be improved to ensure that patients are directed to the most appropriate care.

Figure 3: Current Adult Patient Pathway



The configuration of existing urgent and emergency care services is not fit to deliver the Trust's new clinical model for emergency care which aims to improve clinical streaming and triage at the front door and ensure that facilities are correctly sized and co-located to improve patient flow and increase flexibility. The new clinical model is described in detail in section 4.7.2.

The main problems with the existing services are described below.

ED capacity

The department was originally designed and built to safely manage a maximum of 100 people a day. It currently sees an average of 153 patients a day, with the highest ever daily attendance at 236.

The busiest times are 10am-1pm and 5pm to 7pm every day, with Monday being the busiest day of the week.

In terms of patient acuity, resus activity remains fairly stable. 'Majors' have seen a general decline while 'minor' attendances have increased. These trends are illustrated in the figure below.

Figure 4 ED Majors and MinorsPatients by Acuity Stream

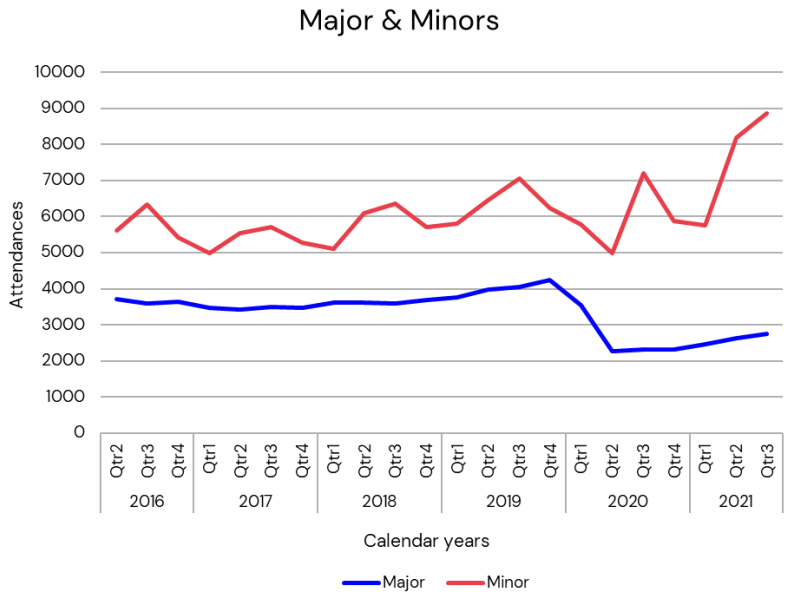
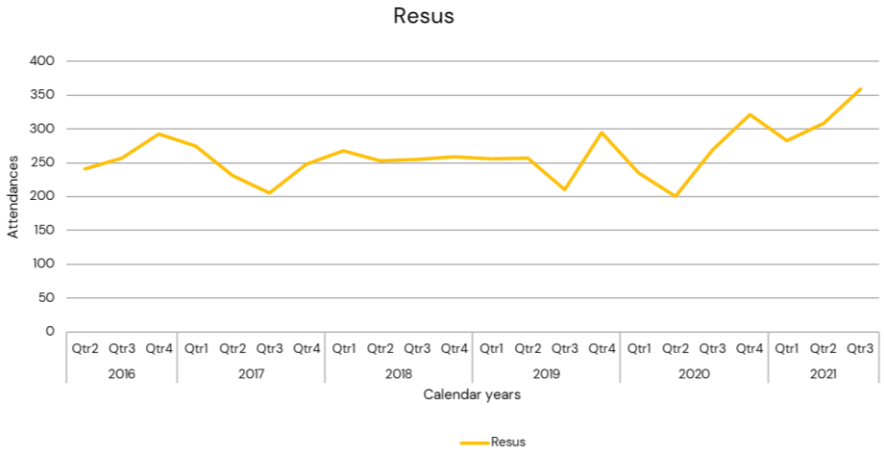


Figure 5 ED Resus Patients by Acuity Stream



Patients are currently being diverted out of the area due to lack of capacity. Demand will continue to increase in the future in line with the growing and ageing demographic of the local population. In addition, the legacy of the Covid-19 pandemic will lead to increasing demand for primary and acute services as many patients who were reluctant to contact their GPs during the pandemic are now coming forward with health concerns.

The urgent care offer is often confusing for patients who are not always sure how and where to access the right care. Extensive patient engagement has revealed that patients generally prefer to come straight to the ED, feeling it is their only option.

Overall, it is clear that the increasing demand for emergency care services cannot be met within existing facilities and that further capacity will be required.

Patient flow

The emergency care pathway is currently fragmented which results in inefficiency and lack of flexibility. For example,, the location of SDEC facilities away from the ED does not encourage same day care and means that the Trust is currently not meeting the requirement for easy access to same day emergency care as set out in the NHS Long Term Plan.

According to the key findings of the report 'Front Door Streaming Model for the Bassetlaw Emergency Village', urgent, ambulatory and assessment services should be co-located. This will support the transformation of patient journeys and optimise flexibility and efficient use of the workforce within the urgent and emergency care pathway, both in terms of supporting the delivery of care in the right place, at the right time, by the right staff, as well as supporting access to senior opinion and decision making at the earliest possible stage in the patient journey.

Streaming patients to the most appropriate care pathway will result in improved clinical outcomes, operational efficiencies and reduced admissions.

A recent review of U&EC services at Bassetlaw Hospital (which formed part of a wider review across the South Yorkshire ICB) made recommendations in the following areas:

- Streaming could be improved by moving from the current model of streaming at the ED front door to a model in which UTCs (staffed by a combination of primary care and acute staff) act as the front door of ED to enable emergency medicine specialists to focus on higher acuity need within the ED.
- Many 'minors' could be considered for alternative care settings. Earlier signposting of patients by community-based teams/ambulance services could avoid ED attendances and admissions.
- Direct access into SDEC facilities avoiding inappropriate use of ED.
- SDEC facilities should be developed to accommodate an enhanced frailty pathway to help older patients access the care they need without having to go through the ED, and other pathways such as respiratory, abrasions/contusions etc.

A more detailed summary of the key findings is contained in Appendix S12 'Front Door Streaming Model for the Bassetlaw Emergency Village'.

Reorganising existing emergency care facilities to ensure that key services are adjacent to each other will improve patient flow, resulting in better clinical outcomes and a more efficient service. This is explored in the clinical pathway model section 4.7.2, the 1:200 design and adjacency matrix, section 4.7.1.

Paediatric urgent and emergency services

In previous inspections, the CQC found that the hospital was not achieving the Royal College of Paediatrics and Child Health (RCPCH) (2018) guidance which stated there should be two paediatric nurses present on each shift. It also stated that adult nurses covering the department should have training to ensure they have the relevant skills and competencies to care for infants, children and young people. Patient pathways within ED were specifically highlighted due to the front door streaming process and the number of paediatric nurses available within the department.

The Trust has had difficulties recruiting paediatric nurses and, as a result of these challenges, in January 2017 the Trust temporarily closed the children's overnight service. The changes meant that the overnight children's inpatient service was temporarily transferred to DRI. The inpatient ward changed into a Children's Assessment Unit (CAU) with 10 clinical assessment spaces open until 9pm but only accepting referrals until 7pm. All children requiring overnight care (including observation) still continue to be transferred to DRI, a 20-mile journey which on average is a 35-40 minute drive. If patients are assessed as being well enough, they can travel in the family's own transport if available. Before the closure of the overnight service there were 14 beds available for children and young people. This was further reduced to six immediately prior to the closure due to staff shortages. Under the current temporary arrangements, the unit has 10 assessment spaces for children and young people. The Trust has recently completed a separate consultation on a permanent solution for children who need urgent and emergency care at Bassetlaw Hospital. The consultation showed that there was overwhelming support (86% of respondents) for building a new CAU next to the ED, which would allow children to stay overnight at Bassetlaw rather than transferring to DRI. See section 2.7.4 for more details.

The co-location of Adult ED, Children's ED, CAU and other services would allow for the required paediatric ratios – two per shift, as indicated by the CQC - to be achieved and improve the offer for children at the Bassetlaw site. Co-location also means that the Trust can provide a greater range of services with the same level of staff, helping to reduce the risk of staff shortages which have an impact on service resilience and safety. It is also expected that the new facilities and clinical model will create a more attractive place to work, helping to maintain staffing levels, and balancing recruitment and retention.

Backlog maintenance and estates issues

The condition of the building is currently too poor to make it suitable for its role in the future as part of the ICS emergency services provision**.** Backlog maintenance costs are high, (see Table 6) and the Bassetlaw Hospital site also has RAAC roofing on a number of buildings which are due to be replaced as part of the national RAAC eradication programme. The Department of Health (DH) Lord Carter productivity and efficiency programme dashboard report has continually indicated that the trust is year-on-year significantly underinvesting with regard to backlog maintenance.

Issues surrounding asbestos management, electrical and mechanical infrastructure also need to be addressed. In addition, the DBTH site was inspected by the NFRS Fire Service under the regulatory reform (fire safety) order 2005 and has been served a fire deficiencies notice at BH (on 22 February 2018).

The provision of new build and refurbished facilities would significantly reduce the amount and cost of backlog maintenance.

Recruitment and retention

One of the longstanding key challenges for services is the recruitment and retention of staff. This is not unique to the local area and workforce shortages have been exacerbated by the pandemic. In December 2016, The Royal College of Nursing published the report 'RCN Safe and Effective Staffing: The Real Picture' which highlights how there are approximately 40,000 registered nursing vacancies in England.

In 2019 that number was reported at 43,000 vacancies, equating to a vacancy rate of 12%. Significantly 22% of all reported hard-to-fill vacancies (hard to fill is defined as vacant for over three months) are in the fields of learning disabilities, mental health and children's nursing. In 2017 challenges in recruiting paediatric nurses led to the need to make temporary changes by closing the children's overnight service.

These temporary changes are still currently in place. Before any temporary changes were made, there were 14 beds available for children and young people needing to stay in hospital at Bassetlaw. Just before the ward was temporarily closed staff shortages meant that there were 6 beds available. Under the current arrangements, the unit has 10 assessment spaces for children and young people.

By relocating the CAU next to the paediatric spaces in the ED, paediatric staff will be able to work across the two areas, which will improve efficiency, make the ED a more attractive place to work and therefore improve recruitment and retention rates.

1.4.2 Potential Scope

The scheme includes:

An upgraded emergency care service at BH, appropriately configured and right-sized to deliver the highest standards in emergency care;

- Full integration of urgent care services with the emergency department (ED), with single ambulant points of access to UTC and ED facilities;
- Co-location and development of a Children's Assessment Unit.
- An environment that maximises efficient and effective use of the workforce to deliver high quality emergency care and sustain the care quality improvement trajectory.

1.4.3 Main Benefits Criteria

Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits. By investment objectives these are as follows:

Table 2: Investment Objectives (IO) and Benefits

IO ref	Main benefits criteria
1 Health Outcomes and People Centred Environment	**Stakeholder Group: Patients / staff / public**
	• Reduced patient time spent in ED leading to improved throughput and releasing capacity • Improved patient and carer experience • Sufficient capacity to meet demand • Flexibility to meet surge and fluctuations in demand • Greater staff satisfaction
2 Innovation	**Stakeholder Group: Patients / staff**
	• Improved streaming through Integrated Front Door reduces ED attendances • Improved management through digital enablement

IO ref	Main benefits criteria
3 Environmental Sustainability	**Stakeholder Group:** Patients / Staff / Public / NHS Trust
	• Reduced greenhouse gases because of reduced energy consumption • Reduced greenhouse gases because of fewer transfers to DRI • Improved compliance with statutory requirements including HTM, HBN, Firecode and BREEAM compliance and infection control approach
4 Community Connections	**Stakeholder Group: Patients / Staff**
	• More equitable access to ED and Paediatrics service • Greater collaboration with partners, such as Notts Healthcare
5 Economic and Financial Sustainability	**Stakeholder Group: NHS Trust**
	• Reduced transport costs due to fewer transfers to DRI • Rota efficiencies due to improved adjacencies between ED and ATC • Improved energy consumption
6 Social Impact	**Stakeholder Group: Patients / Staff**
	• Creation of social value including creation of apprenticeship and job creation

1.4.4 Main Risks

The main risks of this investment are shown below. For further detail on risk, please see the Economic, Commercial and Management Cases.

- **Financial** - Capital funding is not made available by NHSI/DH/Treasury. Project proves unaffordable from a revenue perspective. Hyperinflation increases costs and results in an unaffordable project.
- **Internal and External Approval**, - Business case(s) is/are rejected or there is a delay in approval by the Board of Directors or NHSEI. Dependencies on other business cases eg RAAC, SDEC, ATC may slow progress.
- **Design and Construction**- Planning Approval is severely delayed, comes with onerous conditions or is refused. Project is not delivered to the brief or appropriate standards. Increase in procurement periods/lead ins and material shortages.
- **Operations and Transformation**- Changes to models of care, demand, and/or commissioning adversely impacts upon the future efficiency and suitability of the project design. Poor quality brief that does not accurately portray the Trust's requirements.
- **Human Resources** - Project failure due to poor resourcing/project management. Inability to provide a sufficient and suitably skilled workforce to properly staff and operate the facility post-handover.

1.4.5 Constraints and Dependencies

The project is subject to following constraints:

- The project is constrained by the space available on site for expansion of emergency services while also maintaining colocations.

- The project is constrained by the maximum available/affordable capital envelop for the scheme of £17 million, which may be under pressure due to current market conditions such as hyperinflation.
- The project is constrained by the requirement for net revenue costs maintaining or improving but not deteriorating the Trust financial position.
- The project is constrained by the requirement to achieve all relevant building and design standards set out in HBNs and HTMs.
- The project is constrained by the requirements arising through consultation with the public.
- The project is constrained by the requirements imposed by planning permission approval.
- Building works must be completed by March 2024 in order to access Wave 4 STP funding.

The project is subject to following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Nottinghamshire Healthcare Foundation Trust agrees to vacate part of the premises (it currently provides some of its inpatient and outpatient mental health services from BH).
- Business Case Approval: the project is dependent on the Trust securing NHSE/I approval of the OBC and FBC.
- Planning permission approval.
- Interdependencies between this scheme and other related schemes: ATC, SDEC, Single Site Trauma.
- Effective out of hospital demand management to support the activity and capacity requirements in the scheme.
- For the adjacency benefits to be realised the project is dependent on the RAAC, ATC and SDEC projects to be complete in time.

1.5 Economic Case

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the OBC documents the range of options that have been considered in response to the scope identified within the strategic case; and provides evidence to show that the most economically advantageous offer has been selected, which best meets service needs and optimises value for money.

1.5.1 The Long List

In developing the long list of scope options for this scheme the Project Team ensured that suitable Do Minimum and Do Maximum options were considered which would enable the IOs and CSFs set out in the Strategic Case to be met.

The qualitative options appraisal process outlined in the preceding sections resulted in the following framework summary.

Table 3: qualitative options appraisal

Project	Business as Usual	Do Minimum	Intermediate Option	Intermediate Option	Intermediate Option	Do Maximum
1. Service Scope As outlined in Strategic Case	1A – Continue with current clinical model	1B – Implement Paediatrics model (ED and dedicated CAU)	1C – Implement Paeds model and Front Door model and right size ED	1D – As 1C plus deliver new ATC	1E – As 1C plus deliver new ATC and SDEC	1F – As 1C plus deliver new ATC, SDEC and Fracture Clinic
	Carried Forward	Carried Forward	Preferred Way Forward	Discounted	Discounted	Discounted
2. Service Solution In relation to the preferred scope	2A – Ongoing maintenance	2B – Refurbish existing facilities and deliver Paeds	2C – Refurbish existing facilities and new build (as per SOA v1)			2D – New build (as per SOA v2)
	Carried Forward	Carried Forward	Preferred Way Forward			Carried Forward
3. Service Delivery In relation to the preferred scope and service solution	3A – Continue with existing	3B - Procurement Framework (i.e. P21+)	3C - Full Procurement Process	3D - Development Partner		3E - Public Private Partnership / Joint Venture
	Carried Forward	Preferred Way Forward	Discounted	Discounted		Discounted
4. Implementation In relation to preferred scope, solution and method of service delivery	4A- Continue existing		4B - Phased			4C - Single-Phased Build
	Carried Forward		Preferred Way Forward			Discounted
5. Funding In relation to preferred scope, solution, method of service delivery and implementation	5A – Continue with existing	5B – CRL Funding	5C- PDC Funding of £17.6m	5D - Combination of CRL and PDC funding		5E - Alternative funding models
	Carried Forward	Discounted	Carried Forward	Preferred Way Forward		Discounted

An assessment against the IOs and CSFs and a SWOT analysis for these scope and solution option choices was conducted as part of the options appraisal process. The findings are contained in Appendix E1.

1.5.2 The Short List

In line with guidance and best practice, the business case should identify a minimum of four shortlisted options for further appraisal. These should include:

- Business as Usual: The benchmark for value for money;
- 'Do Minimum': A Realistic way forward that also acts as a further benchmark for Value for Money, in terms of cost justifying further intervention;
- 'Recommended': The preferred way forward at this stage;
- One or more other possible options based on realistic 'more ambitious' and 'less ambitious' choices that were not discounted at the long-list stage.

The options framework can be used to filter the options considered at the long-list stage to generate the potential short-list for the project, as illustrated below. The following table uses the numbering used in the summary table above to map option choices into a summary of the short list identified.

Options	0 - Business as Usual	1 - Do Minimum	2 - Preferred Way Forward (PWF)	3 - More Ambitious PWF
Project Scope	Continue with current clinical model	Minor changes to clinical model: Adult ED model remains largely unchanged Proposed Paediatrics clinical model (ED and dedicated CAU) Enable interfaces with new ATC and SDEC where possible	Deliver proposed clinical model and right-size to meet forecast demand: Integrated front door (Combined primary care + ED triage + streaming) Majors, Minors, Resus, Mental Health, Primary Care Paediatrics ED and dedicated CAU Enable optimum interface with new ATC (to realise associated benefits) Enable optimum interface with new SDEC	Deliver proposed clinical model and right-size to meet forecast demand: Integrated front door (Combined primary care + ED triage + streaming) Majors, Minors, Resus, Mental Health, Primary Care Paediatrics ED and dedicated CAU Enable optimum interface with new ATC (to realise associated benefits) Enable optimum interface with new SDEC
Project Solution	No initial investment but continue with existing arrangements for ongoing maintenance	Refurbish existing facilities: Adult ED remains in current location and current size Deliver SOAv15 for Paediatrics ED and CAU	Refurbish Mental Health building and deliver new build extension: Deliver SOAv15** Achieve improved adjacencies / clinical flow	Demolish Mental Health building and create new build facility: Deliver SOAv15** Achieve optimum adjacencies / clinical flow

Options	0 – Business as Usual	1 – Do Minimum	2 – Preferred Way Forward (PWF)	3 – More Ambitious PWF
			Co-locate with new ATC and SDEC*	Co-locate with new SDEC*
Service Delivery	Continue with existing arrangements	Deliver via procurement framework (eg P21+)	Deliver via procurement framework (eg P21+)	Deliver via procurement framework (eg P21+)
Project Implementation	Continue with existing arrangements	Phased Build – Programme TBC	Phased Build – Programme TBC	Phased Build – Programme TBC
Project Funding	Continue with existing arrangements	CRL funding	Combination of £17.6m PDC funding + additional CRL (inflation only)	Combination of £17.6m PDC funding + additional CRL

*Both ATC and SDEC are subject to separate business cases and so are excluded from the scope of the capital cost forms and drawings for this business case but their locations/sizes/adjacencies need to be factored into the design

It is important to note that the preferred way forward identified above is not the preferred option at this stage. The preferred option is identified from the appraisal of the short-listed options which will be explored in the economic appraisal.

1.5.3 Economic Appraisal

An economic appraisal has been prepared to evaluate the costs, benefits and risks of the shortlisted options to identify the option that is most likely to offer best public value for money.

Capital and revenue costs have been estimated based on 1:200 drawings, agreed schedules of accommodation and anticipated requirements. A robust assessment of benefits and risks was undertaken and, where possible, these have been quantified in monetary values. The resulting assumptions have been used to populate the Comprehensive Investment Appraisal (CIA) model and estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option.

The results of the economic appraisal demonstrate that Option 2, which involves refurbishing and extending the Mental Health building to create Bassetlaw Emergency Village, offers best value for money with the best incremental Net Present Social Value (NPSV) and a Benefit Cost Ratio (BCR) of 4.48.

This is because the £17.98m capital investment required to deliver Option 2 will generate a range of benefits including:

- Providing CAU facilities overnight will result in fewer children being transferred to DRI reducing associated costs.
- Improved adjacencies between ED and ATC will enable more integrated ways of working and deliver rota efficiencies.
- The integrated front door and improved clinical flows will enable ED to achieve national targets and reduce patients' time spent in the department.

- Providing a better working environment and clinical model that will provide opportunities to improve recruitment and retention, reduce sickness absence, and reduce reliance on agency usage.
- Providing modern efficient facilities that will improve energy consumption.
- Delivering social value through local investment including creation of apprenticeship and new construction job opportunities.

Option 1, the Do Minimum, involves refurbishing the existing ED and Mental Health building at a cost of £17.2m. This would deliver minimal benefits as although it enables delivery if the Paediatrics model, it does not change the ED location or model and so will not result in any of the benefits associated with improved adjacencies, front door streaming and clinical flow. It also does not provide sufficient capacity to accommodate predicated ED demand in the future. It therefore results in a whole life Net Present Cost and BCR of just 0.32, representing relatively poor value for money.

While Option 3, which involves investing £35.3m to deliver a new build solution for the Bassetlaw Emergency Care Village, delivers similar benefits to Option 2, the increased level of investment means it results in a lower BCR and so offers less value for money. It is also unlikely to be affordable.

Sensitivity testing was undertaken which demonstrated that these results are not particularly sensitive to changes in key assumptions.

A summary of the results of the economic appraisal is provided in the table below.

Table 4: Options Overview

	Option 0 – BAU	**Option 1 – Do Minimum**	**Option 2 – Refurbish and Extend**	**Option 3 – New Build**
Incremental NPSV	**0**	**-£10.1m**	**£61.9m**	**£51.4m**
Benefit Cost Ratio	**0.00**	**0.32**	**4.48**	**2.81**
Significant non-financial benefits		Some improvement to estate Delivers benefits of adjacencies between Paediatrics ED and CAU	Delivers benefits of Integrated Front Door, ED adjacencies, Paediatrics ED and CAU adjacencies Interface with new ATC allows clinical model benefits to be fully realised Provides adjacencies that enable successful delivery of new SDEC scheme	In addition to Option 2, potentially optimises adjacency benefits

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
Residual risks		Suboptimal adjacencies and clinical flow will reduce benefits Complex phasing increasing risks of delay, disruption to services during works, and delay to achieving benefits	Minor compromises to adjacencies compared to a new build solution	Capital affordability
Lifespan	Does not increase capacity to meet current and future demand	Does not increase capacity to meet current and future demand	Provides capacity to meet predicted demand to 2035	Provides capacity to meet predicted demand to 2035
Rank	4	3	1	2
Switching	N/A	N/A	To rank equal to next best option (Option 3) costs would need to increase by 58.9% or benefits reduce by 13.2%	To rank equal to preferred option (Option 2) costs would need to decrease by 36.9% or benefits increase by 13.1%

It is therefore recommended that Option 2 is carried forward as the preferred option.

1.6 Commercial Case

1.6.1 Commercial Feasibility

The purpose of the Commercial Case is to demonstrate that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers. Demonstrating a viable procurement requires an understanding of the marketplace, knowledge of what is realistically achievable by the supply side and research into the procurement routes that will deliver best value to both parties.

1.6.2 Scope

The scope of the scheme as agreed during the options assessment process is as follows:

To deliver the proposed clinical model and provide the functional content to meet forecast demand for services, including:

- An integrated front door for emergency services (combined primary care, ED triage and streaming)
- Majors, minors, resus, mental health and primary care
- Paediatrics ED and dedicated Children's Assessment Unit
- Enable optimum interface with new ATC and new SDEC.

The construction solution required to achieve these aims is as follows:

- Refurbish the existing mental health building and deliver a new-build extension
- Deliver the agreed Schedule of Accommodation V15
- Achieve improved adjacencies/clinical flow
- Co-locate with new ATC and SDEC.

1.6.3 Procurement Strategy

The procurement strategy has been developed by Edge Cost Consulting. A non-commercial evaluation was undertaken by Edge of the five procurement options (as detailed in their procurement strategy report – see Appendix C1).

The non-commercial procurement evaluation has identified ProCure 21+ as the most appropriate procurement route for the project as this best satisfies the main project criteria around speed of delivery (P21+ is the quickest route to market), and appointment of a trusted contractor to deliver the works in a highly sensitive clinical area (IHP are familiar with Trust estate).

It is acknowledged that concerns have previously been raised with regard to the validity of this procurement route and suitability given that IHP were appointed some eight years ago and the P21+ framework has subsequently been replaced by P22 (and now P23). On the basis that the original scheme information pack which formed the basis of IHP's appointment included an ED development at Doncaster Royal Infirmary (see Appendix C2 for the HLIP), the project team considered that the emergency village project would be an acceptable substitute to the DRI scheme given its similar functional content, scale and value. The Project Team sought advice from Andrew Mitchell, P22/23 Implementation Advisor within the Commercial Directorate at NHSEI, on the Trust's ability to utilise the existing P21+ agreement with IHP to progress this scheme. Following discussion between Andy White, Head of Capital Projects at DBTH, and Andrew Mitchell, this approach has been agreed and the project is live on the P21+ database.

IHP have a strong track record in delivering projects in the healthcare industry and have worked on various projects with the Trust. This includes the RAAC Replacement works that are currently in progress at Bassetlaw Hospital. The co-location of the two projects creates the benefit of being able to offer cost efficiencies by utilising existing trades, plant, accommodation etc, which will result in reduced prelims.

The appointment of IHP also brings risk reduction to Health & Safety variables, including the safety and wellbeing to staff, patients, construction operatives and the public directly and also indirectly through disruption to clinical activities. In addition to this, IHP's experience on a similar scheme at Chesterfield will be invaluable in terms of applying the lessons learned and delivering the project within appropriate timescales.

Given its long-standing relationship with the Trust and the benefits that this brings, IHP were deemed highly suitable candidates to deliver the design and main construction works that align with the key objectives set out by the Trust for the Emergency Village project.

Following analysis, the best option for procurement – the P21+ route - was recommended by Edge to the Project Board and has been endorsed by the Trust's procurement team and the Department of Health.

1.6.4 Procurement Process

This evaluation has scored each of the procurement options against a set of criteria which reflects the Trust's project-specific criteria set out in section 4.4.

1.6.5 Key Contractual Milestones and Delivery Dates

The table below sets out the key contractual milestones and delivery dates:

Table 5: Key Contractual Milestones

Activity	Completion Date
Project Letter of Instruction Provided	December 2020
DBTH Sign Off 1:200s	May 2022
OBC submission to NHSE&I	July 2022
Submit planning application	September 2022
Submission of GMP to DBTH for review	December 2022
FBC submission to NHSE&I	January 2023
NHSE/I FBC review and approval	14 April 2023
Contractor Mobilisation	March 2023
Construction	April 2023-April 2024
Stage 4 - Completion	April 2024
Stage 5 – Handover	June 2024

1.6.6 Key Contractual Issues

The Procure 21+ contract is a bespoke contract based upon the NEC3 Option C Contract. Both process and contract are bespoke to mirror the NHS business case approval process, giving clients the control mechanisms to ensure their scheme remains on budget at each stage, with break clauses (without penalty) throughout the design and development period. The framework contract is set and agreed by partnering organisations, and no project-specific amendments are permitted.

Clients can use the process and the partnership working relationship with their supply chain to drive as much value as they can – often creating long-term relationships with their ProCure21+ supply chains to deliver additional value on long-term objectives.

When a final design is agreed, costed and thoroughly market-tested, the client is given a Guaranteed Maximum Price (GMP) for the scheme. This limits the client's liability to price increases, risk and poor performance. If the scheme is delivered below the budget, a gainshare mechanism shares the savings 50:50. Any overspend (that is not a client-instructed change) is borne 100% by the supply chain.

1.6.7 Risk

The Risk Register is a live document and is critical to the NEC process. During the tender phase, risks will be allocated to parties, which will impact on the agreed contract price.

All risks will be assessed and quantified, the project team will agree which party is best placed to own and manage that risk. This will also give the Trust the opportunity to assign risk to the contracting organisation; albeit this will increase the cost of the agreed guaranteed maximum price. The proposed risk transfer is as below:

Table 6: Risk Transfer Matrix

Risk Category	Potential allocation		
	Trust	PSCP	Shared
1. Design risk		✓	
2. Construction and development risk		✓	
3. Transition and implementation risk		✓	
4. Availability and performance risk		✓	
5. Operating risk	✓		
6. Variability of revenue risks	✓		
7. Termination risks			✓
8. Technology and obsolescence risks			✓
9. Control risks	✓		
10. Residual value risks	✓		
11. Financing risks	✓		
12. Legislative risks			✓

The above Risk Matrix will be reviewed at key milestones and gateways.

1.6.8 Personnel

TUPE –the Transfer of Undertakings (Protection of Employment) Regulations 1981 –will not apply to this investment as there is no transfer of a business, or part of a business, between employing entities.

1.6.9 Design Specific Information

The project team have developed a demand and Capacity Modelling, Schedule of Accommodation, Clinical Brief and 1:200 design with clinical, operational, estates and design stakeholders' involvement. These documents have been signed off by relevant Trust key stakeholders, see Appendix C3 for the sign off sheet.

1.7 Financial Case

1.7.1 Capital Costs

It is anticipated that delivery of the preferred option will require capital investment of £17.89m which will be funded as follows:

- £17.605m provided through Wave 4 STP funding as outlined in the original SOC.
- £0.393m self-financed by the Trust including:
  - £0.186m funded as part of the Trust's wider Mental Health scheme, specifically in this case to provide appropriate Mental Health spaces in ED.
  - Work is underway to explore options to fund the remaining £0.207m, such as value engineering to reduce costs as the design of the scheme matures.

1.7.2 Revenue Consequences

The revenue consequences of this investment include:

- £0.143m of incremental operating costs each year to cover the additional cleaning, utilities, and maintenance requirements incurred as a result of the increased floor area.
- £0.196m of annual depreciation charges, based on a 60-year asset life and applying asset values advised by Cushman & Wakefield.
- Public Dividend Capital (PDC) dividend payments are calculated using the average cost of net relevant assets each year at the current standard 3.5% rate of return until it is repaid.
- Additional costs are largely mitigated by cash releasing benefits of £0.683m p.a.

Recurring revenue costs including capital charges and cash releasing benefits have been included in the financial model with appropriate inflation rates applied.

The results, shown in the table below, demonstrate that the scheme is affordable in revenue terms over the whole life of the asset.

Table 7 Incremental impact on SOCI

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	Remaining Years £'000	Total £'000
Income	0	0	0	0	0	0	0	0	0	0	0	0
Operating expenditure	-50	209	576	589	602	615	628	642	656	670	58,529	63,665
Impairment	-4,135	0	0	0	0	0	0	0	0	0	0	-4,135
Depreciation	0	-173	-196	-196	-196	-196	-196	-196	-196	-196	-9,580	-11,318
Operating surplus / (deficit)	**-4,185**	**36**	**381**	**393**	**406**	**419**	**432**	**446**	**460**	**474**	**48,949**	**48,212**
PDC charges	-235	-466	-461	-459	-456	-455	-454	-453	-453	-450	-32,384	-36,726
Surplus / (deficit)	**-4,419**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**11,486**
Impairment reversal	4,135	-0	-0	-0	0	-0	0	0	0	-0	0	4,135
Adjusted surplus / (deficit)	**-284**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**15,621**

However, it should be noted that:

- There is an initial cost pressure in the early years of the scheme as new ways of working are embedded and cash releasing benefits established.
- Affordability is dependent on the delivery of the cash releasing benefits. and further work is required to develop the workforce model behind this at FBC stage.

1.8 Management Case

The Management Case considers the approach taken to support the successful delivery of the programme, in accordance with best practice.

1.8.1 Project Plan

The anticipated project programme is attached at Appendix M1. High level milestones are set out in the following table:

Table 8: Project Milestones

Activity	Start Date	End Date
OBC Production	05/05/2022	26/07/2022
NHSE&I OBC Approval	30/07/2022	21/10/2022
Design Development (RIBA stage 3)	18/07/2022	31/10/2022
Design Completion (RIBA Stage 4 Co-ordinated Design)	11/10/2022	17/01/2023
Market Testing	27/09/2022	28/11/2022
Receipt of GMP	13/12/2022	13/12/2022
Finalisation of FBC	14/12/2022	13/01/2023
Trust Approval	16/01/2023	20/01/2023
Submit FBC to NHSE&I	14/04/2023	14/04/2023
NHSE&I FBC Approval	23/01/2023	31/03/2023
Stage 4 Enabling works	20/02/2023	31/03/2023
Stage 4 Construction Works	03/04/2023	05/04/2024
Handover and Completion	05/04/2024	19/06/2024

1.8.2 Project Management Arrangements

The project will be managed in accordance with PRINCE 2 methodology. The Programme Board is responsible for driving forward and delivering the outcomes and benefits of this development. Members will provide resource and specific commitment to support the project manager in respect of the key deliverables.

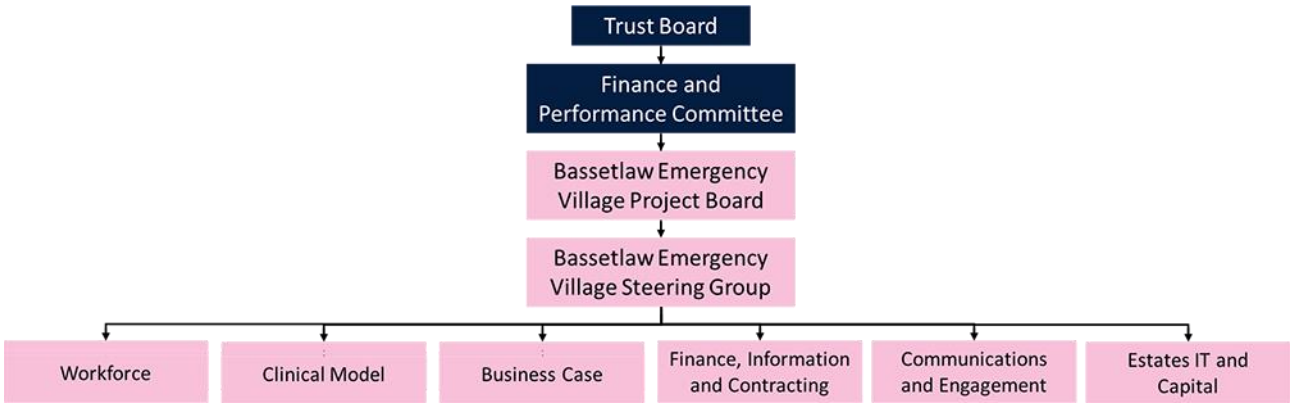
The key principles behind PRINCE 2 are the identification of the following functional areas of the project governance structure:

- Governance functions;
- Delivery functions;
- Assurance functions.

1.8.3 Project Governance

The Project Board, chaired by the SRO, Dr Kirsty Edmondson-Jones, will oversee the delivery of the project through the identified work-streams from conception to completion.

Accountability for the outputs of the individual workstreams sits with the respective workstream leads. The project is governed as indicated below:



1.8.4 Benefits Management

Benefits have been identified and quantified in line with the Green Book and the Treasury Comprehensive Investment Appraisal model. The delivery of benefits will be managed through the Project Board.

An assessment has been undertaken to compare the benefits to the project investment objectives. This has determined that each investment objective has been met by one or more benefits.

As part of the OBC, benefits have been identified and measures established, and a plan agreed to collect baseline data and agree targets and methods of monitoring.

1.8.5 Change Management

Change management associated with the project will be managed through the Project Team and authorising bodies that preside over it, under the chairmanship of the SRO. Day to day change management issues will be discussed at the Project Board and any resultant contract and/or cost changes will need to be approved accordingly.

1.8.6 Risk Management

The responsibility for managing the risks of the project resides with the Capital Project Manager. Key project risks will be identified and recorded on a Risk Register, where they will be allocated a Risk Manager, who is responsible for managing the risk together with the mitigation measure identified for that risk.

The Risk Register has been developed and presented to the Steering Group and Project Board. It is a separate stand-alone 'live document' which is reviewed and updated throughout the life of the project to capture new risks, identify those whose status has changed, examine mitigation strategies and close risks which are no longer applicable.

1.8.7 Post Project Evaluation

The arrangements for PPE have been established in accordance with best practice. This will be a two-stage approach, with the Project Completion Report (PCR) being completed at six months of the building being in use; followed by the full post-project evaluation at two years

1.8.8 Publication of the OBC

Arrangements will be made to publish this OBC on the Trust's website, excluding any commercially sensitive information, following formal approval.

2 The Strategic Case

2.1 Introduction

This Outline Business Case (OBC) is for the investment of £17.98m to create a modern, fit-for-purpose emergency village at Bassetlaw Hospital which is part of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The new facilities will include a new emergency department for children and adults, which is adjacent to the assessment and treatment centre, same day emergency care services and the fracture clinic. A children's assessment unit will also be relocated and developed near the emergency department. Facilities will be part new build and part refurbishment, and will be appropriately configured and right sized to deliver high quality care and meet the rising demand for services.

2.2 Structure and content of the document

The OBC has been prepared using the agreed standards and format for business cases, as set out in NHS Improvement Capital regime investment and property business case approval guidance for NHS trusts and foundation trusts (NHS Improvement 2016).

The approved format is the Five Case Model, which comprises the following key components:

Strategic Case	This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
Economic Case	This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM).
Commercial Case	This outlines the content and structure of the proposed deal.
Financial Case	This confirms funding arrangements and affordability and explains any impact on the statement of financial position of the organisation.
Management Case	This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

2.3 Approvals and Support

Drafting Note: This section assumes formal approval and support. Note to be remove following formal sign off of OBC

2.3.1 Trust Board of Directors

The Board of Directors are due to formally approved this OBC at their meeting on 26 July 2022, which can be found at Appendix S1.

2.3.2 Integrated Care Board

A letter of support in principle for the OBC was received from Nottingham and Nottinghamshire Integrated Care Board and South Yorkshire Integrated Care Board, which can be found at Appendix S2.

Part A: The Strategic and Policy Context

2.4 Organisational Overview

2.4.1 Trust Overview

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is one of Yorkshire's leading acute trusts, serving a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas.

Hosting three main hospital sites and a number of additional services, the Trust is one of only six teaching hospitals in the region. It was awarded teaching hospital status in 2017. A modern and forward-facing Trust employing over 6,500 members of staff, the hospital provides a full range of local hospital services across the following sites:

Doncaster Royal Infirmary (DRI)

DRI is a large acute hospital with 647 beds, a 24-hour Emergency Department (ED). In addition to a full range of hospital care, it also provides some specialist services including vascular surgery. It has inpatient, day case and outpatient facilities.

Bassetlaw Hospital in Worksop (BH)

BH is an acute hospital with 170 beds, a 24-hour ED and a full range of hospital services including a breast care unit and renal dialysis. It has inpatient, day case and outpatient facilities.

Montagu Hospital in Mexborough

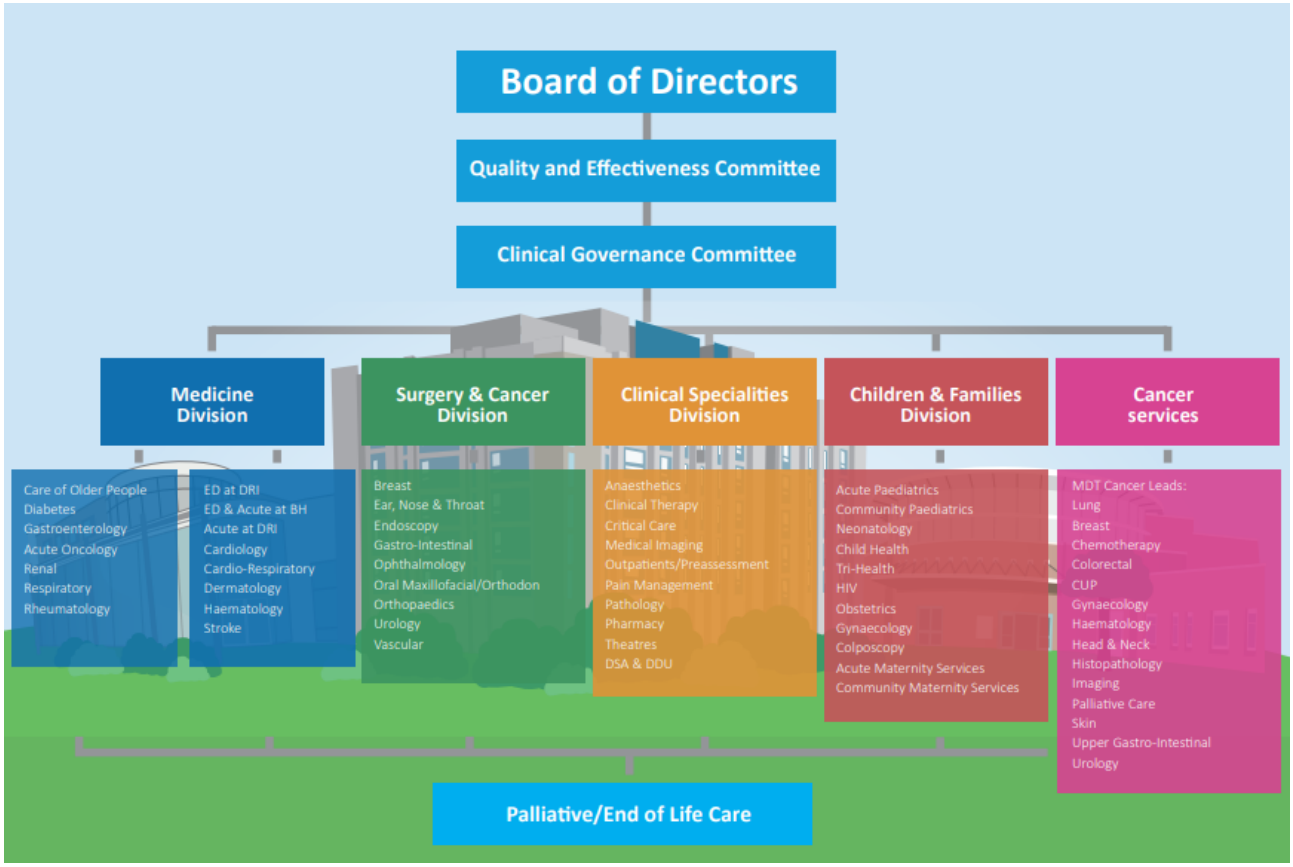
Montagu is a small non-acute hospital with 50 inpatient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am-9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of outpatient clinics. Montagu is the site of the Trust's Rehabilitation Centre, Clinical Simulation Centre and the base for the Abdominal Aortic Aneurysm screening programme. The Trust intend to develop a new CDC and Elective Orthopaedic Centre at this site which are currently subject to business case approval.

The Trust also provides outpatient and other health services at Retford Hospital, including clinical therapies and medical imaging.

2.4.2 Clinical Management Structure

The Trust's clinical services are organised into four divisions as illustrated below.

Figure 6: DBTH Clinical Services



2.4.3 Financial Position

The Trust's financial position is summarised in the tables below.

In 21/22 the National Funding arrangement continued through adjusted block funding which included additional income to support the Covid-19 response of £13m as well as a National System Top-Up of £25m . This financial support has reduced in 2022/23 alongside other funding reductions which are in part impacting the Trust's planned deficit of £10m.

Table 9: Statement of Comprehensive Income

	2021/22 £'000	2020/21 £'000	2019/20 £'000	2018/19 £'000	2017/18 - restated £'000
Operating income from patient care activities	451,183	404,601	379,103	350,865	335,060
Other operating income	51,161	57,902	55,419	62,860	51,952
Operating expenses	(512,914)	(457,245)	(430,268)	(404,254)	(394,949)
Operating surplus/(deficit) from continuing operations	(10,570)	5,258	4,254	9,471	(7,937)
Finance income	318	278	550	424	49
Finance expenses	(282)	(336)	(1,507)	(1,640)	(1,358)
PDC dividends payable	(5,993)	(4,720)	(2,924)	(3,089)	(2,869)
Net finance costs	(5,957)	(4,778)	(3,881)	(4,305)	(4,178)
Other gains / (losses)	581	1,438	(600)	418	(11)
Corporation tax expense	(15)	(33)	-		

	2021/22 £'000	2020/21 £'000	2019/20 £'000	2018/19 £'000	2017/18 - restated £'000
Surplus / (deficit) for the year	**(15,961)**	**1,885**	**(227)**	**5,584**	**(12,126)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Net Impairments	4,743	2,409	(3,116)	(874)	-
Revaluations	-	88	340	-	13,490
Total comprehensive income / (expense) for the period	**(11,218)**	**4,382**	**(3,003)**	**4,710**	**1,364**
Surplus/ (deficit) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	(15,961)	1,885	(227)	5,584	(12,126)
TOTAL	**(15,961)**	**1,885**	**(227)**	**5,584**	**(12,126)**
Total comprehensive income / (expense) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	(11,218)	4,382	(3,003)	4,710	1,364
TOTAL	**(11,218)**	**4,382**	**(3,003)**	**4,710**	**1,364**
Adjusted Financial Performance					
Surplus/ (deficit) for the period for Trust:				1,133	
Surplus/ (deficit) for the period for Wholly Owned Subsidiary:				96	
Surplus/ (deficit) for the period for non-charity aspects of the Group				(2,271)	
Add back all I&E impairments / (reversals)				4,127	
Remove capital donations / grants I&E impact				(10,719)	
Remove impact of prior year PSF post accounts reallocation				(6,592)	
Adjusted financial performance surplus / (deficit) including PSF, FRF, MRET and Top-Up				(6,615)	
				23	

Table 10: Statement of Financial Position

	31 March 2022 £'000	31 March 2021 £'000	31 March 2020 £'000	31 March 2019 £'000	31 March 2018 - restated £'000
Non-current assets					
Intangible assets	9,990	9,370	6,394	6,939	6,792
Property, plant and equipment	234,696	225,459	204,149	197,054	198,424
Other investments / financial assets	9,323	8,741	7,303	8,388	8,025
Receivables	2,371	1,511	2,619	1,695	1,621
Total non-current assets	256,380	245,081	220,465	214,076	214,862
Current assets					

	31 March 2022 £'000	31 March 2021 £'000	31 March 2020 £'000	31 March 2019 £'000	31 March 2018 - restated £'000
Inventories	7,888	7,022	6,637	5,510	5,526
Receivables	17,712	15,090	22,635	36,342	32,376
Non-current assets held for sale and assets in disposal groups		-	343	343	-
Cash and cash equivalents	47,316	52,085	32,079	20,627	12,775
Total current assets	72,916	74,197	61,694	62,822	50,677
Current liabilities					
Trade and other payables	(81,770)	(66,661)	(51,467)	(40,970)	(42,541)
Borrowings	(1,872)	(2,112)	(73,295)	(52,682)	(10,214)
Provisions	(579)	(637)	(603)	(823)	(627)
Other liabilities	(1,573)	(1,383)	(2,503)	(2,178)	(2,054)
Total current liabilities	(85,794)	(70,793)	(127,868)	(96,653)	(55,436)
Total assets less current liabilities	243,502	248,485	154,291	180,245	210,103
Non-Current liabilities					
Borrowings	(10,793)	(12,618)	(14,675)	(42,265)	(79,157)
Provisions	(3,306)	(2,170)	(1,982)	(2,108)	(1,949)
Other liabilities				(307)	-
Total non-current liabilities	(14,099)	(14,788)	(16,657)	(44,680)	(81,106)
Total assets employed	229,403	233,697	137,634	135,565	128,997
Financed by					
Public dividend capital	235,793	228,869	137,188	132,019	130,161
Revaluation reserve	49,688	44,945	42,454	45,327	46,584
Income and expenditure reserve	(65,553)	(49,294)	(49,997)	(51,005)	(56,557)
Charitable fund reserves	9,271	9,038	7,990	9,224	8,809
Doncaster & Bassetlaw Healthcare Services Ltd	204	139	(1)		
Total taxpayers' equity	229,403	233,697	137,634	135,565	128,997

Table 11: Statement of Cash Flows

	2021/22 £'000	2020/21 £'000	2019/20 £'000	2018/19 £'000	2017/18 - restated £'000
Cash flows from operating activities					
Operating surplus / (deficit)	(10,570)	5,258	4,254	9,471	(7,937)
Non-cash income and expense:					
Depreciation and amortisation	11,694	9,828	8,490	9,644	9,272
Net impairments	18,775	4,902	135	1,133	-
Income recognised in respect of capital donations	(347)	(2,038)	-	-	(257)
(Increase) / decrease in receivables and other assets	(3,157)	8,651	12,721	(4,449)	(5,357)

	2021/22 £'000	2020/21 £'000	2019/20 £'000	2018/19 £'000	2017/18 - restated £'000
(Increase) / decrease in inventories	(866)	(385)	(1,127)	16	(942)
Increase / (decrease) in payables and other liabilities	13,618	14,038	2,949	(1,462)	15,019
Increase / (decrease) in provisions	1,100	233	(352)	194	(212)
Movements in charitable fund working capital	544	6	21	(134)	(363)
Corporation Tax (paid)	(15)				
Other movements in operating cash flows	292	156	150	5	600
Net cash flows from / (used in) operating activities	**31,068**	**40,649**	**27,241**	**14,418**	**9,823**
Cash flows from investing activities					
Interest received	25	11	272	131	49
Purchase of investments - Doncaster & Bassetlaw Healthcare Services Limited		-	-	-	-
Purchase of intangible assets	(2,241)	(3,956)	(297)	(1,294)	(1,125)
Purchase of non-current assets and investment property	(31,858)	(30,526)	(9,445)	(8,471)	(5,685)
Sales of non-current assets and investment property	-	454	-	526	75
	(34,074)	**(34,017)**	**(9,470)**	**(9,108)**	**(6,686)**
Cash flows from financing activities					
Public dividend capital received	6,924	91,681	5,169	1,858	1,381
Movement on loans from DHSC	(2,056)	(73,025)	(6,962)	5,290	9,201
Interest on loans	(313)	(562)	(1,516)	(1,453)	(1,358)
PDC dividend (paid) / refunded	(6,318)	(4,720)	(3,010)	(3,153)	(2,773)
Net cash flows from / (used in) financing activities	**(1,763)**	**13,374**	**(6,319)**	**2,542**	**6,451**
Increase / (decrease) in cash and cash equivalents	**(4,769)**	**20,006**	**11,452**	**7,852**	**9,588**
Cash and cash equivalents at 1 April - brought forward	**52,085**	**32,079**	**20,627**	**12,775**	**3,187**
Cash and cash equivalents at 31 March	**47,316**	**52,085**	**32,079**	**20,627**	**12,775**

2.4.4 Services Provided

The Trust provides a full range of acute clinical services, including:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services
- Breast care unit
- Renal dialysis.

In addition, the Trust provides some community services (including family planning and audiology) and some specialist tertiary services including vascular surgery.

2.4.5 Population

The Trust serves a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas. The health of people in Doncaster and Bassetlaw is generally worse than the England average. Deprivation is worse than the England average and there are higher numbers of children living in poverty. Life expectancy for both males and females is lower than the England average. See section 2.6.3 for more details on the health needs of the local population.

2.4.6 Commissioners Served

The majority of the Trust's services are commissioned by the local clinical commissioning groups (CCGs) that make up the South Yorkshire Integrated Care Board (ICB). These include Doncaster CCG, Bassetlaw CCG, Rotherham CCG, Barnsley CCG and Sheffield CCG. From July 2022 Bassetlaw CCG will fully move from South Yorkshire ICB to Nottingham and Nottinghamshire ICB (see section 2.6 for more details). For further details regarding this see section 2.6.

Some specialist services, such as vascular surgery, are commissioned by NHS England.

2.4.7 Local Health System

Over recent years the Trust has strengthened its links with health and care partners in Doncaster and Bassetlaw and it is an integral partner in the South Yorkshire Integrated Care Board (ICB). This has established, strong relationships with neighbouring health and social care providers and CCGs, which has built on the foundations of a proven history of working together to improve health and care for the local population. The Trust recognises its role as an "anchor organisation" in its locality and plans to further cement this role in advancing the welfare of the population it serves.

From July 2022 Bassetlaw Place Based Partnership, a collaborative of organisations from across the district, will become the local driving force for ensuring people in Bassetlaw receive appropriate health care for their needs. The Partnership involves DBTH, Bassetlaw District Council, Healthwatch Nottingham and Nottinghamshire, Bassetlaw Community Voluntary Service (BCVS), Nottinghamshire County Council, Nottinghamshire Healthcare NHS Trust and

the local Primary Care Network. They will all be working together more closely to address key issues that impact on health inequalities.

2.4.8 Impact of the Covid-19 Pandemic

Since the start of the pandemic the Trust has cared for 6,526 patients. When national infection rates were at their highest, the Trust's hospitals were some of the busiest in the country.

During the pandemic the Trust worked with its independent sector partner, Ramsay Health, to establish a protected, safe environment for its cancer patients at Parkhill Hospital. Many outpatient services rapidly transferred many face-to-face services to telephone or video appointments. Technology helped to establish rapid and efficient ways of working with system partners and colleagues across the Trust.

Key changes to the hospital estate included:

- Separated corridors for enhanced infection control.
- Reconfiguration of some wards to maximise oxygen flow.
- Intensive care beds increased from 28 to 130.

Although Covid-19 is likely to remain a fact of life beyond the pandemic, the Trust is putting plans in place to recover its performance and activity, working through waiting lists in order of urgency as well as chronology. This will be done as it keeps a watching brief on levels of Covid-19 infection within the local community, including responding to new variants of the disease.

In the 2021/22 financial year, the Trust refreshed its strategy, reset its objectives and factored in much that it learnt throughout the pandemic. This was done within the context of a transitioning healthcare system within the region. This year the Trust intends, within reason, to continue to keep the things that have proven successful, whilst improving in those areas where it can do better.

As of July 2022, staff absence rates at the Trust were 8.18%, which was having a significant impact on the delivery of care. In addition, there will be increasing pressures on emergency care services as transmission rates are expected to rise in the autumn and winter. Capacity within existing emergency care facilities will not be sufficient to cope with this increase in demand.

2.4.9 CQC Inspection

A CQC inspection 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.

Figure 7: CQC Summary Rating 2019/202

Overall trust quality rating	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good
Combined quality and resource rating	Good

In rating the Trust, the CQC took into account the current ratings of the services not inspected. 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.

Specific areas of concern for urgent and emergency care services at Bassetlaw included:

- At peak times the department experiences crowding with patients waiting in the corridor. The escalation arrangements in place to mitigate crowding were unclear, particularly for specialty referral standards, ambulatory care, frailty pathways, or cancer care.
- Although paediatric nurse cover had improved it did not achieve the Royal College of Paediatrics and Child Health (RCPCH) (2018) guidance and night cover remained a challenge.

The provision of an emergency village at the Trust will address these concerns by improving care pathways for patients and providing new accommodation that is correctly sized to cope with peaks in demand.

For the full CQC report see Appendix S3.

2.5 National Strategies

National strategies and their relevance to this scheme are summarised below along with the Emergency Village scheme will support them. For a full description of each strategy see Appendix S4.

NHS Long Term Plan

The NHS Long Term Plan (LTP), published in 2019, is a new plan for the NHS to improve the quality of patient care and health outcomes and to make it fit for future purpose. The plan sets out a range of aims for the NHS over the next ten years making sure everyone gets the best start in life; delivering world class care for major health problems; and supporting people to age well. The LTP provides a framework for local systems to develop plans, based on the principles of collaboration and co-design.

How the emergency village will support this

People across Bassetlaw will have equitable access to urgent and emergency care services. The outcomes of the project will improve the care patients receive with the latest facilities.

NHS Long Term Plan: Emergency Care

The LTP sets out action to ensure patients get the care they need, fast, and to relieve pressures on A&Es.

How the emergency village will support this

The creation of an emergency village at Bassetlaw Hospital, with a single ambulant front door, improves the emergency care pathway, making it easier for patients to access the right service for them. It will ensure patients receive the correct treatment quickly.

Lord Carter's Report: Operational Productivity & Performance in English NHS Acute Hospitals

Lord Carter of Coles' report sets out how non-specialist acute trusts can reduce unwarranted variation in productivity and efficiency across every area in the hospital, to save the NHS £5 billion each year by 2020/2021.

- Staffing: the review calls for an improvement in the way the NHS deploys its staff, ending the use of outdated and inefficient paper rosters.
- Procurement: as part of the review, from April 2016, Trusts will publish their receipts on a monthly basis for the top 100 items bought by the NHS such as bandages, needles and rubber gloves.
- Use of Floor Space: Trusts' unused floor space should not exceed 2.5% and floor space used for non-clinical purposes should not exceed 35%.
- Administration Costs: these should not exceed 7% by 2018 and 6% by 2020.
- Delayed Transfer of Care: Lord Carter has called for action to be taken on the 'major problem' of delayed transfers of care, which affects hospitals and trusts' earning and spending capacity.
- Working with Neighbourhood Hospitals: Lord Carter advises Trusts to work closely with their neighbouring hospitals, sharing services and resources to improve efficiency and reduce costs.

How the emergency village will support this

By delivering against some of report's key recommendations:

Procurement

The Trust has been benchmarked using the Model Health System which assesses how well the Trust is progressing towards national procurement efficiency targets for workforce, processes, and securing the best products at the best prices. The trust is rated Green (quartiles 3 and 4) for process efficiency.

Use of Floor Space

The Trust would look to continue to improve on these measures for the emergency village project along with its other capital development plans and in line with ICB workstreams around estates strategy.

Annual NHS Estates Return Information Collection (ERIC) return work that helps to demonstrate the 'Use of Floor Space' criteria including the categorisation of accommodation. All floor space is 100% clinical. There is no space for corporate services or space for services not associated with the delivery of urgent and emergency clinical care.

More effective streaming at the front door will improve clinical pathways, increasing productivity and efficiency across the Trust's emergency care service

Working with Neighbourhood Hospitals

The Trust will continue to collaborate with the wider Integrated Care Board to consider and align: sustainability, estates strategies, backlog maintenance, ERIC, EMBE and procurement.

The Trust will ensure good quality estates planning to help:

- Enhance patient and staff experience (through co-located services that improve the patient journey and enable staff to co-operate across areas eg paediatrics ED and CAU).
- Maximise use of facilities (the new scheme is concise and ensures that adjacencies are optimised for maximum efficiency).
- Deliver value for money.

The Naylor Review

The Naylor Review evaluated the condition of NHS premises and concluded that major investment is required to develop new models of care. The review calls for the NHS, through the ICS process, to rapidly develop robust capital plans that are aligned with clinical strategies, maximise value for money and address backlog maintenance.

The scheme will enable new models of care for emergency care and paediatric services to be delivered in new and refurbished facilities that are fit for purpose and sized to meet the forecast rise in demand for services. See section 4.9.1 for more detail.

Delivering a Net Zero National Health Service

In October 2020 the NHS published two clear targets for achieving net zero:

- For the emissions the NHS controls directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions that can be influenced (the NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The scheme is aiming to achieve a BREEAM 'very good' rating in refurbished and BREEAM 'excellent' rating in new build accommodation.

Estates 'Net Zero' Carbon Delivery Plan (August 2021)

This delivery plan addresses the aspects of the 2020 NHS net zero strategy pertinent to estates and facilities activities. It sets out a four-step approach to decarbonising the NHS estate:

- Making every kWh count: investing in no-regrets energy saving measures
- Preparing buildings for electricity-led heating: upgrading building fabric
- Switching to non-fossil fuel heating: investing in innovative new energy sources
- Increasing on-site renewables: investing in on-site generation.

The trust supports the NHS ambitions and wants to reduce the impact on climate change and to support sustainability issues. Sustainability is at the core of the Trust, developing the knowledge of our staff. The trust green plan is attached at Appendix S5.

2.5.1 Other National Policies and Strategies

Other key national drivers underpinning the case for change in service delivery and support safe practice include:

Health and Care Act 2022

The Act establishes a legislative framework that supports collaboration and partnership working to integrate services for patients. It formalises Integrated Care Systems (ICSs) which brings together providers and commissioners of NHS services across a geographical region to plan health and care services to meet the needs of their local population.

How the emergency village will support this

Tackles the problems of ill health, health inequalities and access to health care for people across Bassetlaw.

Health and Social Care Act 2012

The Government's Health and Social Care Bill outlines the future commissioning arrangements across the NHS. This introduced the first explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. This led to a commitment in the NHS constitution that the NHS is "designed to diagnose, treat and improve both physical and mental health".

How the emergency village will support this

People across Bassetlaw will have equitable access to urgent and emergency care services.

Department of Health Emergency Department Clinical Quality Indicators

The clinical quality indicators for ED have been designed to present a comprehensive and balanced view of the care, and accurately reflect the experience and safety of patients and the effectiveness of the care they receive. These indicators support patient and public expectations of high-quality emergency services and allow EDs to demonstrate their ambition to deliver consistently excellent services which continuously improve.

How the emergency village will support this

The emergency village will create modern, fit-for-purpose facilities that will enhance patients' experience of care. The facilities will also be designed with flexibility in mind to ensure the service can adapt quickly to changes in services.

Co-locating services will improve patient flow and enable staff to work more effectively together.

Care Quality Commission

The Care Quality Commission (CQC) implemented 5 domains of quality care, against which to assess provision of care. These domains are defined as Safety, Effectiveness, Caring, and Responsive to people's needs and well led organisation. In addition, the CQC have also implemented an intelligent monitoring approach to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust.

How the emergency village will support this

The emergency village has been designed to meet the requirements of the five domains. The new design addresses specific issues identified in earlier CQC inspections:

- Increased capacity to meet growing demand
- Single ambulant front door to triage and stream patients, ensuring they access the right service and improving patient flow.
- Co-locating paediatrics ED and CAU, which will improve the care pathway for children and increase the paediatrics nursing staff ratios.

NHS 2022/23 Priorities and Operational Planning Guidance

This describes the business and planning arrangements for the NHS as it recovers from the Covid-19 pandemic. It sets out 10 key aims to help restore services, meet the new care demands and reduce the care backlogs that were a direct consequence of the pandemic.

A	Invest in the NHS workforce.	F	Improve mental health services.
B	Respond to Covid-19 ever more effectively.	G	Focus on population health management to prevent ill health and address health inequalities.
C	Deliver more elective care to tackle the elective backlog.	H	Use digital technologies to transform care and patient outcomes.
D	Improve the effectiveness of urgent and community care and build community care capacity.	I	Make effective use of resources.
E	Improve timely access to primary care.	J	Establish ICBs and collaborative system working.

How the emergency village will support this

- The emergency village supports this strategy by:
- Streaming patients to ensure they receive the most appropriate care quickly.

- Improving patient flow, which will lead to more efficient services and a more positive experience for patients.
- Creating modern, fit-for-purpose facilities that will enhance patients' experience of urgent and emergency care.

Quality, Innovation, Productivity and Prevention (QIPP)

QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate. By assessing reforms against the four components – Quality, Innovation, Productivity and Prevention – the NHS is meant to provide better quality services in the most productive and cost-effective way possible, making the best use of the potential of innovation and targeted investment in prevention. The four QIPP elements can be seen as both distinct and inter-related. There will be initiatives which focus on particular elements or which bring some or all of the components together.

How the emergency village will support this

The emergency village will improve the way emergency services are provided across the Trust, making them more efficient and cost effective. This aligns with the Trust's Quality Improvement and Innovation Strategy 2017-2022, which sets out how services can be reviewed to identify innovative improvements. The strategy includes an annual Qi action plan which for 2021/2022 identifies engagement events for staff and patients to input into the design of the emergency village.

Getting it Right First Time in Emergency Care (October 2020 update)

Advice pack for Trusts on how to improve pathways at the front door, including:

- Reducing admissions or improving flow to enable faster admissions and transfers.
- Accelerating time to decision to discharge, admit or transfer.

The pack provides good practice examples of:

- Reducing the number of acute surgical attendances.
- Reducing length of stay for acute medical attendances.
- 'Hot and cold' split sites for trauma and orthopaedic attendances.

How the emergency village will support this

Introducing a new triage system at the front door will ensure that patients are streamed quickly and effectively to the most appropriate service, including primary care, which will help to reduce admissions. The co-location of services will also help to improve patient flow.

Transforming Urgent & Emergency Care Services in England: Urgent & Emergency Care Review, End of Phase 1 Report, High Quality Care For All, Now and for Future Generations, NHS England (November 2013) (Update published August 2014)

In 2013, NHS England completed phase one of their review of urgent and emergency care in England, which proposes a fundamental shift in how urgent care and emergency services are delivered. It aims to introduce two levels of hospital-based emergency centre with specialist services in larger units. The report highlights the importance of emergency services being able to provide access to the very best care for the most seriously ill and injured patients, 24 hours

a day and 7 days a week. The review highlights five key elements to ensure the success of implementing the review's proposal of two-tiered emergency centres.

The update, published in 2014, sets out the progress of the review since the initial publication; specifically progress by NHS England working with local commissioners to develop their five-year strategic and two-year operational plans, as well as updates on plans to trial new models such as the new NHS 111 service specification.

How the emergency village will support this

The emergency village builds on improvements which have already been implemented for Urgent and Emergency Care services at DBTH and continues to support the transformation of services in partnership with local health and social care providers.

Safer, Faster, Better: Good Practice in Delivering Urgent and Emergency Care (Transforming Urgent Care Services in England 2015)

For adults and children with urgent care needs, a highly responsive service should be provided that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

For those people with more serious or life-threatening emergency care needs, trusts should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

How the emergency village will support this

The emergency village will support patients by providing the correct care closest to home in partnership with PCNs. Technology will be introduced to help manage patients' care out of the hospital setting to improve choice and quality of care. There will also be opportunities for system-wide working with local authorities and the voluntary sector.

High Quality Care for All, now and for Future Generations: Transforming Urgent and Emergency Care Services in England (June 2013)

NHS England has implemented an initiative that focuses on high quality care for all, now and for future generations. This initiative focuses on how emergency services can deliver the best outcomes for patients and the community in the future.

This document is designed to help frontline providers and commissioners deliver safer, faster and better urgent and emergency care to patients of all ages, collaborating in Urgent and Emergency Care Networks to deliver best practice.

How the emergency village will support this

Patients will be directed to the most appropriate service at the right time, leading to more efficient care pathways, better clinical outcomes and a better patient experience. Integration between all Urgent and Emergency Care Services will be improved.

Royal College of Paediatric and Child Health – Facing the Future: Standards for Children in Emergency Care Settings (2018)

In 2018, the Royal College of Paediatrics and Child Health (RCPCH) published "Facing the Future: Standards in Emergency Care Settings". This document provides healthcare professionals and service planners with clear standards of care that are applicable to children

in urgent and emergency care settings. Emergency care settings are designed and provided to accommodate the needs of children and their parents/carers.

How the emergency village will support this

The new model of care for paediatrics co-locates services which will enable the required paediatric nursing ratios to be achieved and improve the offer for children at the Bassetlaw site.

HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)

HBN 15-01 provides guidance on design considerations for the built environment in ED areas. These areas include designated clinical spaces such as minors, majors, resuscitation, mental health, children's and adult spaces and other hospital locations that are key to adjacency requirements, as well as the support facilities that underpin these areas. The guidance outlines the emerging principles in planning facilities for emergency care such as user requirements and their views, location and departmental factors.

The new facility is designed to these standards.

HBN 15-02 Facilities for Same Day Emergency Care (May 2021)

Same Day Emergency Care (SDEC) is the provision of patient care with an investigation and/or treatment within the same day for non-elective patients who in the past would otherwise be admitted to a hospital bed.

HBN 15-02 gives guidance on the planning and design of an SDEC department. A well-designed SDEC unit will help to manage patients effectively with minimal delays as they move through stages of care. Good patient flow is central to patient experience, clinical safety and reducing pressure on staff. It is a key factor in providing effective healthcare.

How the emergency village will support this

Although the SDEC will be subject to a separate business case, it will be adjacent to the ED and will be designed to HBN 15-02 standards.

HBN 23 Planning and Design Guidance: Hospital Accommodation for Children and Young People (January 2004)

HBN 23 provides guidance on design considerations for the built environment of hospital accommodation for children and young people. It describes what form a comprehensive unit would take and identifies best practice in the built environment from a child-centred perspective. It is primarily intended for new-builds and upgrades of existing facilities.

How the emergency village will support this

The new facility will be designed to these standards.

Guidance for commissioning integrated urgent & emergency care - A 'whole system' approach (August 2011)

This guidance document focuses on the interdependencies between services. It describes what urgent and emergency care is, why it is important to commissioners, and the need to have a holistic system. It provides guidance on how to ensure integrated 24-hour urgent and

emergency care focussing on consistency, quality, safety and improved patient experience, including how patient pathways can be streamlined.

How the emergency village will support this

The emergency village supports these aims by:

- Integrating urgent and emergency care services
- Streaming patients to ensure they receive the most appropriate care quickly;
- Improving patient flow, which will lead to a more positive patient experience;
- Creating modern, fit-for-purpose facilities that will enhance patients' experience of care.

2.6 Regional and Local Strategies

The strategy for Bassetlaw and this project were incorporated in Bassetlaw CCG plans, due to the original STP bid being submitted in 2015, however, recent boundary and organisational changes have resulted in Bassetlaw being including in Nottingham and Nottinghamshire ICB with Trust wide associations with South Yorkshire ICB. It is to be noted that Nottingham and Nottinghamshire ICB and South Yorkshire ICB are supportive of the scheme however, may wish to adapt the project approach to align with their strategies.

2.6.1 Nottingham and Nottinghamshire Integrated Care Board

Prior to 1st July 2022 the majority of the Trust's services were commissioned by the local clinical commissioning groups (CCGs) that make up the South Yorkshire and Bassetlaw Integrated Care System (ICBICS). These include Doncaster CCG, Bassetlaw CCG, Rotherham CCG, Barnsley CCG and Sheffield CCG. From July 2022 Bassetlaw CCG will fully move to Nottingham and Nottinghamshire ICB (NN ICB) and Doncaster will remain in the newly formed South Yorkshire ICB. It is expected that Bassetlaw Hospital will align to NN ICB clinical policies and feed into N&N UEC and elective meetings etc. DBTH will sit in both ICBs but DRI with South Yorkshire ICB and BH with NN ICB.

NN ICB has three levels of partnership, each with different responsibilities and tasks according to the size of community it serves:

NN ICB has three levels of partnership, each with different responsibilities and tasks according to the size of community it serves:

- Neighbourhood level – 20 primary care networks (PCN), each supporting groups of GP practices and serving 30,000 to 50,000 people.
- Integrated care partnerships (ICP) – three ICPs, each serving a population of 250,000 to 500,000 people. The ICPs support the neighbourhood PCNs and make sure the wider health and care needs of their areas are recognised.
- Strategic Commissioner and ICB – they look after the entire system across Nottingham and Nottinghamshire, setting the goals and strategy for the ICPs and PCNs.

The ICB's priorities are:

- Prevention. More action on and improvements in the upstream prevention of avoidable illness and its exacerbations.
- Proactive care, self-management and personalisation. Improve support to people at risk of living with single and multiple long-term conditions and disabilities through greater proactive care, self-management and personalisation.
- Urgent and emergency care. To redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting.
- Mental health. Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population.
- Value, resilience and sustainability. Deliver increased value, resilience and sustainability across the system, including estates.

This project does not impact the current pathway models associated with the ICB at this time.

2.6.2 South Yorkshire Integrated Care Board

DBTH is associated with South Yorkshire Integrated Care Board (SYB ICB, formerly the South Yorkshire & Bassetlaw ICS).

The ICB is a group of NHS partners, with support from other statutory bodies in the region which joins forces where it makes sense to do so. It aims to make a positive difference to patients, staff and the public through its transformational change projects, joining up of services and reducing health inequalities (such as preventable illness and death caused by smoking, alcohol and obesity) in the region.

Its main aim is to break down organisational barriers so that it can wrap support, care and services around people as individuals, and positively change lives.

The majority of the ICB's work takes place locally in its five Places – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield with a total combined population size of 1.5 million.

Each of the Places has a plan which sets out what the partners want to achieve together. These are focused on improving health and wellbeing but also other factors often called the wider determinants that affect health - employment, housing and education.

With 36 neighbourhoods with populations between 30-50,000, this town or city level sees health and care organisations working closely together.

The ICB's priority for urgent and emergency care in South Yorkshire is to ensure that people will always be able to access the most appropriate care in an urgent or emergency situation. The vision is that all of its urgent and emergency services are the best – with world-class facilities and the specialist expertise to treat and care for patients with life threatening and non-life threatening injuries or conditions. This includes urgent and emergency mental health services and signposting. High quality urgent care services in a community setting (for treating non-life threatening injuries or conditions) will complement the urgent and emergency services within the region's hospitals.

To help achieve this, the ICB is working together across the region to make sure its services meet the needs of its local population. It aims to:

- Provide better signposting to all the urgent care services available, such as walk-in services, pharmacy care and A&E departments.
- Make sure that it uses technology to help offer the most up to date services and treatments.
- Work as a network so that care is given at the right time by the right staff in the right place with the right equipment.
- Reshape services where necessary to provide the best patient care and experience.
- Transform services in the community, working closely with primary care colleagues and community teams to meet the needs of patients close to their home/where they live to make sure that only the people most in need will go to hospital.

In Bassetlaw, commissioners identified Urgent and Emergency Care as one of their five key strategic priorities within their Place Plan. As part of the Provider Alliance at Bassetlaw Place, BDTH chair the Urgent and Emergency Care Board. At the Board there were representatives from all the key stakeholders, including the Deputy Accountable Officer for Bassetlaw Clinical Commissioning Group. Over the past two years the Board has reviewed the pathways for patients attending the department and has been looking at alternatives to Emergency presentation. The CCG have acknowledged the increased activity levels to the Bassetlaw ED and have analysed the information to look at alternative plans with community partners and Primary Care.

Bassetlaw Hospital is centrally located and is held in high regard by local residents and by the surrounding areas so emergency attendances continue to rise year on year.

The development of the emergency village is fully endorsed by Bassetlaw CCG as it delivers more efficient and effective pathways. The current paediatric services are limited due to staffing and the new model allows for an improved service which will reduce the numbers of children requiring transfer to Doncaster Royal Infirmary.

2.6.3 Joint Strategic Needs Assessment

The development of a Joint Strategic Needs Assessment (JSNA) is a statutory requirement that is placed upon the Directors of Public Health, Adult and Children's Services in all boroughs to guide the commissioning of heath, well-being, and social care services within local authority areas, as part of the Health and Social Care Act (2012).

The JSNA provides a systematic method for reviewing the health and well-being needs of a population, taking account of those groups or individuals whose needs are not being met, who are experiencing poor outcomes, or for whom special arrangements may be necessary. It aims to understand both short-term needs (three to five years) and long-term needs (five to ten years) and service requirements for patients in a given population.

The JSNA is an ongoing process, drawing together information in order to forecast the main health and wellbeing needs of a given population. The JSNA supports re-design of services to ensure demand is met and health inequalities are identified, providing a framework for planning across services and agencies to deliver more cost-effective services.

Nottingham JSNA

The JSNA for Nottinghamshire has been in progress since 2007 and is constantly being updated, improved and extended. It provides the Trust with the evidence base for its Strategy and enables it to make informed decisions.

The JSNA identifies that the population of Nottinghamshire County is approx. 840,700, with the proportion of older people slightly higher than the national average. This proportion is predicted to grow over the next ten years, and many local older people live alone, some in rural areas without access to public transport. This has implications for local health services, as older people are more likely to experience disability and limiting long-term illnesses.

Disability affects one in ten adults in the county, and disability among older adults is expected to increase from 29,000 in 2015 to 43,000 to 2030.

Deprivation levels for Nottinghamshire are comparable with England. However, there are some communities with the highest deprivation levels in the country. People living in these deprived areas have higher levels of unemployment, lower levels of qualifications, make less healthy lifestyle choices and have poorer health and wellbeing outcomes.

There are substantial inequalities in life expectancy across the county. More deprived districts, such as Bassetlaw, have shorter life expectancy – approximately 1.5 years shorter than the national average. The biggest causes of premature death (deaths under 75 years) are: circulatory, cancer, respiratory, digestive and external causes.

2.7 Trust Strategies

2.7.1 Trust Values

The Trust's vision is "*To be the safest trust in England, outstanding in all that we do*". The Trust values are:

- **W**e always put the patient first.
- **E**veryone counts – we treat each other with courtesy, honest, 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.

The Trust strategic objectives are:

- **Patients:** Work with patients to continue to develop accessible, high quality and responsive services.
- **People:** As a Teaching Hospital the Trust are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.
- **Performance:** The Trust will ensure 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**: The Trust will increase partnership working to benefit people and communities.
- **Prevention:** Support the development of enhanced community-based services, prevention and self-care.
- **Quality Improvement:** Working together using methods, tools, data measurement, curiosity and an open mindset to make improvements in healthcare (Health Foundation).

The 'True North' (how the Trust will arrive at its vision)

- To provide outstanding care and improve patient experience.
- 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.

The 'Breakthrough Objectives' (how the Trust will move to deliver its True North)

- Achieve measurable improvement in our quality standards and patient experience.
- 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.
- Team DBTH feel valued and feedback from staff and learners in top 25%.
- Every team achieves their financial plan for the year.

Figure 8: Figure 9 DBTH Vision and Values

2.7.2 Strategic Objectives / Priorities

The Trust's strategic principles, as set out in its Strategic Direction 2017-2022 document, are illustrated in the figure below.

Figure 9 DBTH Strategic Principles

The Trust developed its five-year Strategic Plan 2017 - 2022 to identify the objectives for the way in which its services will be developed and provided in a sustainable way. The objectives are in line with local priorities. For example, streaming at the front door improves care pathways and enables patients to access the most appropriate care. In addition, co-locating the children's assessment unit with ED enables more effective use of paediatrics staff, leading to improved emergency care for children and fewer children being transferred to DRI.

The full Strategic Direction can be found in Appendix S18.

2.7.3 Clinical Strategies

In September 2016, DBTH embarked on a detailed review of its clinical services at speciality level, led by the Divisional Directors and supported by the senior clinical and managerial staff. This enabled detailed plans for each of the services to be developed in line with national best practice and local need. This helped the Trust to form its vision and objectives.

The place plans for Doncaster and Bassetlaw are focused on urgent and emergency care, intermediate care, key elective services and early years to ensure the population are treated effectively in the right place, first time.

Urgent and emergency care.

The Trust's clinical objectives are:

- To continue to work with health and social care partners to make it easier for people to access the right services in the right place.
- To continue to develop the ED at DRI which is the second largest in South Yorkshire, including the development of front door streaming and co-located urgent care facilities.
- To bid for national funding to expand clinical areas to address the demand of the service as pathways to DRI increase with the proposed changes and the potential impact from ICB developments. Part of this development will be the co-location of a CT scanner to improve emergency care patient pathways.
- To provide a 24/7 ED at Bassetlaw Hospital and to continue to work with the CCG to improve streaming pathways and develop greater access to other urgent care services from the ED. It plans to develop its acute medicine and paediatric services and co-locate to develop dedicated facilities which combine acute assessment, short stay beds and ambulatory care.
- To work in partnership with Rotherham, Doncaster and South Humber (RDASH) and Nottinghamshire Healthcare NHS Foundation Trusts to further enhance the mental health urgent care offer at both DRI and BH.
- To develop services to respond specifically to the needs of frail older people, including access to specialist assessment skills and appropriate assessment areas.
- To continue to provide the well-used minor injuries service at Montagu Hospital and look to enhance the nurse-led model in this area.

Because of Covid-19 pressures, the Trust made an emergency decision to operate Trauma services from a single site, temporarily centralising services at Doncaster Royal Infirmary. The Trust is now developing proposals to make single site trauma a permanent arrangement. This will be subject to the outcome of a public consultation and approval of the supporting business case.

The emergency village project supports the Trust's clinical objectives for urgent and emergency care by:

- Improving streaming at the front door.
- Providing easier access to other urgent care services.
- Co-locating services to increase staff efficiency and improve the patient experience.

Intermediate care.

DBTH is committed to improving the provision of Intermediate Care. Within the Doncaster Place Plan it is working with partners to ensure that alternatives to admission and appropriate non acute bed-based pathways are effective. These plans will assist with capacity on the DRI site. The further improvements in the frailty pathways play a key role in this plan. Within the Bassetlaw Place Plan the need to enhance the provision of frailty assessment is pivotal in improving the pathways across primary and secondary care. The Trust is committed to supporting the provision of intermediate care on the Bassetlaw site.

Rehabilitation.

Montagu Hospital provides medically led rehabilitation and offers excellent facilities for patients. With the Trust's Teaching Hospital status it is exploring the opportunities to develop

the site as a rehabilitation educational facility, offering enhanced services for staff and patients.

Planned care.

DBTH will continue to deliver a comprehensive portfolio of planned care which is complementary to the delivery of its core acute services. As part of its efficiency programme the Trust will improve the utilisation and productivity of its out-patient services and theatres. It will transfer day cases to outpatient procedures and inpatient work to day-case in line with best practice to be top performing in all areas. Demand and capacity work has been undertaken to review how services will be delivered, in line with its strategic objectives.

Diagnostic services.

The Trust is planning to increase the capacity for key diagnostic services as demand for these services increases.

Cancer care.

The delivery of effective cancer care remains a core service for the hospital. It will continue to work as part of the Cancer Alliance seeking to deliver as much care locally where possible. The development of a second CT scanner is planned to ensure timely scans for the detection and staging of cancer patients.

Acute Paediatrics.

The Trust will continue to provide assessment and treatment of paediatrics on both the DRI and BH sites. The Trust is an active stakeholder in reviewing the provision of safe, effective, paediatric care for its local population. The Trust is working with commissioners and primary care to review paediatric services across the whole pathway to improve outcomes for children.

Maternity Services.

The Trust will continue to provide a maternity service on both DRI and BH sites. These services will offer women a choice for local delivery including the increased provision for home births, depending on their needs. The Trust is working with the Accountable Care System to review the impact of the Better Births plan and how this may influence the services provided within the locality.

The Trust is also working alongside clinical colleagues as a key partner in the ICB, to make best use of clinical collaboration and it already provides a number of services on behalf of partner organisations on its sites. The Trust is reviewing a range of options to address issues and opportunities in each service element within the divisions, such as development and expansion, partnership models of working or providing care in a different way. A key element of this has been to ensure its three main sites are utilised effectively and efficiently by the services.

For the full Clinical Strategy see Appendix S6.

2.7.4 Patient Experience and Engagement Strategy

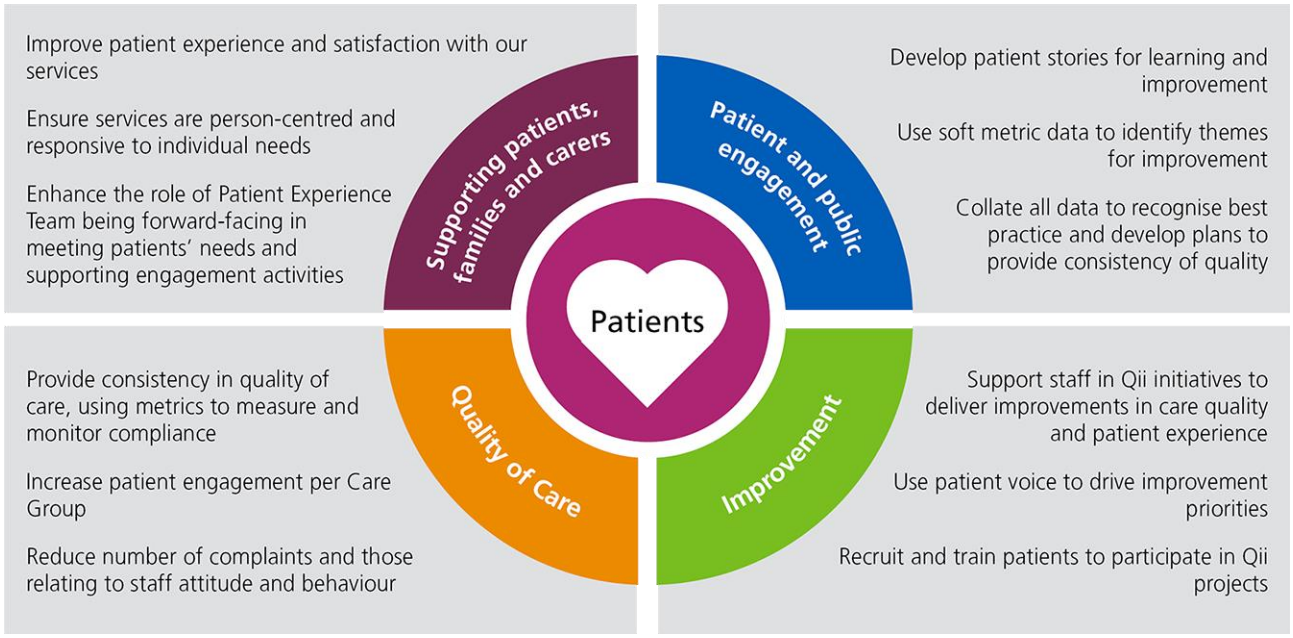
The Trust's Patient Experience and Engagement Strategy is the golden thread running through each of the Trust's enabling strategies and describes how patient experience will be

enhanced. It recognises that positive patient experience leads to positive clinical outcomes and good quality and financial performance.

The key principles of the Patient Experience Strategy are:

- To listen to patients, families and carers.
- To put things right if they go wrong.
- To use feedback to identify opportunities for quality improvement.
- To work in partnership with patients, families and carers in co-designing services.
- To establish standards of best practice identified using the Always Events® toolkit.

Figure 10 Patient Experience and Engagement Strategy



For the full Patient Experience and Engagement Strategy see Appendix S7. See also section 6.6 for more details on stakeholder engagement with the project.

2.7.5 Quality Improvement Strategy

Providing the best possible care and outcomes for patients means continual improvement. Staff, patients, carers, governors and other partner organisations have all the ideas and experience to improve the quality, safety, effectiveness and efficiency of services. The Trust's Quality Improvement and Innovation (Qii) Strategy 2017-2022 sets out its vision and aims to embed Qii into its culture. The strategy will bring a systematic approach to tackling complex problems, with a focus on outcomes. Staff, patients and partners will work together to improve and redesign the way that care is provided, including emergency care services.

The Trust's Quality Improvement and Innovation Strategy is contained in Appendix S8.

2.7.6 Workforce Strategy

The Trust's workforce strategy is described in two documents:

- People and Organisational Development Strategy 2017-2022

- Workforce Plan 2019-2021

People and Organisational Development Strategy 2017-2022

The major focus of the strategy is workforce - ensuring the Trust's staff have a positive experience, enhancing recruitment, retention, training and development. Key aims of the strategy, which align with ICB priorities, include:

- Tackle well known 'supply' and shortage issues in some professions by careful planning, joined up recruitment and designing alternative models of care with emphasis upon enablement and self-care.
- Encourage employers to work innovatively together on things like recruitment and to avoid competing for scarce skills.
- Continue to invest, at all levels, in professional and personal development for the workforce of over 48,000 staff.
- Focus upon retaining existing staff within the health and care community – retention, retention, retention.
- Ensure staff are well led and managed, motivated and that their health and well-being is looked after.

The aspiration is that people will recommend the Trust as a good place to work, staff will be well cared for and the Trust's vacancy and absence rates will be low and falling.

The full strategy can be found in Appendix S9a.

Workforce Plan 2019-2021

The Trust's Workforce Plan 2019-2021 demonstrates how the Trust is addressing its current workforce gaps and how in the longer term the workforce will need to adapt and change in line with the Trust's strategic direction. The Workforce Strategy priorities are:

- Retain the workforce, making DBTH the employer of choice.
- Develop existing talent into new and existing roles.
- Attract new workers, from current and future generations of working adults, into priority health, care and support careers.
- Introduce a robust approach to workforce planning.

In order to assess whether the Strategy is making a difference, the Trust will monitor progress against its key performance indicators for:

- Vacancy rates (target of 5%)
- Bank and agency spend
- Turnover (target 10%) and retention rates (target 90%)
- Sickness rates (target 3.5%) and staff engagement (target 4.00)

The Trust's Workforce Plan is contained in Appendix S9b.

The emergency village project will have a positive impact on the workforce through the:

- Reduction in current 'fractured' staffing models within elements of emergency care currently dislocated across the BH site;
- The project will allow a much greater ability for staff to cross-cover both within their own departments and across others, greatly enhancing the ability to work as a 'team' and reducing frustration felt due to time being wasted travelling between site areas;
- Meeting recommended professional guidance on paediatric staffing levels;
- Increased clinical specialist input at the most appropriate times, greatly enhancing the ability of the workforce to provide better quality of care for patients;
- Increased ability of the workforce to implement more innovative and effective staffing models to deal with key local workforce issues, such as the high reliance on temporary staffing;
- Reduction in the reliance of significant amounts of temporary staff usage in key high risk operational areas;
- Improvement in staff morale – more effective staffing models and less frustration at inefficiencies in current working conditions is expected to yield a reduction in short-term staff sickness and turnover, which again will improve the workforce's productivity and reduce its current reliance on temporary staffing arrangements.

Both the People and Organisational Development Strategy and Workforce Plan are being updated by the Trust and will be included at FBC.

2.7.7 Digital Strategy

The Trust's Digital Strategy 2017-2022 has been developed to articulate a vision for both Information and Technology that supports the development of health services as identified in the overarching Trust strategy. The IT programmes, projects and activities described within it will fully support the achievement of the Trust strategic goals. Specifically, the strategy addresses the following areas:

- Movement towards a digitally enabled healthcare environment within the Trust, within the Doncaster and Bassetlaw healthcare communities and within the ICB.
- Improving the patient experience.
- Supporting Agile Working and care in the community.
- Eliminating or considerably reducing the use of paper.
- Reducing administrative overheads.

The creation of a full Electronic Patient Record (EPR) across the Trust remains a strategic objective in line with the Five Year Forward View requirement as published by NHS Digital. The Trust's previous 'best of breed' strategy for the purchase of replacement time-expired systems means that patient data now resides in multiple systems.

For the full Digital Strategy see Appendix S10.

The Bassetlaw Emergency Village project team are in the process of developing a scheme-specific Digital Strategy and ICT Employers requirements, that will align with the Trust's overarching Digital Strategy. A draft of the ICT Employers requirements has been shared with the Trust and an initial engagement workshop for the Digital Strategy has taken place to inform

its development. Once complete, both documents will set out the design requirements for the scheme from an ICT perspective, and will form part of the P21+ Stage 3 Employers Requirements. The documents will be further described in, and appended to, the FBC.

DBTH is one of four Acute NHS Trusts to be selected in 2021 to take part in the National Digital Aspirent Plus (DA+) EPR Programme. The DA+ EPR Accelerator Programme is aimed at fast tracking the levelling up agenda to provide Acute Trusts without an existing EPR (either Patient Administration only or paper based) with the funding and support to procure a new EPR solution to enhance their digital maturity, deliver their digital strategy and improve patient outcomes.

The vision is for an EPR for DBTH that has a single login and provides a single, structured, real-time healthcare record with role-based configurable views. This will be essential in enabling DBTH to meet its objectives to improve efficiency and quality of care. It will support the outcomes of the BEV scheme by:

- Providing paper-free ways of working at the point of care
- Enabling remote working, and enabling management of care outside of a care environment
- Leveraging data better to understand patient needs
- Delivering solutions that enable the citizen to self-help
- Embracing SMART technologies and enable the Trust to become a hospital of the future

2.7.8 Estates Strategy

The five-year Estates and Facilities Strategy 2017-2022 ensures that the Trust provides safe, secure, high quality healthcare accommodation to support current and future needs. The strategy identifies where the Trust is now, where it wants to be, and how it will get there.

Identifying the current state is achieved by evaluating the condition of the existing estate across all Trust sites through 7-facet condition and performance surveys and identifying backlog costs linked to estates risks. The Trust's future state aligns with the clinical site development plans and reflects local and national drivers for change. Key estates aims will be derived from this work, which will form the basis of estates development plans detailing how the Trust will get to its future state position taking account of key financial assumptions and risks to achievement. Performance will be measured against the following five estates and facilities strategic aims:

- Have in place suitable systems and processes designed to ensure delivery of high-quality services, working with internal customers to develop a Transformation Plan for Service Improvement.
- Have appropriate staff deployed to deliver Estates and Facilities services to required standards.
- Train and develop staff to maximise their individual performance and potential, ensuring they are engaged, motivated and empowered.
- Demonstrate the achievement of both quality and efficiency through the delivery of quantitative KPI's and qualitative outcomes and measures.
- Ensure the estate is fit for purpose in line with NHS Estate Code definitions.

Specifically, this project formed part of an STP bid in 2018 which was one of four schemes identified in the submission. The other three related to Doncaster Royal Infirmary (DRI) and focussed primarily on clinical efficacy, co-location and improvement of infrastructure. The DRI schemes have been superseded by the recent Trust application to be included in the Hospital Improvement Programme, however the Bassetlaw Emergency Village scheme remains an intrinsic part of the Trust Estate and Clinical strategy.

Additionally and co-dependant is the recent approval through NHSI/E of Public Dividend Capital in relation with the NHS Reinforced Aerated Autoclaved Concrete (RAAC) roof removal at Bassetlaw and specifically the Mental Illness (MI) block. The MI block is part of the development zone for the Emergency Village where the refurbishment element of the scheme will take place and is due to commence later in the year. Approval was given in this financial year (2022/23) on the basis of the Emergency Village proceeding post the completion of the RAAC scheme and the two programmes and logistics planning have been developed to reflect this through IHP who are currently engaged to deliver both schemes.

The estimated costs to eradicate backlog maintenance are shown in the table below.

Table 12: Summary of Costs to Eradicate Backlog Maintenance at Bassetlaw Hospital

	DBTH total (£) (GIA 160,408m²)	Bassetlaw Hospital (£) (GIA 37,785m²)	Current ED, Paeds CAU, and Building 47 areas £ (GIA 2,471 m²)
Cost to eradicate high risk backlog	19,400,016	7,911,284	532,850
Cost to eradicate significant risk backlog	105,018,647	5,321,309	358,407
Cost to eradicate moderate risk backlog	23,104,152	13,353,110	899,374
Cost to eradicate low risk backlog	1,837,349	446,105	30,047
Total backlog maintenance	**149,360,164**	**27,031,808**	**1,821,427**

Source: ERIC data 2020/21

For the full Estates and Facilities Strategy see Appendix S11.

The Trust doesn't have a Development Control Plan but is currently developing a Clinical Site Services Strategy, which will be available at FBC.

2.7.9 Green Plan

The DBTH Green Plan 'Our sustainable path to net zero' sets out the Trust's commitment to achieving net zero in line with the NHS ambition to reach net zero by 2040 and to improve the sustainability of the healthcare services it provides. The Plan sets out the Trust's ambitions in the following areas:

Estates and facilities:

- Develop a decarbonisation strategy for the estate across all sites.

- Develop criteria for assessing the sustainability of refurbishments and new construction works.
- Implement a whole life costing policy for refurbishment and new buildings.
- Implement efficient design principles and new technologies in collaboration with the Trust's contractors.
- Reduce energy and water consumption:
  - Upgrade existing heating, lighting and ventilation systems to 'make every kWh count'.
  - Improve the insulation of existing buildings to reduce the energy required to heat them.
  - Switch from gas to electricity-led or alternative non-fossil fuel heating (a separate Heat Decarbonisation Plan will be developed to address this).
  - Reduce water consumption by 15% over the Green Plan period.

Sustainable models of care:

- Conduct sustainability assessments of current care models.
- Support activities that help prevent the need for healthcare interventions, improve the wellbeing of the local community and reduce hospital visits.
- Reduce the carbon emissions associated with equipment use.

The Green Plan also describes the strategies for:

- Increasing the reuse of medical equipment.
- Reducing waste, particularly single use plastics.
- Maintaining and enhancing the biodiversity of its green space.
- Developing a climate change adaptation plan.
- Travel and transport.
- Supply chain and procurement
- Medicines.

Details about how the emergency village scheme supports these sustainability targets are provided in section 4.9.4.

The full Green Plan is contained in Appendix S5.

Part B: The Case for Change

2.8 Rationale and Objectives

2.8.1 Existing Arrangements

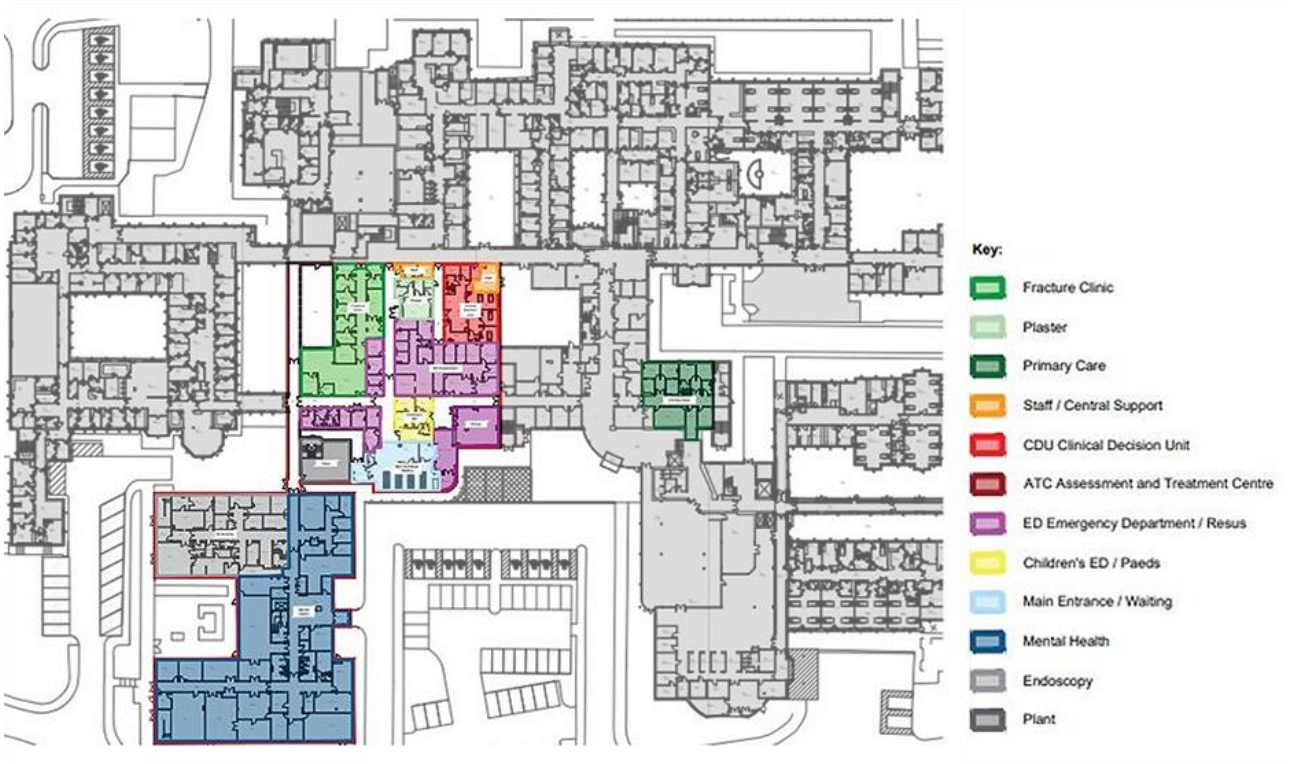
Urgent and emergency care services at BH are currently provided in a number of locations across the site:

Table 13: Existing Urgent and Emergency Care Services

Service	Role
Emergency Department (ED)	Minors (UTC)/Majors/Resus for adults and children. Open 24/7
Assessment and Treatment Centre (ATC)	For medical, surgical or frailty assessment. LoS 24-72 hours
Children's Assessment Unit	10 spaces for assessment and treatment of children and young people. Open until 9pm, last referral 7pm. Children needing overnight care/observation transferred to DRI.
Fracture Clinic	Open 9 hours per day, 5 days per week.
Same Day Emergency Care (SDEC)	For medical, surgical, gynae or frailty non elective care. LoS up to 12 hours. Open 12 hours per day, 7 days per week
Primary Care	Primary care is an appointment-based system on site but not co-located. It is generally managed by advance nurse practitioners and limited GP input.

The current location of services is illustrated in the figure below

Figure 11: Emergency Services - Existing Site Layout



The figure illustrates how fragmented some of the current urgent and emergency care services are. For example, the paediatric spaces within the ED are not adjacent to the children's assessment unit (which is located elsewhere in the hospital), which means that staff cannot easily work across both areas. In addition, the location of SDEC away from the ED does

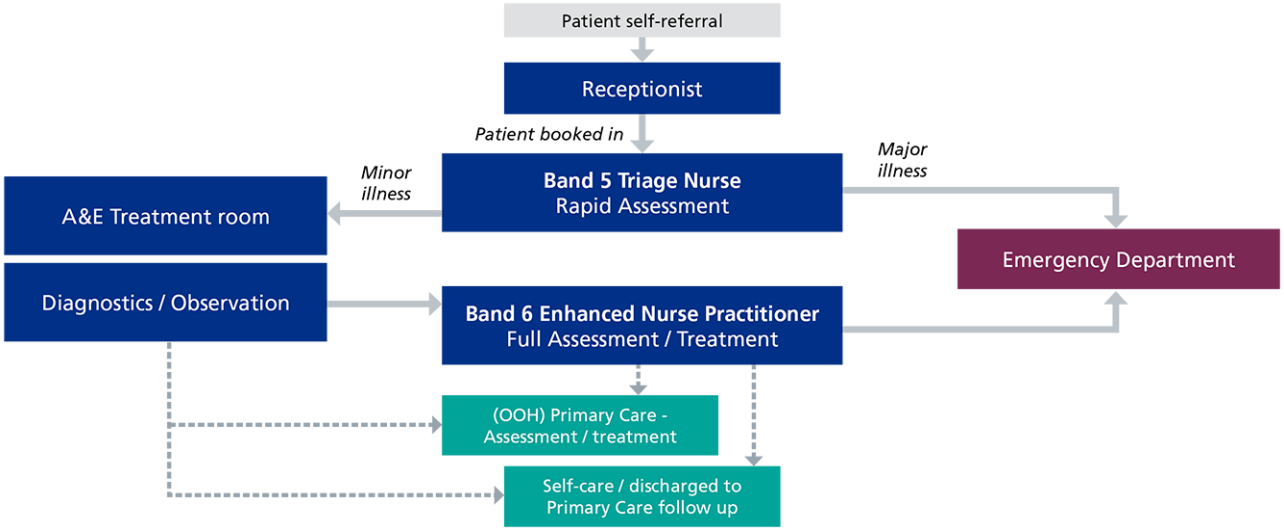
not encourage same day care. The existing footprint for re-use is disjointed and would not allow for the required interdependency and co-location that the emergency care services require. Without additional accommodation the required schedule of accommodation to meet service demand cannot be met.

Figure 12 illustrates the current patient pathway for urgent and emergency care services at BH. The front door process is as follows:

- 24/7 Receptionist books patients in.
- 24/7 Band 5 Triage Nurse triage minor illness / injury patients in the A&E treatment rooms. Blood tests, ECGs, observations etc are initiated here.
- 24/7 Band 6 Enhanced Nurse Practitioner undertakes full assessment and treatment for minor illness.

The existing process is not as efficient as it could be. For example, patients suitable for SDEC often end up in ED first, and many minors could be directed away from ED to be treated elsewhere. Triage and clinical streaming could be improved to ensure that patients are directed to the most appropriate care.

Figure 12 Current Adult Patient Pathway



2.8.2 Rationale

The configuration of existing urgent and emergency care services is not fit to deliver the Trust's new clinical model for emergency care which aims to improve clinical streaming and triage at the front door and ensure that facilities are correctly sized and co-located to improve patient flow and increase flexibility. The new clinical model is described in detail in section 4.7.2.

The main problems with the existing services are described below.

ED capacity

The department was originally designed and built to safely manage a maximum of 100 people a day. It currently sees an average of 153 patients a day, with the highest ever daily attendance at 236.

The busiest times are 10am-1pm and 5pm to 7pm every day, with Monday being the busiest day of the week.

In terms of patient acuity, resus activity remains fairly stable. 'Majors' have seen a general decline while 'minor' attendances have increased. These trends are illustrated in the figure below.

Figure 13 ED Majors and MinorsPatients by Acuity Stream

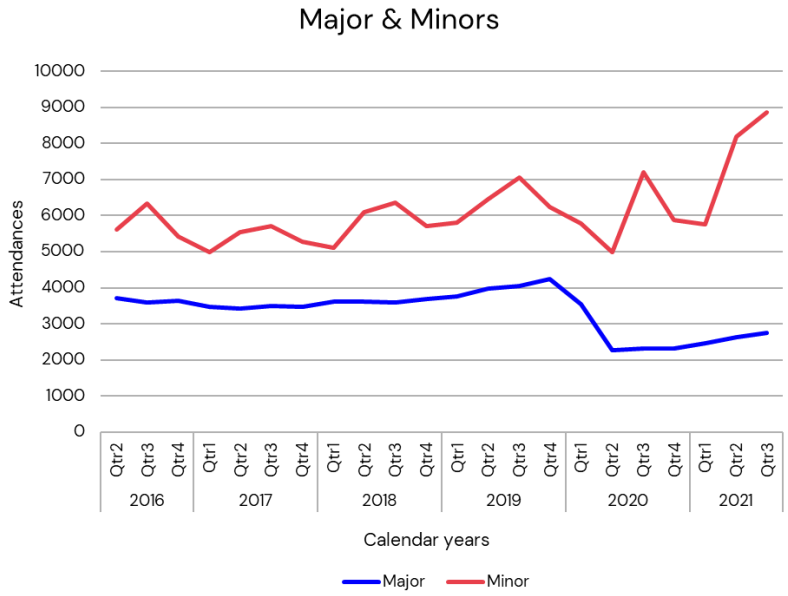
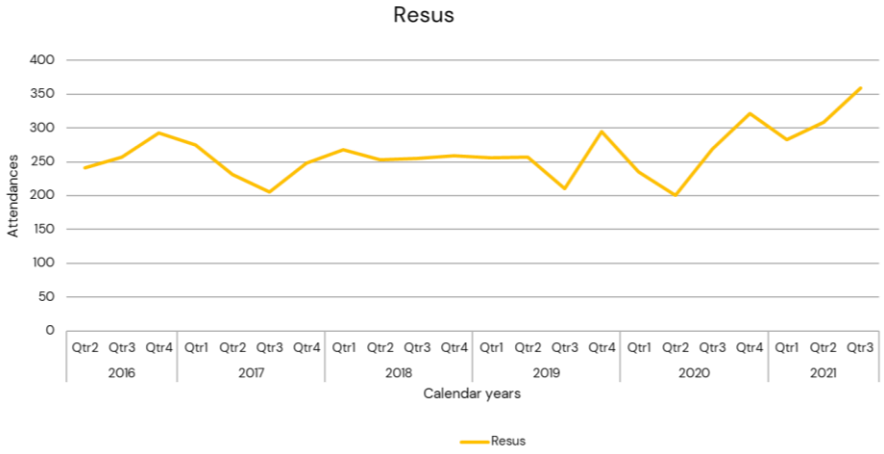


Figure 14 ED Resus Patients by Acuity Stream



Patients are currently being diverted out of the area due to lack of capacity. Demand will continue to increase in the future in line with the growing and ageing demographic of the local population. In addition, the legacy of the Covid-19 pandemic will lead to increasing demand for

primary and acute services as many patients who were reluctant to contact their GPs during the pandemic are now coming forward with health concerns.

The urgent care offer is often confusing for patients who are not always sure how and where to access the right care. Extensive patient engagement has revealed that patients generally prefer to come straight to the ED, feeling it is their only option.

Overall, it is clear that the increasing demand for emergency care services cannot be met within existing facilities and that further capacity will be required.

Patient flow

The emergency care pathway is currently fragmented which results in inefficiency and lack of flexibility. For example,, the location of SDEC facilities away from the ED does not encourage same day care and means that the Trust is currently not meeting the requirement for easy access to same day emergency care as set out in the NHS Long Term Plan.

According to the key findings of the report 'Front Door Streaming Model for the Bassetlaw Emergency Village', urgent, ambulatory and assessment services should be co-located. This will support the transformation of patient journeys and optimise flexibility and efficient use of the workforce within the urgent and emergency care pathway, both in terms of supporting the delivery of care in the right place, at the right time, by the right staff, as well as supporting access to senior opinion and decision making at the earliest possible stage in the patient journey.

Streaming patients to the most appropriate care pathway will result in improved clinical outcomes, operational efficiencies and reduced admissions.

A recent review of U&EC services at Bassetlaw Hospital (which formed part of a wider review across the South Yorkshire ICB) made recommendations in the following areas:

- Streaming could be improved by moving from the current model of streaming at the ED front door to a model in which UTCs (staffed by a combination of primary care and acute staff) act as the front door of ED to enable emergency medicine specialists to focus on higher acuity need within the ED.
- Many 'minors' could be considered for alternative care settings. Earlier signposting of patients by community-based teams/ambulance services could avoid ED attendances and admissions.
- Direct access into SDEC facilities avoiding inappropriate use of ED.
- SDEC facilities should be developed to accommodate an enhanced frailty pathway to help older patients access the care they need without having to go through the ED, and other pathways such as respiratory, abrasions/contusions etc.

A more detailed summary of the key findings is contained in Appendix S12 'Front Door Streaming Model for the Bassetlaw Emergency Village'.

Reorganising existing emergency care facilities to ensure that key services are adjacent to each other will improve patient flow, resulting in better clinical outcomes and a more efficient service. This is explored in the clinical pathway model section 4.7.2, the 1:200 design and adjacency matrix, section 4.7.1.

Paediatric urgent and emergency services

In previous inspections, the CQC found that the hospital was not achieving the Royal College of Paediatrics and Child Health (RCPCH) (2018) guidance which stated there should be two paediatric nurses present on each shift. It also stated that adult nurses covering the department should have training to ensure they have the relevant skills and competencies to care for infants, children and young people. Patient pathways within ED were specifically highlighted due to the front door streaming process and the number of paediatric nurses available within the department.

The Trust has had difficulties recruiting paediatric nurses and, as a result of these challenges, in January 2017 the Trust temporarily closed the children's overnight service. The changes meant that the overnight children's inpatient service was temporarily transferred to DRI. The inpatient ward changed into a Children's Assessment Unit (CAU) with 10 clinical assessment spaces open until 9pm but only accepting referrals until 7pm. All children requiring overnight care (including observation) still continue to be transferred to DRI, a 20-mile journey which on average is a 35-40 minute drive. If patients are assessed as being well enough, they can travel in the family's own transport if available. Before the closure of the overnight service there were 14 beds available for children and young people. This was further reduced to six immediately prior to the closure due to staff shortages. Under the current temporary arrangements, the unit has 10 assessment spaces for children and young people. The Trust has recently completed a separate consultation on a permanent solution for children who need urgent and emergency care at Bassetlaw Hospital. The consultation showed that there was overwhelming support (86% of respondents) for building a new CAU next to the ED, which would allow children to stay overnight at Bassetlaw rather than transferring to DRI. See section 2.7.4 for more details.

The co-location of Adult ED, Children's ED, CAU and other services would allow for the required paediatric ratios – two per shift, as indicated by the CQC - to be achieved and improve the offer for children at the Bassetlaw site. Co-location also means that the Trust can provide a greater range of services with the same level of staff, helping to reduce the risk of staff shortages which have an impact on service resilience and safety. It is also expected that the new facilities and clinical model will create a more attractive place to work, helping to maintain staffing levels, and balancing recruitment and retention.

Backlog maintenance and estates issues

The condition of the building is currently too poor to make it suitable for its role in the future as part of the ICB emergency services provision**.** Backlog maintenance costs are high, (see Table 6) and the Bassetlaw Hospital site also has RAAC roofing on a number of buildings which are due to be replaced as part of the national RAAC eradication programme. The Department of Health (DH) Lord Carter productivity and efficiency programme dashboard report has continually indicated that the trust is year-on-year significantly underinvesting with regard to backlog maintenance.

Issues surrounding asbestos management, electrical and mechanical infrastructure also need to be addressed. In addition, the DBTH site was inspected by the NFRS Fire Service under the regulatory reform (fire safety) order 2005 and has been served a fire deficiencies notice at BH (on 22 February 2018).

The provision of new build and refurbished facilities would significantly reduce the amount and cost of backlog maintenance.

Recruitment and retention

One of the longstanding key challenges for services is the recruitment and retention of staff. This is not unique to the local area and workforce shortages have been exacerbated by the pandemic. In December 2016, The Royal College of Nursing published the report 'RCN Safe and Effective Staffing: The Real Picture' which highlights how there are approximately 40,000 registered nursing vacancies in England.

In 2019 that number was reported at 43,000 vacancies, equating to a vacancy rate of 12%. Significantly 22% of all reported hard-to-fill vacancies (hard to fill is defined as vacant for over three months) are in the fields of learning disabilities, mental health and children's nursing. In 2017 challenges in recruiting paediatric nurses led to the need to make temporary changes by closing the children's overnight service.

These temporary changes are still currently in place. Before any temporary changes were made, there were 14 beds available for children and young people needing to stay in hospital at Bassetlaw. Just before the ward was temporarily closed staff shortages meant that there were 6 beds available. Under the current arrangements, the unit has 10 assessment spaces for children and young people.

By relocating the CAU next to the paediatric spaces in the ED, paediatric staff will be able to work across the two areas, which will improve efficiency, make the ED a more attractive place to work and therefore improve recruitment and retention rates.

2.8.3 Investment Objectives

The investment objectives for this project are as follows:

Table 14 Investment Objectives

Objective	SMART Goals
IO1: Health Outcomes & People centred Environment -To deliver an estate which enables the best possible experience for adults and children requiring urgent and emergency care, staff and visitors; and clinical quality, patient flow and outcomes performance improvement as a result of the programme.	• Reduce average patient time in ED, achieving national benchmarks, such as NHP exemplars, by 2024/25. • Reduce the number of children being transferred to DRI for overnight assessment. • Provide sufficient capacity to meet forecast demand to 2035 with the flexibility and adaptability to deal with surge and demand fluctuations. • Contribute to achieving Trust sickness absence rates of 3.5% by 2025/26.
IO2: Innovation -To create an adaptable, flexible and digitally enabled estate, scaled for future demand growth, shifts in care setting, improved patient flow and best use of workforce skills.	• Improve streaming at front door from current average of 7.7% to target identified in 2020 trials of 33.2% by 2024/25. • Enable more integrated ways of working between ED, ATC, and SDEC by 2024/25. • Enable more integrated ways of working between ED and Paediatrics by 2024/25.

Objective	SMART Goals
	• Deliver requirements outlined in Trust Digital Strategy in the department by 2024/25.
IO3: Environmental Sustainability: To create a physical environment that meets statutory and regulatory requirements, eradicates Backlog Maintenance and Critical Infrastructure Risk, and complies with all relevant national policies and guidance including and Pandemic Proofing.	• Ensure the department complies with relevant NHS standards, including HTM, HBN, Fire Code and BREEAM compliance, by 2024/25. • Contribute to reduction in greenhouse gases by reducing energy usage, achieving target 250kWH from 2024/25, and reducing mileage associated with the transport of children between Bassetlaw and DRI.
IO4: **Community Connections** -Create an environment that fosters partnership working and integration. This enables sustainability in adults and children's UEC services across the South Yorkshire and Nottinghamshire ICBs.	• Deliver the preferred model for Paediatrics identified as a result of the public consultation by 2024/25. • Deliver an integrated front door model in partnership with Notts Healthcare by 2024/25.
IO5: Economic & Financial Sustainability To create an estates solution which reduces the overall cost of delivering acute care services for financial sustainability and ongoing value for money in operation.	• Streamline the staffing rotas for ED and ATC, reducing pay costs by the middle of 2024/25. • Reduce backlog maintenance by circa £1.8m from 2024/25. • Reduce energy usage, achieving target 250kWH from 2024/25, and reducing associated costs.
IO6: Social Impact -To develop the Bassetlaw emergency village in a way which maximises the positive economic and social benefits for the area and fulfils the Trust's role as an 'anchor' organisation.	• Provide more equitable access to ED and Paediatrics services by 2024/25. • Deliver social value by working with a partner during the construction period that will create apprenticeships and new job opportunities as a result of the investment.

2.8.4 Health Service Needs

The ICB has identified that emergency care facilities at Bassetlaw are not sufficient to meet the current demand for services and that further capacity will be needed to avoid patients being transferred out of the area.

The proposed emergency care model supports the integration of local community, primary and social care providers. The aim is to create a seamless care pathway with a 'home first' approach to care, which minimises the need for patients to access secondary care services. This integrated approach will reduce presentations at the emergency department and allow faster 'stepping-down' of patients into care settings closer to their homes.

Demand for local health services generally is forecast to increase over the next 10 to 15 years as the proportion of older people continues to grow. There are also substantial health inequalities across the region, which need to be addressed. For example, children who require an overnight stay are currently being transferred to DRI, where they may remain for only a few hours. For people living in Worksop, DRI is further away than Bassetlaw Hospital. Worksop is a deprived area with many families not owning a car, which can be a challenge when visiting or

bringing children home from DRI after discharge. Other health inequalities are further described in the local Joint Strategic Needs Assessment - see section 2.6.3.

Worksop has two of the largest GP practices in the country, with 30,000 patients living in close proximity to the hospital. Easy access to the hospital by public transport is important because 40% of the local population do not have access to a car.

2.8.5 Engagement with Stakeholders

Engagement objectives

The successful delivery of the Emergency Village at Bassetlaw requires the active engagement and support of many key stakeholders, including the clinical staff based in the services delivered at Bassetlaw Hospital. The principles of good communications and engagement will be adhered to as set out in the Trust's communications and engagement strategy (see Appendix S13).

Whilst the development is an extremely positive for the Bassetlaw community change can be unsettling for staff, patients, public, and other stakeholders. The need to explain the changes and developments at time critical points in a coherent and positive way will be paramount.

The key objectives of the project's communications plan are:

- To enhance the reputation of DBTH and the Bassetlaw Emergency village Programme
- To deliver consistent core messages
- To actively engage with stakeholders, involving real dialogue and a two way process
- To maximise support for, and minimise opposition to, what is planned:
  - by helping staff through a major change/development by keeping them informed and asking them for suggestions and feedback; and
  - keeping stakeholders informed of all key milestones of the project.

The full communications plan for the project can be found at Appendix S13.

Engagement activity to date

At SOC stage robust stakeholder engagement was carried out through the Place Plan. The Emergency Village provides accommodation for mental health, primary care and community colleagues. Engagement with East Midlands Ambulance Service to increase the number of by-pass conditions continues to positively progress, though as these are not nationally mandated they are agreed at a clinical level. A bypass is a situation in which an ED instructs the ambulance service to divert ambulances elsewhere, and hence bypass the nearest ED. The reason for this is because it is unsafe for more patients to attend.

Part of the footprint required is currently occupied by colleagues from Nottinghamshire Healthcare Foundation Trust. This includes the current Out of Hours provision and BUCS (Bassetlaw Urgent Care Service) which will be incorporated into the new front door model. Part of the Outpatient Mental Health services will need to be moved from its current location but this in principle is agreed with Nottinghamshire Healthcare.

As part of the development of its clinical strategy, the Trust has engaged with staff and patients using a variety of methods including social media, postcards, posters and

presentations, meetings with teams in the hospital, meetings and presentations with partners. Over 600 responses have been received. In addition, the Governors have played a vital role in shaping the strategy.

During the development of the OBC the design team have engaged with key stakeholders including trust fire officers, ambulance teams, clinicians, infection control and facilities management through multiple design workshops to ensure that the building designed meets the expectations for the use and standards required. These meetings have influenced the demand and capacity modelling, Schedule of Accommodation, 1:200 design and department adjacencies.

Engagement and communications timetable

The planned timetable for communicating with key stakeholders is set out below. Full details can be found in Appendix S13.

Table 15 Timetable for Stakeholder Engagement

Date of engagement	Action
May 2022	Engage with staff and public about the proposed name of the project 'Bassetlaw emergency village'
June 2022	Communicate with staff regarding project progress (milestones, significant developments, photos, designs etc).
June / July / August 2022	Hold Marketplace event to engage with staff and other stakeholders to raise awareness of the business case before submission and of Bassetlaw Emergency Village project development in general. Gather feedback.
August 2022	Communicate with staff and stakeholders when confirmation has been received that the business case has been approved. Communication will be via press release, social media, website, and internal comms.
August 2022	Detailed design review communicated with stakeholders
November 2022	Install signage and messages outside the development to promote and inform on the development itself and progress.
April 2023	Invite the media along to a 'spade in the ground' event to mark the start of the build (also include on social media, website, internal communications).
Ongoing	Attend steering group project meetings to allow micro-management of communication messages on a weekly basis (i.e.: noise, disruption, signage, et)
2022/2023	Communicate 'Milestone moments' including: • demolition of existing building • progress re floor level/ building in position • first clinical staff walk arounds • press invite to see the site Shared through all internal and communications channels
Ongoing	Continue to respond to media inquiries related to ED performance and the build.
2024	Invite VIPs and media to an event to celebrate the launch of service (to take place post soft launch)

Public Consultation on Paediatric Services

Following the temporary closure of the overnight children's inpatient service in January 2017 as a result of safety concerns raised by the CQC, the Trust and CCG have been looking at ways to improve the service for children and families.

A public consultation took place between 7th December 2021 and 28th February 2022, which sought people's views on three options for the urgent and emergency care of children at Bassetlaw Hospital:

- Option 1. Continue the current temporary model, with the CAU staying where it is, closing at 9pm each evening and patients being transferred to DRI from 4pm.
- Option 2. Build a new CAU next to the emergency department but to close the unit at 9pm each evening and transfer patients to DRI from 4pm.
- Option 3. Build a new CAU next to the emergency department, allowing children to stay at Bassetlaw Hospital for a short stay, including overnight, and patients requiring a longer length of stay being transferred to DRI.

The engagement document can be found in Appendix S14.

People were offered a number of ways to make their views known including:

- Online survey
- Paper survey
- Meetings and public engagement events
- Social media.
- Written feedback (letters, emails and long form submissions)
- Targeted engagement (with parents and carers, children and young people and rural and Eastern European communities).

A total of 1,983 responses were received. These were analysed by independent research company and published in a separate report. The key findings are that:

- 88% of respondents opposed Option 1.
- 82% of respondents opposed Option 2.
- 84% of respondents supported Option 3.

When asked their preferred option, 85% of respondents indicated that Option 3 was their preference. Option 3 has therefore been taken forward for further analysis as part of the wider options assessment process for the project as a whole (see section 3.3).

The consultation feedback report can be found in Appendix S15.

2.9 Potential Scope and Key Service Requirements

2.9.1 Scope

The purpose of this scheme is to provide upgraded emergency care services at BH, appropriately configured and right-sized to deliver the highest standards in emergency care which meet the demands of the service.

Considerations for the scheme include:

- Full integration of urgent care services with the emergency department (ED), with single ambulant points of access to UTC and ED facilities.
- Co-location and development of a Children's Assessment Unit.
- An environment that maximises efficient and effective use of the workforce to deliver high quality emergency care and sustain the care quality improvement trajectory.

Changes to Scope

The project's original scope included a fracture clinic, Assessment and Treatment Centre. However, due to increased inflation rates and project costs, the Project Board have concluded that the best way forward would be to fund only the ED and CAU elements as part of this project and seek alternative funding streams to provide the ATC, fracture clinic. Although these three elements have been excluded from the scope of this business case their locations/sizes/adjacencies have been factored into the design to ensure that the benefits of co-location can be achieved.

2.9.2 Local Sensitivities

Key stakeholders have been consulted as part of the new proposal for emergency care. To date there have been no local sensitivities and people are generally supportive of the scheme. The project team will manage any local issues that may emerge and another update will be provided at FBC. A Stakeholder Engagement and Communication Plan Report has been developed to explore how stakeholder engagement can be managed effectively to minimise local sensitivities. Further details regarding stakeholder engagement can be found in Section 2.8.5.

2.9.3 Integrated Working

The scheme supports integrated working in the following ways:

Emergency care:

The scheme will reduce current 'fractured' staffing models within elements of emergency care currently dislocated across the BH site. There will be a much greater ability for staff to cross-cover both within their own departments and across others, greatly enhancing the ability to work as a 'team' and reducing the frustration felt due to time being wasted travelling between service areas. For example, the co-location of ED paediatrics with the CAU will enable resources and staffing to be shared, increasing efficiency.

The scheme supports improved working and better integration with the ambulance service. A new ambulance parking area will be located at the entrance for ease of access and to avoid cross over or queuing for ambulance arrivals. Following engagement with the ambulance team it has been agreed that five covered ambulance bays will be provided, with one additional bay in close proximity. The resuscitation area will be located adjacent to the ambulance arrivals area, supporting easy access and faster handover between paramedics and ED staff.

Integrated working with SDEC to improve pathways for frailty and surgical patients.

The scheme has designed shared staff zones, these zones include staff rests, staffing changing, offices and Seminar Room. This will allow for staff to collaborate with different

departments and allow for information to be shared across departments. It will provide a sense of a united staff group, who support each other.

Primary care:

As part of the development of local place plans* in Bassetlaw, proposals have been developed by the three local PCNs for greater integration of primary care and secondary care services. This project recognises and builds upon the benefits that this integration will deliver both for local patients, both in terms of attendance avoidance strategies which will support a reduction in presentations at the ED, as well as the faster stepping-down of patients into care settings closer to, and ideally in, patients' homes. More effective signposting in the community to appropriate primary care services will lead to fewer attendances at the ED. For patients presenting at the ED, a more effective streaming service at the front door should direct those who need primary care to the onsite GP/PCN service.

> *Place Plans are more local plans that cover smaller geographical areas within the wider Integrated Care Board. Each ICB will have a number of Place Plans.

2.9.4 Activity and Capacity Planning

Trends in activity

Recent trends indicate that resus activity remains fairly stable. 'Majors' have seen a general decline while 'minor' attendances have increased, due in part to the reclassification of 'null' as 'minor'. These trends are illustrated in the figures below.

Figure 15 Resus Activity

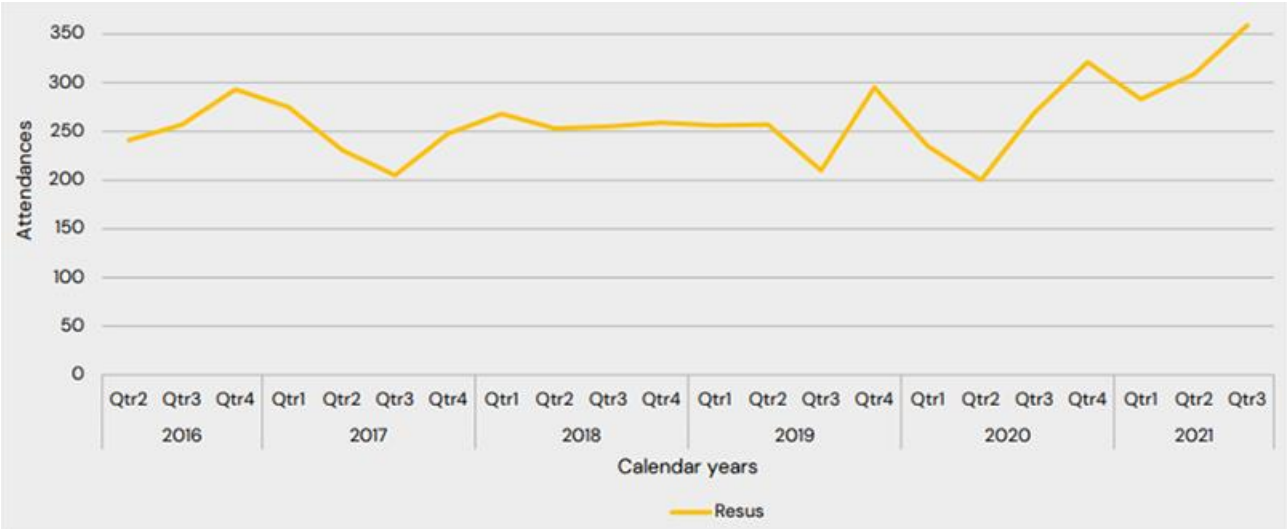


Figure 16 Majors and Minors Activity (ED scenario 1)

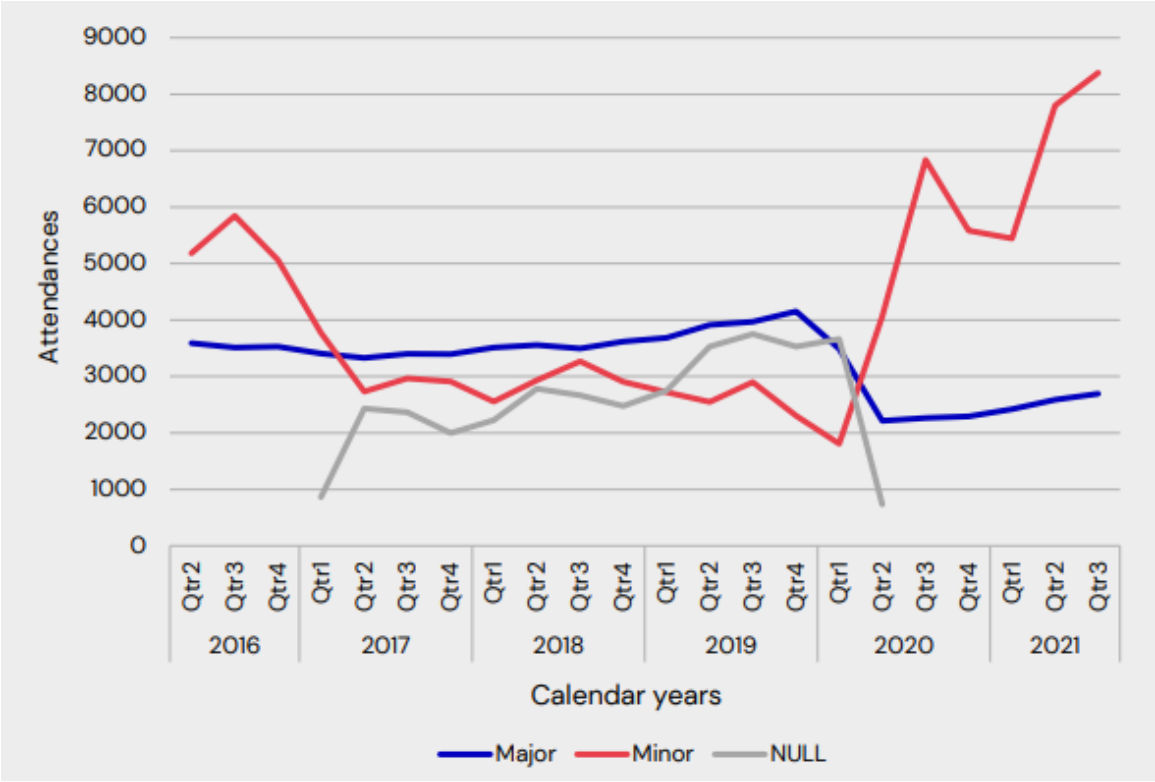


Figure 17 Majors and Minors Activity - with Null reclassified as Minor (ED scenario 2)

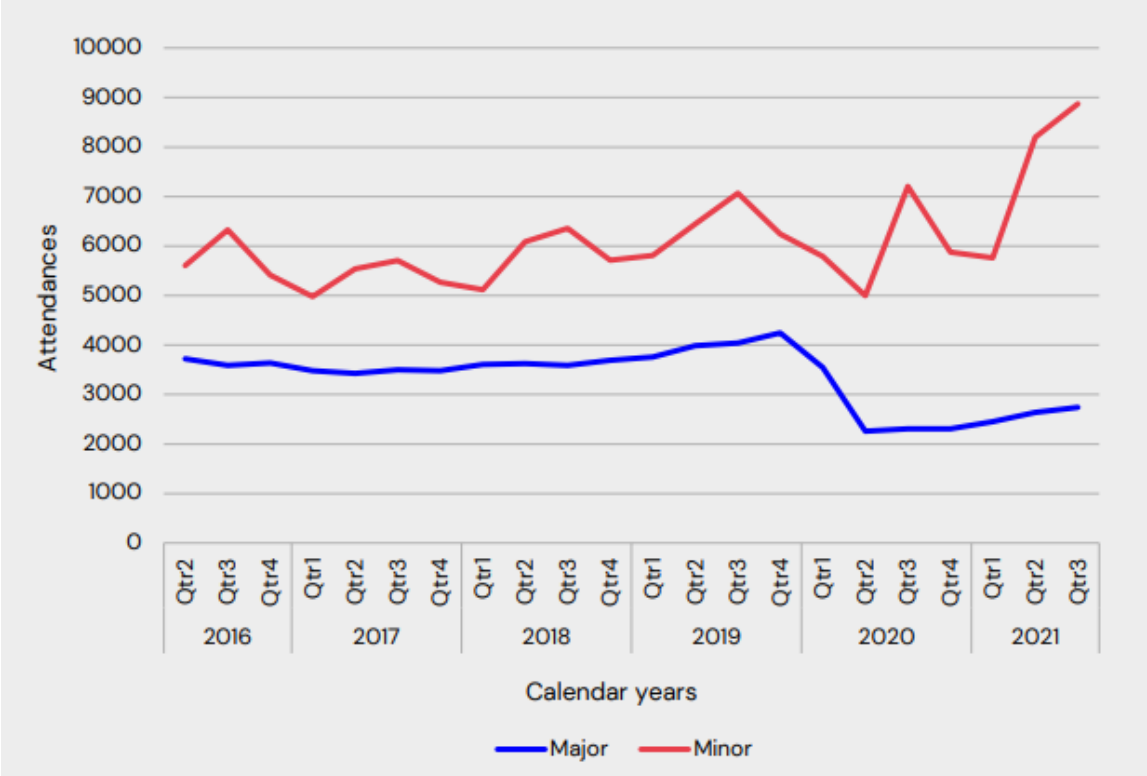


Figure 18 Time Spent in ED

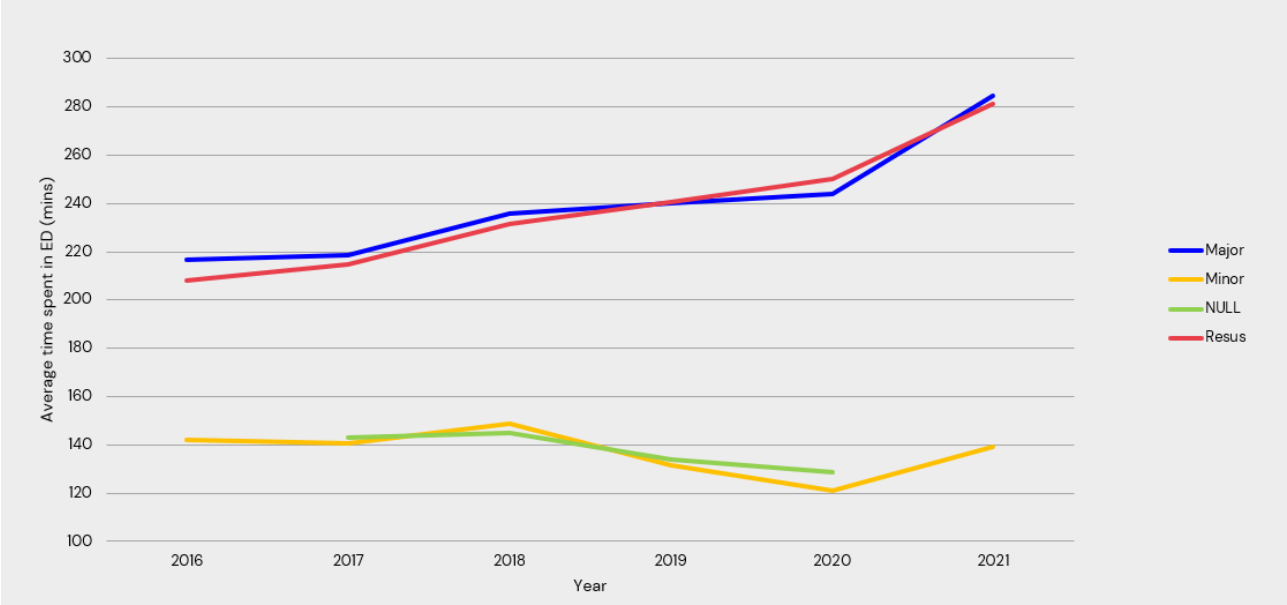
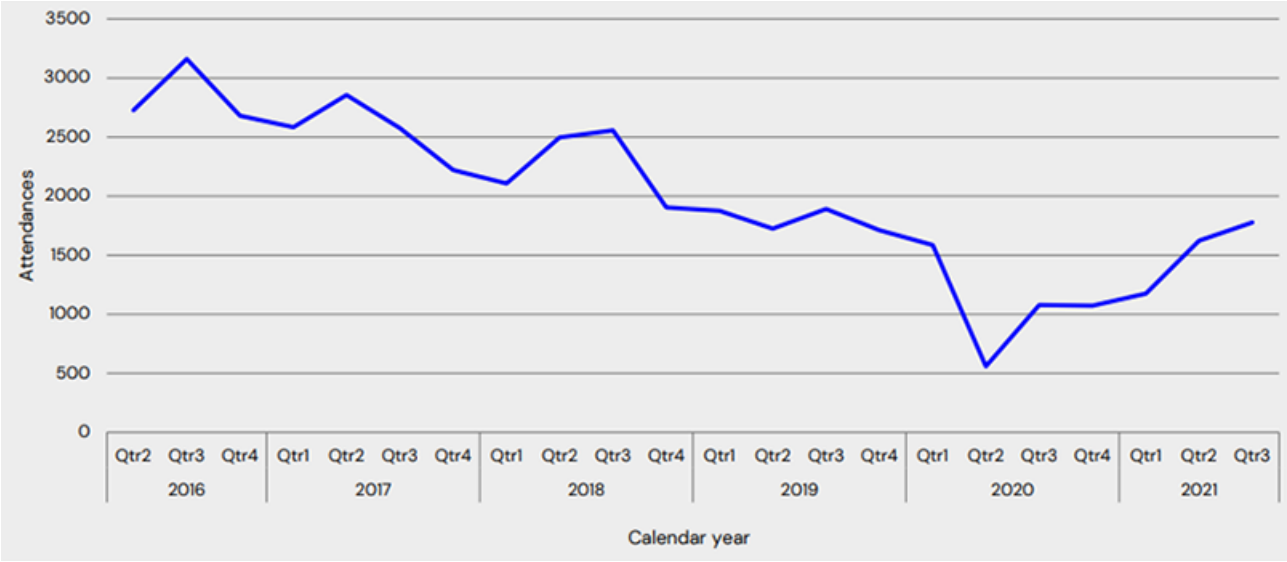


Figure 18 shows that the amount of time patients spend in the ED has been rising steadily for majors and resus. However, this is not necessarily a reflection of increasing treatment time but the time between arrival and discharge.

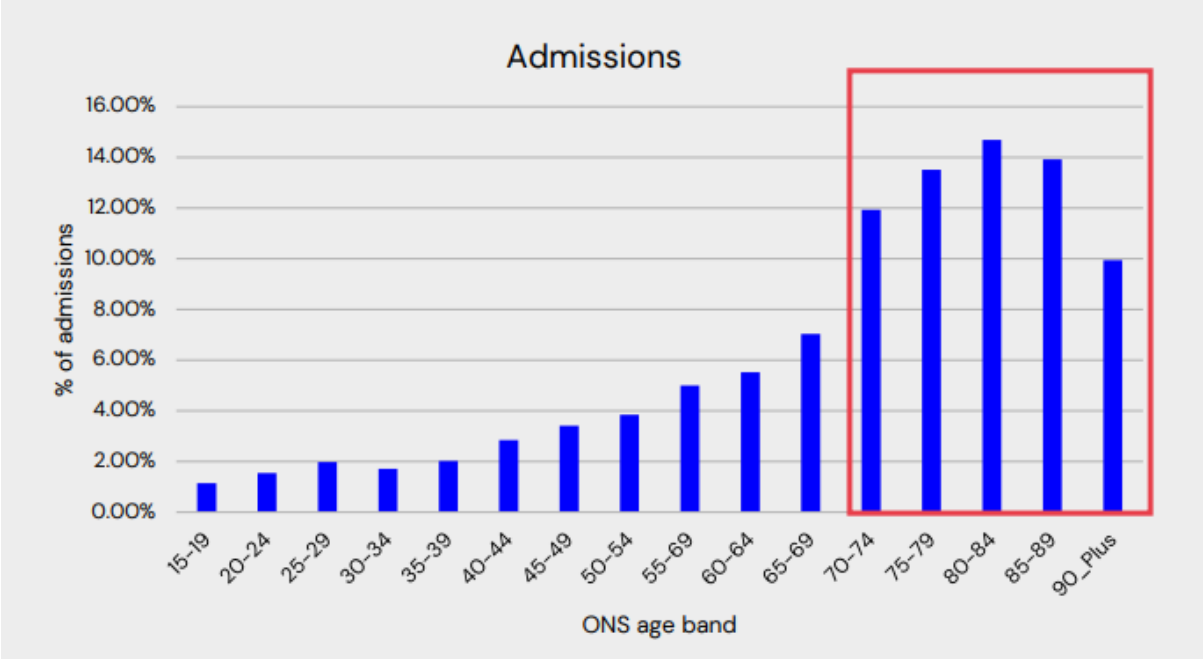
Figure 19 indicates that activity in the fracture clinic has been gradually decreasing, reflecting the change in service model to more virtual follow ups delivered from DRI. The significant drop in early 2020 is related to Covid-19.

Figure 19 Fracture Clinic Activity



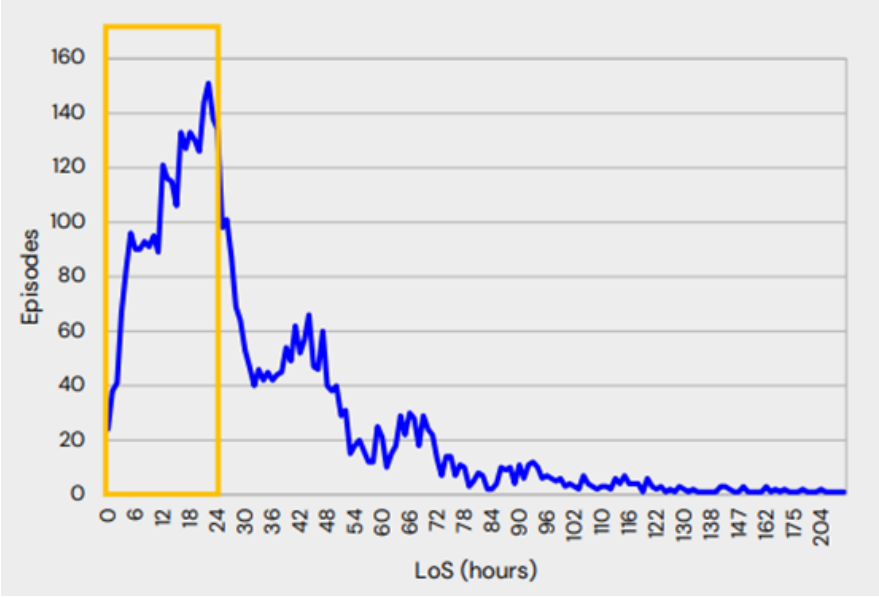
In terms of the Assessment and Treatment Centre, 64% of activity is within the 70+ age group, as indicated in the red box in the figure below. This age group has the highest rate of growth in demand for services. This activity may benefit from dedicated frailty support.

Figure 20 ATC Activity



The length of stay for 53% of episodes is less than 24 hours, as indicated in the yellow box on the figure below, which may make it suitable for transferring to the SDEC.

Figure 21 ATC Length of Stay



Projected future activity

Growth in activity across the Trust's urgent and emergency care services has been projected to 2035 using data from February 2019 to January 2020 as the baseline. The table below shows this growth in activity and the estimated number of physical spaces required to accommodate it.

Table 16: Activity and Capacity Projections to 2035

Stream	Baseline activity	2035	
		Projected activity	Spaces estimated
ED Scenario 1: Majors, Minors and Null			
Majors	18,214	28,846	14
UTC/Minors	23,523	37,254	5
Children's ED	10,705	13,863	4
ED Total	***52,442***	***79,964***	***23***
ED Scenario 2: Majors and Minors with Null reclassified as Minor			
Majors	16,083	25,471	12
UTC/Minors	25,654	40,629	5
Children's ED	10,705	13,863	4
ED Total	***52,442***	***79,964***	***21***
Other areas[1]			
SDEC	4,713	7,464	12
ATC	4,819	8,454	37[3]
Fracture Clinic[2]	13,826	21,609	5

[1] *Subject to separate business cases but included here to support co-location with ED*

[2] *Fracture clinic includes additional orthopaedic elective outpatient activity.*

[3] *A change in the model of care to transfer activity to SDEC and/or a frailty assessment setting could reduce bed requirements.*

The assumptions upon which the modelling has been carried out are set out in the table below.

Table 17: Activity and Capacity Modelling Assumptions

ED assumptions					
Occupancy rate	Resus 45.0%	Majors 70.0%	Minors 70.0%	Paediatrics 70.0%	
Treatment times (minutes)	Resus: 180	Majors: 120	Minors: 30	Paediatrics: 60	
SDEC and ATC assumptions					
Operational parameters	SDEC Operating hours: 12	ATC Operating hours: 24	Operating days: 7	Operating weeks: 52	Utilisation rate: 85.0%
Fracture clinic assumptions					
Operational parameters	Operating hours: 9	Operating days: 5	Operating weeks: 48	Utilisation rate: 85.0%	
Appointment time (minutes)	First: 30		Follow up: 20		
Activity and growth assumptions					
Baseline activity	Feb 2019-Jan 2020				

Growth	Age adjusted based on DBTH demand growth and market share
Projection date	2034/35
ED modelling	80% peak period activity model applied

Functional content

Following the analysis of the current and proposed activity and capacity at BH, the functional content set out in the table below has been agreed.

Table 18 Functional Content

Stream	Spaces
Functional Content - Adults	
Majors[1]	14
Resus[2]	3
Minors[3]	5
Mental health	2
Primary care[4]	4
Fracture clinic	5
Functional Content – Children	
Children's ED[1]	4
Children's Assessment Unit (CAU)[4]	
Children's Assessment Beds	6
Children's Assessment Spaces	8
Children's Treatment Spaces	2

1 Adult Majors and Children's ED ideally to include 1 x each high acuity bays to enable step-down from resus
2 Includes 1 x children's resus space
3 Minors and primary care spaces to be ideally located to maximise flexibility of use
4 Trust instructed as per Option3 of the children's urgent and emergency services consultation
5 Agreed in clinical workshop

The functional content, which was produced alongside clinical leads and the project team to ensure that it is aligned with the qualitative demands of the department, has been used to develop a schedule of accommodation. See Appendix S16 for more details on the capacity and modelling. See Appendices C4 and C5 for the schedule of accommodation.

2.9.5 Patient Choice

The proposed Emergency Village is part of a commissioned plan for a new model for emergency care services for Bassetlaw.

The new model will provide a range of options for emergency care and increase choice for patients. The creation of a single ambulant front door will improve the care pathway, giving patients easy access to alternative providers, for example GPs, or self-care.

A new model for paediatric emergency services will provide longer hours of service at Bassetlaw. This means that patients have the choice to be treated closer to home instead of being transferred to DRI.

2.9.6 Equality and Diversity

The Equality Act 2010 lists nine protected characteristics, which are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnerships
- Pregnancy and Maternity
- Race and Ethnicity
- Religion or Belief
- Sex
- Sexual Orientation

The Trust recognises the diversity of the local community it serves. Its aim is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. These principles underpin all service developments and reviews will be undertaken at various points during the life of the project. Particular attention has been given to the equality dimensions at design stage.

An Equality and Health Inequalities Impact Assessment has been carried out to ensure the project does not discriminate against any disadvantaged or vulnerable people. This assessment can be found at Appendix S17. As the project moves towards detailed service planning, the following areas will continue to be considered:

- Models of Care and Care Pathways
- Workforce Planning
- Design and Security
- Transport and Access
- Communication / Interpretation services

2.9.7 Four Key Tests for Service Reconfiguration

The development of the emergency village proposal supports the delivery of the Trust's clinical strategy and is aligned to commissioning intentions. The proposal satisfies the four tests laid out in the NHSE/I guidance: "Planning, assuring and delivering service change of Patients":

- Strong public and patient engagement – see section 2.8.5 Engagement with Stakeholders.
- Consistency with current and prospective need for patient choice - see section 2.9.5 Patient Choice.
- Clear, clinical evidence base – see section 2.9.4 Activity and Capacity Planning.
- Support for proposals from commissioners – see section 2.3.2 Commissioner approvals.

2.9.8 Strategic or Organisational Changes

During the development of the scheme there have been several changes to the strategic and organisational structure:

- Senior Staffing – Since commencement of the project there has been a change in Trust Chief Operating Officer and a different project Senior Responsible officer and Clinical Lead.
- The Trust has joined the South Yorkshire Integrated Care Board.

These changes in strategic and organisational structure have not impacted the project and the new staff and Integrated Care Board are supportive of this project.

2.10 Main Benefits Criteria

Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits. By investment objectives these are as follows:

Table 19 Investment Objectives (IO) and Benefits

IO ref	Main benefits criteria
1 Health Outcomes and People Centred Environment	**Stakeholder Group: Patients / staff / public** • Reduced patient time spent in ED leading to improved throughput and releasing capacity • Improved patient and carer experience • Sufficient capacity to meet demand • Flexibility to meet surge and fluctuations in demand • Greater staff satisfaction
2 Innovation	**Stakeholder Group: Patients / staff** • Improved streaming through Integrated Front Door reduces ED attendances • Improved management through digital enablement
3 Environmental Sustainability	**Stakeholder Group:** Patients / Staff / Public / NHS Trust • Reduced greenhouse gases because of reduced energy consumption • Reduced greenhouse gases because of fewer transfers to DRI • Improved compliance with statutory requirements including HTM, HBN, Firecode and BREEAM compliance and infection control approach
4 Community Connections	**Stakeholder Group: Patients / Staff** • More equitable access to ED and Paediatrics service • Greater collaboration with partners, such as Notts Healthcare
5 Economic and Financial Sustainability	**Stakeholder Group: NHS Trust** • Reduced transport costs due to fewer transfers to DRI • Rota efficiencies due to improved adjacencies between ED and ATC • Improved energy consumption
6 Social Impact	**Stakeholder Group: Patients / Staff** • Creation of social value including creation of apprenticeship and job creation

2.11 Main Risks

The main risks of this investment are shown in the table below, together with their counter measures. For further detail on risk, please see the Economic, Commercial and Management Cases.

Table 20 Main Risks and Mitigations

Main Risk	Mitigation
Financial	
Capital funding is not made available by NHSE/I	Investigate potential alternative sources of funding.
Project proves unaffordable from a revenue perspective	Detailed and robust financial modelling/control. Maximise potential for efficiencies.
Hyperinflation increases costs and results in unaffordable project	Predetermine the inflationary consequences and allocate the management of hyperinflation to the party best able to manage it. Implement inflationary price adjustment formulae to factor in the rise in costs before they occur.
Internal and External Approval	
Business case is/are rejected or there is a delay in approval by the Board of Directors. If NHSE/I exceed the overall agreed period this could impact the final completion date requirement.	Ensure business case is are/robust and continue to engage with key stakeholders to gauge commitment and support.
Business case is/are rejected or there is a delay in approval by NHSE/I	Ensure business cases are robust and continue liaison with NHSE/I to ensure support and commitment. Undertake page-turn meetings with NHSE/I colleagues prior to business case submissions.
Dependencies on other business cases e.g. RAAC, ATC & SDEC may slow progress	Construction works are inter-related and the other projects need to be brought forward in parallel to ensure the Emergency Village project does not pick up additional costs associated with works outside of this business case.
Design and Construction	
Planning Approval is severely delayed, comes with onerous conditions or is refused.	Engage with planning authority, council and stakeholders to gain support and impress upon them the urgent need ad wide reaching community benefits.
Increase in procurement periods/lead ins & Material shortages	PSCP to identify long lead items, which could be ordered in advance to mitigate delay. Identify alternate options.
Project is not delivered to the brief or appropriate standards.	Robust and clear brief and contract, with stringent quality control procedures and effective site supervision/monitoring.
Operations and Transformation	
Changes to models of care, demand, and/or commissioning adversely impacts upon the future efficiency and suitability of the project design.	Close working with users and commissioners to understand the direction of healthcare service provision, along with a flexible design solution.

Main Risk	Mitigation
Poor quality brief that does not accurately portray the Trust's requirements.	Robust and informed strategic review, modelling, activity trend analysis, challenge and business planning.
Human Resources	
Project failure due to poor resourcing/project management.	Ensure sufficient, competent resources are directed to the project.
Inability to provide a sufficient and suitably skilled workforce to properly staff and operate the facility post-handover.	Ensure a suitable programme of staff engagement, training, recruitment and retention is implemented in sufficient time to meet the service needs.

2.12 Constraints

The project is subject to following constraints:

- The project is constrained by the space available on site for expansion of emergency services while also maintaining colocations.
- The project is constrained by the maximum available/affordable capital envelop for the scheme of £17 million, which may be under pressure due to current market conditions such as hyperinflation.
- The project is constrained by the requirement for net revenue costs maintaining or improving but not deteriorating the Trust financial position.
- The project is constrained by the requirement to achieve all relevant building and design standards set out in HBNs and HTMs.
- The project is constrained by the requirements arising through consultation with the public.
- The project is constrained by the requirements imposed by planning permission approval.
- Building works must be completed by March 2024 in order to access Wave 4 STP funding.

2.13 Dependencies

The project is subject to following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Nottinghamshire Healthcare Foundation Trust agrees to vacate part of the premises (it currently provides some of its inpatient and outpatient mental health services from BH).
- Business Case Approval: the project is dependent on the Trust securing NHSE/I approval of the OBC and FBC.
- Planning permission approval.
- Interdependencies between this scheme and other related schemes: ATC, SDEC, Single Site Trauma.
- Effective out of hospital demand management to support the activity and capacity requirements in the scheme.

- For the adjacency benefits to be realised the project is dependent on the RAAC, ATC and SDEC projects to be complete in time.

3 The Economic Case

3.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the OBC documents the range of options that have been considered in response to the scope identified within the strategic case; and provides evidence to show that the most economically advantageous option has been selected, which best meets service needs and optimises value for money.

3.2 Critical Success Factors

The critical success factors (CSFs) as outlined in the Strategic Case are:

Table 21: Critical Success Factors

CSF	How well the option:
Strategic Fit and Business Needs	◆ Meets the agreed spending objectives, related business needs and service requirements, and ◆ Provides holistic fit and synergy with other strategies, programmes and projects.
Potential Value for Money	◆ Optimises public value (social, economic and environmental), in terms of the potential costs, benefits and risks.
Supplier Capacity and Capability	◆ Matches the ability of potential suppliers to deliver the required services, and ◆ Is likely to be attractive to the supply side.
Potential Affordability	◆ Can be funded from available sources of finance, and ◆ Aligns with sourcing constraints.
Potential Achievability	◆ Is likely to be delivered given the organisation's ability to respond to the changes required, and ◆ Matches the level of available skills required for successful delivery.

3.3 Options Assessment

3.3.1 Options Framework

Methodology

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the business case documents the wide range of options that have been considered that could deliver the agreed investment objectives for five categories of choice:

- Scope (service and geographical coverage);
- Solution (including services and required infrastructure);
- Service delivery (who will deliver the required services);
- Timing and phasing of delivery;

- Funding of the investment.

The long list must include an option that provides the baseline for measuring improvement and value for money. This option is known as 'Business as Usual'. It must also include a realistic 'Do Minimum' based on the core functionality and essential requirements for the project.

A long list of options were identified and documented. Options were generated for each category of choice by ascertaining the least ambitious, most ambitious and intermediate option for scope, solution, service delivery, timing and funding.

This process results in an assessment of each option in terms of how well it will deliver each investment objective and CSF and is assessed as either:

Does Not Meet	Weakly Meets	Broadly Meets	Strongly Meets

Options were scored on a consensus basis against the agreed investment objectives and critical success factors.

3.3.2 Service Scope and Solution

In developing the long list of scope options for this scheme the Project Team ensured that suitable Do Minimum and Do Maximum options were considered which would enable the IOs and CSFs set out in the Strategic Case to be met.

There are six options for the scope:

- 1A Business as usual – continue with current clinical model
- 1B Do Minimum – Implement the paediatrics model (ED and dedicated CAU)*
- Option 1C – Implement paediatrics model and front door model and right size ED
- Option 1D – As 1C plus deliver new ATC
- Option 1E – As 1C plus deliver new ATC and SDEC
- Option 1F – As 1C plus deliver new ATC, SDEC and fracture clinic

* The paediatrics model of care was defined separately following a public consultation exercise and before the full options assessment process for the scheme as a whole was carried out. It has therefore been included here as a given and is not subject to further assessment. See section 2.8.5 for an explanation of how the paediatrics model was arrived at.

Following a review by the Project Team and the Design Team (including architect, Trust estates, health planners and senior clinicians), a series of potential estate configurations were derived. These were based on known infrastructure constraints, current estate limitations and available space at Trust sites. The Trust considers that there are four potential solutions for the scheme:

- 2A Business as usual – Ongoing maintenance
- 2B Do Minimum – Refurbish existing facilities and deliver paediatrics
- Option 2C – Refurbish existing facilities and new build (as per SOA v15)
- Option 2D – New build (as per SOA v15).

An assessment against the IOs and CSFs and a SWOT analysis for these scope and solution option choices was conducted as part of the options appraisal process. The findings are contained in Appendix E1.

3.3.3 Service Delivery, Implementation & Funding

The Trust has considered potential routes to market for the delivery of the scheme, based upon the high-level assessment within the Commercial Case. Following assessment by the Project Team, four potential delivery options have been considered for the project:

- Option 3B - Procurement Framework (i.e. P21+)
- Option 3C - Full procurement process
- Option 3D - Development Partner
- Option 3E – Public Private Partnership/Joint Venture.

The Trust considers that there are two fundamental approaches to implementing the scheme:

- Option 4B - Phased build
- Option 4C - Single build

The Trust has considered a range of options for funding the works in an affordable and sustainable manner:

- Option 5B - Central funding
- Option 5C - PDC funding
- Option 5D - Combination of Central funding and PDC funding
- Option 5E - Alternative models of funding

An assessment against the IOs and CSFs and a SWOT analysis for these service delivery, implementation and funding options was conducted as part of the options appraisal process. The detailed findings are contained in Appendix E1.

3.4 Options Framework Summary

The qualitative options appraisal process outlined in the preceding sections resulted in the following framework summary.

Project	Business as Usual	Do Minimum	Intermediate Option	Intermediate Option	Intermediate Option	Do Maximum
1. Service Scope As outlined in Strategic Case	1A – Continue with current clinical model	1B – Implement Paediatrics model (ED and dedicated CAU)	1C – Implement Paeds model and Front Door model and right size ED	1D – As 1C plus deliver new ATC	1E – As 1C plus deliver new ATC and SDEC	1F – As 1C plus deliver new ATC, SDEC and Fracture Clinic
	Carried Forward	Carried Forward	Preferred Way Forward	Discounted	Discounted	Discounted
2. Service Solution In relation to the preferred scope	2A – Ongoing maintenance	2B – Refurbish existing facilities and deliver Paeds	2C – Refurbish existing facilities and new build (as per SOA v1)			2D – New build (as per SOA v2)
	Carried Forward	Carried Forward	Preferred Way Forward			Carried Forward
3. Service Delivery In relation to the preferred scope and service solution	3A – Continue with existing	3B - Procurement Framework (i.e. P21+)	3C - Full Procurement Process	3D - Development Partner		3E - Public Private Partnership / Joint Venture
	Carried Forward	Preferred Way Forward	Discounted	Discounted		Discounted
4. Implementation In relation to preferred scope, solution and method of service delivery	4A- Continue existing		4B - Phased			4C - Single-Phased Build
	Carried Forward		Preferred Way Forward			Discounted
5. Funding In relation to preferred scope, solution, method of service delivery and implementation	5A – Continue with existing	5B – CRL Funding	5C- PDC Funding of £17.6m	5D - Combination of CRL and PDC funding		5E - Alternative funding models
	Carried Forward	Discounted	Carried Forward	Preferred Way Forward		Discounted

3.5 Shortlisted Options

In line with guidance and best practice, the business case should identify a minimum of four shortlisted options for further appraisal. These should include:

- Business as Usual: The benchmark for value for money;
- 'Do Minimum': A Realistic way forward that also acts as a further benchmark for Value for Money, in terms of cost justifying further intervention;
- 'Recommended': The preferred way forward at this stage;
- One or more other possible options based on realistic 'more ambitious' and 'less ambitious' choices that were not discounted at the long-list stage.

The options framework can be used to filter the options considered at the long-list stage to generate the potential short-list for the project, as illustrated below. The following table uses the numbering used in the summary table above to map option choices into a summary of the short list identified.

Table 22 Options Framework Shortlist

Options	0 - Business as Usual	1 - Do Minimum	2 - Preferred Way Forward (PWF)	3 - More Ambitious PWF
Project Scope	Continue with current clinical model	**Minor changes to clinical model:** • Adult ED model remains largely unchanged • Proposed Paediatrics clinical model (ED and dedicated CAU) • Enable interfaces with new ATC and SDEC where possible	**Deliver proposed clinical model and right-size to meet forecast demand:** • Integrated front door (Combined primary care + ED triage + streaming) • Majors, Minors, Resus, Mental Health, Primary Care • Paediatrics ED and dedicated CAU • Enable optimum interface with new ATC (to realise associated benefits) • Enable optimum interface with new SDEC	**Deliver proposed clinical model and right-size to meet forecast demand:** • Integrated front door (Combined primary care + ED triage + streaming) • Majors, Minors, Resus, Mental Health, Primary Care • Paediatrics ED and dedicated CAU • Enable optimum interface with new ATC (to realise associated benefits) • Enable optimum interface with new SDEC
Project Solution	No initial investment but continue with existing arrangements for ongoing maintenance	**Refurbish existing facilities:** • Adult ED remains in current location and current size • Deliver SOAv15 for Paediatrics ED and CAU	**Refurbish Mental Health building and deliver new build extension**: • Deliver SOAv15** • Achieve improved adjacencies / clinical flow • Co-locate with new ATC and SDEC*	**Demolish Mental Health building and create new build facility**: • Deliver SOAv15** • Achieve optimum adjacencies / clinical flow • Co-locate with new SDEC*
Service Delivery	Continue with existing arrangements	Deliver via procurement framework (eg P21+)	Deliver via procurement framework (eg P21+)	Deliver via procurement framework (eg P21+)

Options	0 - Business as Usual	1 - Do Minimum	2 - Preferred Way Forward (PWF)	3 - More Ambitious PWF
Project Implementation	Continue with existing arrangements	Phased Build - Programme TBC	Phased Build - Programme TBC	Phased Build - Programme TBC
Project Funding	Continue with existing arrangements	CRL funding	Combination of £17.6m PDC funding + additional CRL (inflation only)	Combination of £17.6m PDC funding + additional CRL

*Both ATC and SDEC are subject to separate business cases and so are excluded from the scope of the capital cost forms and drawings for this business case but their locations/sizes/adjacencies need to be factored into the design

It is important to note that the preferred way forward identified above is not the preferred option at this stage. The preferred option is identified from the appraisal of the short-listed options which will be explored in the economic appraisal.

3.6 Economic Appraisal

3.6.1 Introduction

The purpose of the economic appraisal is to evaluate the costs, benefits and risks of the shortlisted options in order to identify the option that is most likely to offer best public value for money. In line with current NHS England and HM Treasury Green Book project business case guidance, this involves:

- Estimating whole life capital and revenue costs for each option.
- Undertaking an assessment of benefits and risks for each option, wherever possible quantifying these in monetary-equivalent values.
- Using the Comprehensive Investment Appraisal (CIA) Model to prepare discounted cash flows and estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option.
- Presenting the results, including sensitivity analysis, to determine the preferred option.

3.6.2 The Short List of Options

As outlined in the previous section, a short list of options has been identified. A comparison of the floor area by works type for each of the shortlisted options is provided in the table below to provide an indication of the scale of work involved.

Table 23: Comparison of Shortlisted Options

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
Description	Continue with existing arrangements	Refurbishment of existing ED and Mental Health building – No change to Adult ED location or model but	Refurbish and extend Mental Health building to create Emergency Care Village	New build Emergency Care Village

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
		deliver proposed Paediatrics model		
	m2	**m2**	**m2**	**m2**
Retain ED	827	-	-	-
Retain Paeds CAU	491	-	-	-
Retain Building 47 (GF)	1,153	-	-	-
New build	-	116	1,572	3,226
Major refurbishment	-	2,968	1,100	-
Minor refurbishment	-	-	679	-
Costed GIFA	**2,471**	**3,084**	**3,351**	**3,226**

3.6.3 Estimating Initial Capital Costs

Capital costs have been estimated for the shortlisted options by the Trust's Cost Advisors, Edge and a copy of the capital cost plans are provided in Appendix E4.

Costs are based on the following main assumptions:

- Schedules of Accommodation and 1:200 drawings in accordance with the level of design required at OBC stage.
- Works costs calculated using Healthcare Premises Cost Guide @ PUBSEC 281 and 100 Location.
- Allowances for fees, equipment costs, planning contingency and optimism bias have been applied as appropriate.

The resulting capital costs estimates are summarised in the table below.

Table 24: Initial Capital Costs

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
	£'000	£'000	£'000	£'000
Construction	0	9,212	10,628	16,624
Fees	0	1,037	771	1,669
Non works	0	150	150	4,150
Equipment costs	0	811	886	1,269
Planning contingency	0	461	695	831
Subtotal	**0**	**11,671**	**13,131**	**24,543**
Optimism bias	0	1,634	1,313	2,454
Subtotal	**0**	**13,305**	**14,444**	**26,997**

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
VAT	0	2,453	2,734	5,066
Subtotal	**0**	**15,758**	**17,178**	**32,063**
Inflation	0	1,420	802	3,228
Total	**0**	**17,178**	**17,980**	**35,291**

For completeness and ease of reference to capital cost forms, these figures are shown here including VAT and inflation adjustment. However, it should be noted that for the purposes of the economic appraisal all costs exclude VAT and are restated at base year prices in accordance with HM Treasury Green Book guidance.

3.6.4 Residual Value

Based on District Valuer advice, it is anticipated that the preferred option will have a residual value of £7.431m at the end of the asset life, equating to 43.9% of total building costs of £16.917m.

This has been incorporated to the CIA model by applying this percentage to building costs excluding inflation and VAT. It is assumed that a similar proportion of residual value would apply to the alternative options.

Table 25: Residual value

	Option 0 – BAU **£'000**	Option 1 – Do Minimum **£'000**	Option 2 – Refurbish and Extend **£'000**	Option 3 – New Build **£'000**
Building costs	0	12,493	13,558	25,728
Residual value %	0.0%	43.9%	43.9%	43.9%
Residual value in Year 60	**0**	**5,488**	**5,955**	**11,301**

3.6.5 Estimating Lifecycle Capital Costs

Ongoing investment requirements are estimated to reflect the whole life costs of replacing, refurbishing or upgrading of assets over the lifetime of the appraisal period.

Indicative lifecycle costs have been calculated by the Trust's Cost Advisors, Edge, in relation to the ongoing requirements for renewal and maintenance of building fabric and services in relation to Options 1, 2 and 3, based on benchmarked cost data from the BCIS Life Cost Database. Copies of the lifecycle capital cost reports are provided in Appendix E4.

In addition to this, it is assumed that equipment will be replaced every ten years and the associated costs have been incorporated.

Business as Usual lifecycle costs have been estimated based on the Gross Internal Floor Area (GIFA) for the retained areas outlined in Table 22 with the following applied:

- Proportion of Bassetlaw's backlog maintenance from the Trust's 2020/21 ERIC data, uplifted to 2022/23 price base, profiled over a 10-year period.
- Ongoing lifecycle renewal costs based on average cost per m2 in line with the benchmarked cost data used in the other three options.
- Equipment lifecycle costs are expected to be in line with the Do Minimum option.

The resulting lifecycle capital costs estimates are summarised in the table below.

Table 26: Whole Life Lifecycle Costs

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
Backlog maintenance	1,821			
Ongoing lifecycle - building	7,010	8,749	9,507	9,152
Ongoing lifecycle - equipment	4,056	4,056	4,431	6,345
Total lifecycle costs 60 years	**12,888**	**12,805**	**13,937**	**15,497**

3.6.6 Estimating Non-Recurring Revenue Costs

It is anticipated that transitional costs of £48,515 will be incurred as a result of the moves required to deliver the preferred option. It has been assumed that this would apply to all of the 'Do Something' options.

The resulting transitional costs estimates are summarised in the table below.

Table 27: Transitional Costs

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
One-off transitional costs	0	49	49	49
Non-recurring revenue costs	**0**	**49**	**49**	**49**

3.6.7 Estimating Recurring Revenue Costs

Recurring revenue costs have been estimated based on the following:

- Baseline current pay and non-pay costs associated with the ED and ATC teams based on 2022/23 budgets.

- Building running costs based on average cost per m2 from the Trust's 2020/21 ERIC data, uplifted to 2022/23 price base.
- Any efficiencies associated with delivery of new facilities and enablement of the proposed clinical model are considered within the Benefits section below.

The resulting recurring revenue costs estimates are summarised in the table below.

Table 28: Annual Recurring Revenue Costs

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
Pay Costs	10,924	10,924	10,924	10,924
Non-Pay Costs	951	951	951	951
Clinical services	**11,874**	**11,874**	**11,874**	**11,874**
Cleaning	76	94	102	99
Utilities	80	100	109	105
Total FM Costs	246	307	333	321
Building running costs	**402**	**501**	**545**	**525**
Total revenue costs	**12,276**	**12,376**	**12,419**	**12,399**
Impact on annual revenue costs	0	100	143	123

3.6.8 Estimating Benefits

Benefits resulting from the investment have been identified for each of the following categories:

- **Cash releasing benefits (CRBs):** Cost savings that will directly improve the Trust's financial position or mitigate the revenue consequences of the investment.
- **Non-cash releasing benefits (NCRBs):** Gains that can be expressed in financial terms but do not result in cash savings for the Trust, such as efficiency improvements that will allow the Trust to make better use of resources or cost savings that will be realised by other public sector organisations.
- **Societal benefits (SBs):** Indirect benefits to wider society that can be expressed in financial values.
- **Unmonetised benefits (UBs):** benefits that cannot be expressed in financial values including both quantifiable and qualitative benefits.

An overview of the financial benefits that have been quantified within the first three categories is provided in the table below, including an outline of the approach used to quantify them and the estimated values for the preferred way forward.

Table 29: Benefits Assumptions

Output	Outcome	Assumptions	Cash Releasing Benefits	Non-Cash Releasing Benefits	Societal Benefits
CAU Overnight	**Fewer children transferred to DRI**	The SOC identified that, as a result of fewer transfers, the service provided by a dedicated PDC crew will no longer be required. Based on 2021/22 activity data it is estimated that this relates to 216 transfers p.a.	**£94k p.a.** DBTH Cost Saving	**£94k p.a.** BCCG Cost Saving	**£5k p.a.** Carbon values and air quality damage costs associated with 216 fewer return journeys p.a. @ 30km (Based on HMT Green Book Supplementary Guidance rates)
Improved adjacencies between ED and ATC	**Rota efficiencies**	The SOC identified that the improved adjacencies will enable more integrated ways of working and reduce rota requirements between ED and ATC as follows: • Medical – 1 WTE per shift • Nursing – 1 WTE per shift • Porters – 0.3 WTE overall	**£575k p.a.** Updated to reflect 2022/23 average pay costs	-	-
Integrated front door improves streaming and better patient flow in ED	**Reduced patient time in ED**	In 2022, detailed Health Planning work to agree the functional content of the new facilities, resulted in an agreed target to reduce the average patient time in the ED based on New Hospital Programme exemplars, as follows: • Resus – 230 to 180 minutes • Majors - 220 to 120 minutes • Minors – 140 to 30 minutes	-	**£1,361k p.a.** **Increased costs avoided by 2035** Continuing with current average patient time in ED would result in an estimated 27 additional spaces being required in ED by 2035. Based on an average nursing cost per space (Using 2022/23 average pay costs, assuming 50% of nursing requirements variable in relation to number of spaces).	**£477k p.a.** 74,316 patient hours saved p.a. x Perceived Value of Time (DfT TAG Data used as proxy)

Output	Outcome	Assumptions	Cash Releasing Benefits	Non-Cash Releasing Benefits	Societal Benefits
	Improved streaming	Outcomes of a trial undertaken at Bassetlaw of the Nav Nurse and ESA Model in 2020, suggested that streaming at the front door could be improved from 7.7% to 33.2%. The co-location of the BUC's service would support this model and help to improve streaming figures.		**£972k p.a.** Applying the streaming improvement to current Minors activity at an average cost per ED attendance.	
Design efficiencies	**Energy efficiencies**	Based on 2020/21 ERIC data the Trust's current energy consumption is an average of 294 KWH/m2. Aecom's Net Zero Carbon Pathway report (May 2022) identified a target for the scheme to reduce consumption to 250 KWH/m2, with a stretch target to 180.	**£14k p.a.** Based on achieving the target 250KWH/m2 and applying the current average cost per KWH (2020/21 ERIC data uplifted to 2022/23 prices)	-	**£38k p.a.** Based on carbon values and air quality damage costs provided in HMT Green Book Supplementary Guidance
Investment delivers social value	**Apprenticeships**	Based on information from IHP it is anticipated that the investment will deliver 14 apprentice weeks per £1m of construction value. Average person value = £12,208 p.a. less 2% deadweight factor	-	**-**	**£55k non-recurring** Based on 238 apprenticeship weeks @ £230 per week
	Construction jobs	1 new job opportunity per £2m of construction Average person value = £21,460 p.a. less 40% deadweight factor	-	**-**	**£116k non-recurring** Based on 9 new job opportunities @ £12,876 p.a.

A copy of the detailed benefits register is provided in Appendix M5.

Benefits values have been applied to the options according to the degree to which they deliver these outcomes, as outlined in the table below.

Table 30: Benefits applied to options

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
Fewer children transferred to DRI	-	100%	100%	100%
Rota efficiencies	-	-	100%	100%
Reduced patient time in ED	-	-	100%	100%
Improved streaming	-	-	100%	100%
Energy efficiencies	-	-	100%	100%
Apprenticeships and construction jobs	-	Based on level of investment	Based on level of investment	Based on level of investment

The resulting estimated whole life benefits values over the 60-year appraisal period for each option are summarised in the table below.

Table 31: Monetised Benefits

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
Cash releasing benefits	0	5,569	40,653	40,653
Non-cash releasing benefits	0	5,569	135,029	135,029
Societal benefits	0	465	31,095	31,191
Total benefits	**0**	**11,604**	**206,778**	**206,874**

An assessment of unmonetized benefits is provided in the table below.

Table 32: Unmonetised Benefits

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
Improved patient and carer experience	X	Partially	✓	✓
Equitable access to services	X	For Paediatrics only	✓	✓

Sufficient capacity to meet demand	X	X	✓	✓
Flexibility to meet surge demand	X	X	✓	✓
Greater staff satisfaction	X	X	✓	✓
Greater collaboration with other providers	X	X	✓	✓
Improved compliance with statutory requirements	X	Partially	✓	✓
Improved infection prevention	X	Partially	✓	✓
Improved ventilation	X	Partially	✓	✓
Improved management through digital enablement	X	Partially	✓	✓

3.6.9 Estimating Risks

The risks for each option have been assessed and, as far as possible, quantified and expressed in monetary equivalent terms, including:

- Quantified risk in relation to planning contingency included in capital cost forms.
- Optimism bias factor included in capital cost forms.

The costed risk register is available in Appendix M8.

3.6.10 Comprehensive Investment Appraisal Results

The Comprehensive Investment Appraisal (CIA) model has been populated with the assumptions outlined above to support the appraisal of overall value for money by producing a cost-benefit analysis of the shortlisted options.

The assumptions above have been incorporated into a discounted cash flow over a 62-year appraisal period including Year 0 (baseline year) + construction period + 60 years estimated useful life.

- Year 0 is 2022/23
- Costs and benefits use real base year prices – all costs are expressed at …… prices in line with the baseline costs.
- The following costs are excluded from the economic appraisal:
  - Exchequer 'transfer' payments, such as VAT.
  - General inflation.
  - Sunk costs.
  - Non-cash items such as depreciation and impairments.
- A discount rate of 3.5% is applied to years 1-30, 3.0% from year 31 onwards.

A copy of the CIA model is provided in Appendix E2 and the economic summary from the CIA model is shown in the table below.

Table 33: Key Results of Economic Appraisal

	Option 0 – BAU £'000	Option 1 – Do Minimum £'000	Option 2 – Refurbish and Extend £'000	Option 3 – New Build £'000
Incremental costs	0	-14,903	-17,799	-28,372
Incremental benefits	0	4,780	79,697	79,790
Risk adjusted NPSV	**0**	**-10,123**	**61,898**	**51,418**
Benefit-cost ratio	**0.00**	**0.32**	**4.48**	**2.81**

This demonstrates that Option 2, which involves refurbishing and extending the Mental Health building to create Bassetlaw Emergency Care Village, offers best value for money with the best incremental Net Present Social Value (NPSV) and a Benefit Cost Ratio (BCR) of 4.48.

3.6.11 Sensitivity Analysis

Sensitivity analysis has been undertaken on these results in the form of switching analysis which tests the degree to which costs and benefits would need to change to affect the ranking of options between the preferred option and the next best option.

Table 34: Switching analysis

	For Preferred to Rank Equal to Next Best Option 2 – Refurbish and Extend	For Next Best to Rank Equal to Preferred Option 3 – New Build
Costs	58.9%	-36.9%
Benefits	-13.2%	13.1%

This analysis demonstrates that in order for Option 3 to rank equal to Option 2, the following changes in assumptions would be required:

- Option 2 costs would need to increase by 58.9% or benefits reduce 13.2%.
- Option 3 costs would need to reduce by 36.94% or benefits increase by 13.13%.

This suggests that the ranking of options is not particularly sensitive to changes in assumptions.

In addition, scenario testing has been undertaken to estimate the impact on the results of the preferred option of changes in assumptions.

Table 35: Sensitivity testing

Scenario	NPSV £'000	BCR
CIA Results	**61,898**	**4.48**
Scenario 1: Capital costs increase by 25%	57,268	3.55

Scenario 2: Revenue costs increase by 10%	28,993	1.57
Scenario 3: Total benefits reduce by 50%	22,049	2.24
Scenario 4: Cash releasing benefits reduce by 100%	45,442	3.55
Scenario 5: Non-cash releasing benefits reduce by 100%	11,339	1.64
Scenario 6: Societal benefits reduce by 100%	49,215	3.77

This analysis suggests that the preferred option frequently will continue to deliver a higher BCR than the next best option (Option 3, which results in a BCR of 2.81) in most scenarios, with the exception of:

- Revenue costs increasing by 10%, which arguably would apply equally to other options, therefore is unlikely to be a differentiating factor.
- Benefits reducing by 50% or non-cash releasing benefits being excluded overall, which again would likely apply equally to Option 3.

This provides further assurance that the ranking of options is not particularly sensitive to changes in key assumptions.

In all scenarios outlined, the preferred option delivers a BCR of greater than 1.0, providing assurance that the value for money of the preferred option is not over reliant on individual assumptions.

3.6.12 Summary of Options Appraisal Results

The results of the economic appraisal demonstrate that Option 2, which involves refurbishing and extending the Mental Health building to create Bassetlaw Emergency Care Village, offers best value for money with the best incremental Net Present Social Value (NPSV) and a Benefit Cost Ratio (BCR) of 4.48.

This is because the £17.98m capital investment required to deliver Option 2 will generate a range of benefits including:

- Providing CAU facilities overnight will result in fewer children being transferred to DRI reducing associated costs.
- Improved adjacencies between ED and ATC will enable more integrated ways of working and deliver rota efficiencies.
- The integrated front door and improved clinical flows will enable ED to achieve national targets and reduce patients' time spent in the department.
- Providing a better working environment and clinical model that will provide opportunities to improve recruitment and retention, reduce sickness absence, and reduce reliance on agency usage.
- Providing modern efficient facilities that will improve energy consumption.
- Delivering social value through local investment including creation of apprenticeship and new construction job opportunities.

Option 1, the Do Minimum, involves refurbishing the existing ED and Mental Health building at a cost of £17.2m. This would deliver minimal benefits as although it enables delivery if the Paediatrics model, it does not change the ED location or model and so will not result in any of the benefits associated with improved adjacencies, front door streaming and clinical flow. It also does not provide sufficient capacity to accommodate predicated ED demand in the future. It therefore results in a whole life Net Present Cost and BCR of just 0.32, representing relatively poor value for money.

While Option 3, which involves investing £35.3m to deliver a new build solution for the Bassetlaw Emergency Care Village, delivers similar benefits to Option 2, the increased level of investment means it results in a lower BCR and so offers less value for money. It is also unlikely to be affordable. A summary of the results of the economic appraisal is provided in the table below.

Table 36: Options Overview

	Option 0 – BAU	**Option 1 – Do Minimum**	**Option 2 – Refurbish and Extend**	**Option 3 – New Build**
Incremental NPSV	**0**	**-£10.1m**	**£61.9m**	**£51.4m**
Benefit Cost Ratio	**0.00**	**0.32**	**4.48**	**2.81**
Significant non-financial benefits		Some improvement to estate Delivers benefits of adjacencies between Paediatrics ED and CAU	Delivers benefits of Integrated Front Door, ED adjacencies, Paediatrics ED and CAU adjacencies Interface with new ATC allows clinical model benefits to be fully realised Provides adjacencies that enable successful delivery of new SDEC scheme	In addition to Option 2, potentially optimises adjacency benefits
Residual risks		Suboptimal adjacencies and clinical flow will reduce benefits Complex phasing increasing risks of delay, disruption to services during works, and delay to achieving benefits	Minor compromises to adjacencies compared to a new build solution	Capital affordability

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
Lifespan	Does not increase capacity to meet current and future demand	Does not increase capacity to meet current and future demand	Provides capacity to meet predicted demand to 2035	Provides capacity to meet predicted demand to 2035
Rank	4	3	1	2
Switching	N/A	N/A	To rank equal to next best option (Option 3) costs would need to increase by 58.9% or benefits reduce by 13.2%	To rank equal to preferred option (Option 2) costs would need to decrease by 36.9% or benefits increase by 13.1%

The CIA model including supporting calculations and the sensitivity analysis is provided in Appendix E2.

4 The Commercial Case

4.1 Introduction

This section of the OBC outlines the proposed deal in relation to the preferred option outlined in the Economic Case.

The purpose of the Commercial Case is to demonstrate that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers. Demonstrating a viable procurement requires an understanding of the marketplace, knowledge of what is realistically achievable by the supply side and research into the procurement routes that will deliver best value to both parties.

Putting in place a well-structured deal requires a clear understanding of the services, outputs and milestones required to be achieved and of how the potential risks in the Design, Build, Funding and Operational (DBFO) phases of the scheme can best be allocated between the public and private sectors and reflected in the charging mechanism and contractual arrangements.

4.2 Commercial Feasibility

Cost certainty and the ability to control and manage cost will be completed using the New Engineering Contract (NEC3) ECC, Main Option 'C', together with the development and engrossment into the Contract of the Guaranteed Maximum Price (GMP).

IHP have been appointed as P21+ PSCP. Cost certainty and deliverability will be agreed in advance of construction with the PSCP and their supply chain through market testing, negotiation, and the joint development between PSCP and the Trust of the costed Risk Register (Appendix M8). Weekly commercial meetings have taken place between the PSCP, the P21+ PM and the Cost Advisor due to the challenges being faced in the construction market. The findings of these meetings have been escalated to the Trust and incorporated into the commercial reporting process.

Main Option 'C' is a cost plus contract which is subject to a pain/gain share mechanism by reference to the agreed Target Cost advised in the PSCP's GMP; and built up from the Activity Schedule included in the GMP.

The Target Cost introduces a mechanism enabling the contractor, and/or the Trust, to share in any benefits of cost savings realised once the contract has been executed as a Deed.

Where cost overruns are encountered, Main Option 'C' also provides a mechanism whereby the PSCP and/or the Trust bear some element of an overrun.

4.2.1 Timeline for Procurement

The table below sets out the procurement milestones and complies with all applicable legal requirements. The schedule is based on the selection process for a contractor to carry out a series of works at DRI in 2015. As the original HLIP included an ED development at DRI, which

was not carried out, it has been agreed that for simplicity and speed the ED scheme at Bassetlaw can be substituted. See section 4.4.2 for further information.

Table 37 Key Procurement Milestones

Activity	Date
HLIP released	30 January 2015
Deadline for PSCPs to express interest	18 February 2015
Shortlisting	20 February 2015
Open Day	27 February 2015
Interviews	10 March 2015
Appointment of PSCP	12 March 2015
Launch Event	18 March 2015

4.3 Scope

The scope of the scheme as agreed during the options assessment process is as follows:

To deliver the proposed clinical model (referenced in section 4.7.2) and provide the functional content to meet forecast demand for services, including:

- An integrated front door for emergency services (combined primary care, ED triage and streaming)
- Majors, minors, resus, mental health and primary care
- Paediatrics ED and dedicated Children's Assessment Unit
- Enable optimum interface with new ATC and new SDEC.

The construction solution required to achieve these aims is as follows:

- Refurbish the existing mental health building and deliver a new-build extension
- Deliver the agreed Schedule of Accommodation V15
- Achieve improved adjacencies/clinical flow
- Co-locate with new ATC and SDEC.

4.4 Procurement Strategy

The procurement strategy has been developed by Edge Cost Consulting (see Appendix C1 for full strategy). The purpose of the procurement strategy is to select the most appropriate procurement route for the Bassetlaw Emergency Village.

In developing the procurement strategy, Edge considered the following criteria:

Public procurement regulations.

Appointing a tried and tested contractor that can be trusted is desired due to clinical sensitivity of the area as well as the requirement to work as a collaborative and integrated team.

SME's participation and how this will be encouraged through the supply chain.

Project readiness in relation to the current market structure.

Procurement process must be able to demonstrate value for money has been achieved in delivering the project.

Commercial framework must encourage all parties to successfully deliver the project on time and on budget. Cost certainty is required throughout and prior to construction.

Level of risk to the project; the Trust would prefer majority of the construction/design risk to sit with or transfer to the contractor.

Certainty of programme delivery.

Funding allocation and cashflow may require the project proceed to market with urgency (once approved by HM Treasury).

The design is at RIBA Stage 2 level. The design brief and outline design have been agreed. The project team fully expect there to be changes to the brief and requests to amend the previously agreed design. These requests for change will be managed through AECOM as project managers.

4.4.1 Procurement Options

From a long list of options, the following procurement options have been considered and are described below.

- a competitive tender following a traditional route;
- a competitive tender following a design and build route;
- continuation of the existing ProCure 21+ contract with IHP (Vinci Construction);
- ProCure 22 National Framework (new version of ProCure 21+);
- alternative National Framework (unspecified).

Management contracting and construction management procurement options have been discounted due to capacity and expertise issues, and appetite to risk within the client organisation.

Traditional Procurement

Traditional procurement consists of separating design from construction. The Trust would appoint an architect to complete the design and produce the building specifications. On completion of the design the Trust will tender to appoint a contractor to complete the construction works.

This method allows potential contractors to prepare their tender based on the specifications and drawings. Subsequently, the Trust can choose the contractor based on their expertise to meet the design requirements. Due to the design process preceding construction, architects may not have the opportunity to communicate with specialist contractors who could provide valuable project expertise. However, traditional procurement enables the responsibility of design to remain with the Trust, giving the Trust greater control and guaranteed quality.

Typically, the contractor's services would be engaged under a lumpsum contract. Providing a full design has been achieved prior to tendering and significant design changes are unlikely, the contractor can accurately price the required works. The build would then be completed to a fixed price, irrespective of additional claims. Hence, the Trust could expect a high degree of cost certainty.

Traditional procurement provides minimal flexibility in the programme due to no overlap between design and construction. If significant changes need to be made to the design once the contractor has been appointed, the financial and time cost to the Trust could be significant.

Traditional procurement allows for the Trust to have individual relationships with all parties, providing greater control and responsibility over the project.

Design and Build

Design and Build is a construction procurement route where the main contractor is appointed to design and construct the works to the site. The cost of design and construction is generally pre-agreed between the Trust and the contractor prior to any work commencing. If the build exceeds the pre-agreed budget, additional cost is at the responsibility of the contractor. Therefore, greater financial risk is transferred to the contractor and cost certainty is secured for the Trust.

The contractor is also responsible for the design, planning, organisation, control and construction of the works to the Trust's requirements. The contractor can be appointed to carry out both the design and build, they may choose to make cost savings which could impact the overall quality. However, if the Trust would like greater control of the design process, a concept design or outline design can be prepared internally. A contractor can then be appointed to complete the design and construction process.

Programme delivery time can be reduced significantly due to the contractor's ability to overlap the design and construction stages. However, once the programme is underway, the flexibility of the design and build route is limited. Additional time and cost implications need to be considered if the Trust wants to make changes to the design.

Design and Build procurement is best suited to projects which:

- Need to commence construction promptly as the design and construction are able to overlap;
- Require minimal risk transfer to with suppliers as there is only one organisation procured;
- Are technically complex projects which can benefit from the contractor's expertise;
- Where the Trust requests less control over the design development.

Benefits of Design and Build include:

- Single point of responsibility for design and construction;
- Earlier commencement on site;
- Early price certainty;
- Benefit of contractor's experience harnessed during design.

The overall risk and responsibility for the delivery of the programme will sit with the contractor. The Trust will have less direct control and the quality of the programme cannot be guaranteed. The Design and Build approach is preferred for simple projects, where design quality is not the main consideration. It is one of the three procurement routes favoured by the government for publicly funded projects, as it allows a fully integrated team to work together on the project from the beginning.

Procure22 National Framework

ProCure22 (P22) is a Construction Procurement Framework which is administrated by the Department of Health and Social Care to be used for the development and delivery of NHS and Social Care capital schemes in England and is compliant with Government policies. P22 represents the third iteration of the DHSC Framework providing Design and Construction Services which are used by the NHS and Social Care organisations.

P22 builds on the principles of P21+ and aims to streamline the procurement process to create an environment where clients, Principal Supply Chain partners (PSCP) and the supply chain can develop stronger partnerships. The outcome of this is increased efficiency and productivity whilst supporting enhanced clinical outputs for patients and improved environments for staff and visitors.

Benefits of P22 include:

- Access to advice and Estate Development expertise;
- The ability to control cost and get cost certainty by agreement to a Guaranteed Maximum Price;
- Close integration of the supply chain and client ensuring agreed quality standards are achieved;
- The ability to use various funding methods to support the development of a scheme;
- PSCPs and supply chains are pre-vetted on appointment to Framework which complies with current government standards for construction procurement.

The P22 approach provides cost certainty by agreeing a Target Cost from the earliest possible stage. A Guaranteed Maximum Price is set out as soon as the design has been developed. The exact capital cost associated with the project will then be available to the Trust, conditional on any changes made by the Trust. P22 can protect the financial position of the Trust because it adopts ongoing auditing of project costs from PSCP through to project completion. This enables the Trust to closely monitor costs and deliver cost efficiency savings.

PSCPs are given Key Performance Indicators (KPIs) which must be fulfilled throughout the project. This approach ensures that quality standards and best practice guidelines can be clearly defined and achieved, guaranteeing a high degree of quality for the Trust.

The programme for P22 facilitates the overlap of design and construction phases, making it a flexible process. The development of the project is carried out collectively between the Trust, the PSCP and the supply chain. This collegiate approach gives rise to shared goals and objectives, minimising the risk and impact of potential change.

The use of P22 will ensure improved estate performance while lowering construction and maintenance costs and improving the scheme's time, cost and quality standards. P22 aims to support the NHS with master planning their estate reconfigurations, carrying out extensive maintenance and refurbishment programmes and delivering small and major capital construction work.

P21+ is the predecessor of P22. See section below for details on why P21+ is relevant to this project.

4.4.2 Preferred Procurement Route/Procurement Evaluation

A non-commercial evaluation was undertaken by Edge of the five procurement options (as detailed in their procurement strategy report – see Appendix C1).

This evaluation has scored each of the procurement options against a set of criteria which reflects the Trust's project-specific criteria set out in section 4.4 above. The scores and ranks are summarised in the table below with the highest score proving to be the best option.

Table 38 Evaluation of Procurement Routes

Evaluation Criteria		Weighted Score				
Category	**Maximum Score**	**Competitive Tender – Design and Build**	**Competitive Tender – Traditional**	**Continuation of ProCure 21+ Framework**	**Procure 22 Framework**	**Alternative National Framework**
Compliance	5.5	5.3	5.3	4.5	5.5	5.5
Risk	15	12.4	11	13.4	12.4	10.8
Programme	14	11.4	8.6	14	12.2	12.2
Cost	18	15	15.5	15.6	15.6	13.2
Quality	7.5	5.9	5.5	6	6	6
Total	**60**	**50**	**45.9**	**53.5**	**51.7**	**47.7**
Rank		**3**	**5**	**1**	**2**	**4**

The non-commercial procurement evaluation has identified ProCure 21+ as the most appropriate procurement route for the project as this best satisfies the main project criteria around speed of delivery (P21+ is the quickest route to market), and appointment of a trusted contractor to deliver the works in a highly sensitive clinical area (IHP are familiar with Trust estate).

It is acknowledged that concerns have previously been raised with regard to the validity of this procurement route and suitability given that IHP were appointed some eight years ago and the P21+ framework has subsequently been replaced by P22 (and now P23). On the basis that the original scheme information pack which formed the basis of IHP's appointment included an ED development at Doncaster Royal Infirmary (see Appendix C2 for the HLIP), the project team considered that the emergency village project would be an acceptable substitute to the DRI scheme given its similar functional content, scale and value. The Project Team sought advice from Andrew Mitchell, P22/23 Implementation Advisor within the Commercial Directorate at NHSEI, on the Trust's ability to utilise the existing P21+ agreement with IHP to progress this scheme. Following discussion between Andy White, Head of Capital Projects at DBTH, and Andrew Mitchell, this approach has been agreed and the project is live on the P21+ database.

IHP have a strong track record in delivering projects in the healthcare industry and have worked on various projects with the Trust. This includes the RAAC Replacement works that are currently in progress at Bassetlaw Hospital. The co-location of the two projects creates the benefit of being able to offer cost efficiencies by utilising existing trades, plant, accommodation etc, which will result in reduced prelims.

The appointment of IHP also brings risk reduction to Health & Safety variables, including the safety and wellbeing to staff, patients, construction operatives and the public directly and also indirectly through disruption to clinical activities. It would not be feasible to have two separate contractors working in such close proximity to each other, as this could cause logistical phasing issues, an increased number of plant and vehicular movements and an increased risk of delay.

In addition to this, IHP's experience on a similar scheme at Chesterfield will be invaluable in terms of applying the lessons learned and delivering the project within appropriate timescales.

Given its long-standing relationship with the Trust and the benefits that this brings, IHP were deemed highly suitable candidates to deliver the design and main construction works that align with the key objectives set out by the Trust for the emergency village project.

Following analysis, the best option for procurement – the P21+ route - was recommended by Edge to the Project Board and has been endorsed by the Trust's procurement team and the Department of Health.

4.4.3 Accounting Treatment of the Scheme

The proposed accounting treatment is a straightforward capital purchase and ongoing revenue consequences. The assets will sit on the balance sheet and have no impact on IFRS16.

4.4.4 Key Contractual Milestones and Delivery Dates

The table below sets out the key contractual milestones and delivery dates:

Table 39 Key Contractual Milestones

Activity	Date
Project Letter of Instruction Provided	December 2020
DBTH Sign Off 1:200s	May 2022
OBC submission to NHSE&I	July 2022

Activity	Date
Submit planning application	September 2022
Submission of GMP to DBTH for review	December 2022
FBC submission to NHSE&I	January 2023
NHSE/I FBC review and approval	14 April 2023
Contractor Mobilisation	March 2023
Construction	April 2023-April 2024
Stage 4 - Completion	April 2024
Stage 5 – Handover	June 2024

4.4.5 Key Contractual Issues

Contract Type

The Procure 21+ contract is a bespoke contract based upon the NEC3 Option C Contract. Both process and contract are bespoke to mirror the NHS business case approval process, giving clients the control mechanisms to ensure their scheme remains on budget at each stage, with break clauses (without penalty) throughout the design and development period. The framework contract is set and agreed by partnering organisations, and no project-specific amendments are permitted.

Clients can use the process and the partnership working relationship with their supply chain to drive as much value as they can – often creating long-term relationships with their ProCure21+ supply chains to deliver additional value on long-term objectives.

Cost certainty and the ability to control cost will be managed through the use of the NEC3 Engineering and Construction Contract (ECC), Option 'C'. Cost certainty and deliverability will be agreed in advance of construction by the PSCP with their supply chain through market testing, negotiation and the joint development, between the PSCP and the Trust, of the costed Risk Register. This can be found in Appendix M8.

Option 'C' is a cost plus contract which is subject to a pain / gain share mechanism by reference to the agreed Target Cost. The Target Cost introduces a mechanism enabling the contractor, and / or the Trust, to share in any benefits of cost savings realised once the Contract has been executed as a Deed. Where cost overruns are encountered, Option 'C' also provides a mechanism whereby the PSCP and / or the Trust bear some element of an overrun.

Roles and Responsibilities

The Trust have appointed AECOM as client representative project manager to act as the NEC project manager. The Trust will fulfil the role of NHS P21+ project director. Edge Cost Consulting will act as cost managers.

Payment Mechanism

The payment mechanism will be commensurate with the Compliance with Government Prompt Payment Policy. This will be automatically achieved through the use of the P21+ Framework, which sets out the details of how the framework and associated NEC3 project level Contract allow for these policies, including:

- Public Contract Regulations 2015: Public sector buyers must pay prime contractors (Tier 1 suppliers) within 30 days and must ensure that their prime contractor includes equivalent 30-day payment terms in any subcontracts through the supply chain. The P21+ contract requirements include 21-day payment term as standard to ensure subcontractors receive payment within 30 days.
- Late payment of Commercial Debts (interest) Act 1998.
- Contractual mechanisms around payment and payment disputes.
- On-going monitoring of payment performance.

The proposed procurement route via the Procure 21+ framework will mean the majority of works packages (all large packages) will be competitively tendered giving assurances that best value is being delivered, however prelims and risk provisions will be on a negotiated basis; post contract changes also to be negotiated. The client cost managers will negotiate and agree the prelims and provide a value for money report to ensure that the agreed prelims represent value for money.

The contract type means that a target sum agreement is reached between the client and contractor. Any savings achieved by the contractor are shared 50/50 between the Trust and the contractor and any additional costs not covered by agreed changes are borne by the contractor.

During the procurement process a risk register will be developed and risks assigned. As much construction risk as possible will be transferred to the main contractor – inevitably there will be a small number of site / project specific items which will require negotiation ahead of contract execution. Client risk events occurring, or client change, would entitle contractors to additional cost and or programme.

Contract management processes will be in place as standard to monitor and manage cost, programme, change control and quality. This is approached with rigour as standard practice regardless of the procurement route taken.

The KPIs upon which payment will be based are outlined in the table below:

Table 40 Key Performance Indicators

KPI	Description
Safety Management	Supply Chain Partners framework wide accident incidence rate is captured monthly. The number of weeks accident fee for each project is captured.
Cost / Design	Cost predictability is monitored during pre-construction (excl. client changes). The price with value of client variations is compared to the final account value.
Time / Design	Time predictability is monitored during pre-construction (excl. client changes). The planned programme period with client agreed extensions is measured against actual completion period.
Satisfaction	Clients score supply chain partners in relation to service satisfaction
Defect management	Supply Chain Partners ability to deliver projects with zero defects is monitored through the number of defects at project completion
Cost Construction	Cost predictability is monitored during construction (excl. client changes). The price with value of client variations is compared to the final account value.

KPI	Description
Time/ Construction	Cost predictability is monitored during construction (excl. client changes). The planned programme period with client agreed extensions is measured against actual completion period.
Satisfaction / product	Clients score supply chain partners in relation to product satisfaction
Sustainability	12% of the total project value reinvested in Social Value activities. Also measures number of supply chain partners within 30 miles of site.

Social Value

Social value requirements are not part of the Procure 21+ plus contract requirements. Nonetheless, both IHP and the client Trust are committed to using this project to deliver social value benefit in the local community. This will be achieved in three stages:

Develop a Social Value plan

In advance of commencement of site activity IHP will develop a Social Value plan to comply with its business standards and will work with the delivery programme to identify the appropriate opportunities to create the maximum impact in social value terms. For a project of this scale /value IHP will allocate a target of 9 new employment opportunities (1 per £2M construction value) and 238 Apprentice weeks (14 weeks per £1M construction value). New employment opportunities will be available at the commencement of works but apprenticeship opportunities may be more limited due to academic timetables. The plan will identify an overall target to be achieved by the end of construction and also identify when these commitments will be delivered.

Implement the plan

The plan will be reviewed and implemented by the whole site team, including the supply chain, to identify both new employment opportunities and formal training through recognised apprenticeship schemes. All parties are encouraged to invest in apprentices and some of the larger packages of work and key suppliers will have a target set upon them to contribute to the wider scheme objectives. IHP's preference is always to identify local sources of employment as this tends to lead to more successful candidates.

Liaison with local colleges and education providers will identify potential candidates to supplement the established workforce and provide both employment and training opportunities.

Monitor progress and take action accordingly

IHP's site access system automatically monitors personal time on site and by identifying individuals as Apprentices can easily monitor progress against the targets. This provides a real time month-on-month review of progress against targets and allows appropriate action to be taken should the monitoring identify a shortfall in expected progress.

Duration and Break Clauses

The Procure 21+ contract is a bespoke contract based upon the NEC3 Option C Contract. Both process and contract are bespoke to mirror the NHS business case approval process, giving Clients the control mechanisms to ensure their scheme remains on budget at each stage, with break clauses (without penalty) throughout the design and development period. The

framework contract is set and agreed by partnering organisations, and no project specific amendments are permitted.

Change Control

As discussed above, Procure 21+ is based upon an NEC option C contract. The NEC Suite manages changes to the works via a mechanism known as compensation events. These encourage robust and proactive agreement of time, cost and cost of time impacts of a change, within a contractually prescribed time period.

Rapid responses are therefore essential, as delays to making a decision cause the programme to be delayed, resulting in additional cost over and above the cost of any actual instructed change. The NEC Project Manager (in consultation with the construction Project Director) will therefore benefit from clearly defined delegations of authority to make such decisions.

The contractor and the client can raise a compensation event. For example, if the contractor were to discover adverse ground conditions and it is was a client risk, they would notify the client of an upcoming compensation event. Nonetheless they would be contractually obliged to mitigate delay and costs as best they can.

Client requested changes will flow through a Change Request process, with the requestor having to make a justification for the change. The NEC Suite allows for such change, via a process known as “proposed compensation events”, whereby the contractor is asked to provide cost and programme impacts for the anticipated changes. Subject to the clarity of the change, this cost and programme impact is then binding, once accepted and implemented by the Project Manager. Outside of the NEC contractor the Trust and client project manager will establish a review and approval process which may require project board approval.

All change requests will be registered in a change management log, along with the decision reached and rationale for that decision. This is intended to reduce the potential for repeated requests for the same change, but also provides an opportunity to review previous decisions if the project context changes and a key constraint informing the decision is impacted.

The NEC3 contract process encourages and makes contractually binding, good contract management practice. Substantial resources are required to proactively manage and agree time and cost impacts and secure the appropriate quality in the works delivery. These are identified in the management structure provided in section 6.3.2. As such both the client and contractor project teams should be resourced to provide this service effectively.

Legal and contract issues

The Trust is in the process of reviewing and updating existing lease information for Nottinghamshire Healthcare NHS Foundation Trust to ensure it reflects the new provision of space delivered by the BEV project. Engagement has taken place with the Nottinghamshire Healthcare NHS Foundation Trust to date and no issues are expected with this amendment process.

4.5 Risk Management

The objective of the risk management process is to enable ongoing and proactive dentification, assessment and mitigation of project risks. Risk management is an essential part of the development of any project. A Risk Register for the project can be found at Appendix M8. These risks have been established throughout the project to date and are regularly reviewed by the Project Team in risk workshops. Overall risk status is reported monthly to the Project Board. Current and target risk levels, mitigations and review dates are updated on the Register as information becomes available and the project progresses.

The economic modelling contains quantification of risk at a more granular level, which contributes to the CIA model.

The Risk Management strategy for the scheme incorporates the following activities:

- Identifying possible risks at an early stage, allowing minimisation or mitigation to be put in place. Risks can be raised at any time during the project.
- Mitigation measures are recorded via the Risk Register; and reported on at the risk workshops. Key actions and measures are reported on at the monthly progress meeting.
- Allocating individuals responsible for each risk and a timeframe for review.
- Decision making process supported by risk evaluation, with oversight from the Project Board via monthly Board meetings.
- Edge and IHP cost consultants will quantify, where appropriate, the potential cost implications of each risk.

The Risk Register will continue to be further developed, maintained and reviewed by the Project Team during the next phases of the project, from commencement of the FBC through to construction and operational commissioning. The Risk Register will be regularly reviewed to maintain tight project control and ensure new potential risks and mitigations are registered and actioned in a timely way. This includes continued monthly escalation of risk and reporting of risk status to the Project Board.

4.5.1 Risk Transfer

The Risk Register is a live document and is critical to the NEC process. During the tender phase, risks will be allocated to parties, which will impact on the agreed contract price.

All risks will be assessed and quantified, the project team will agree which party is best placed to own and manage that risk. This will also give the Trust the opportunity to assign risk to the contracting organisation; albeit this will increase the cost of the agreed guaranteed maximum price. The proposed risk transfer is as below:

Table 41 Risk Transfer Matrix

Risk Category	Potential allocation		
	Trust	PSCP	Shared
1. Design risk		✓	
2. Construction and development risk		✓	

Risk Category	Potential allocation		
	Trust	PSCP	Shared
3. Transition and implementation risk		✓	
4. Availability and performance risk		✓	
5. Operating risk	✓		
6. Variability of revenue risks	✓		
7. Termination risks			✓
8. Technology and obsolescence risks			✓
9. Control risks	✓		
10. Residual value risks	✓		
11. Financing risks	✓		
12. Legislative risks			✓

The above Risk Matrix will be reviewed at key milestones and gateways.

4.6 Personnel Implications

TUPE –the Transfer of Undertakings (Protection of Employment) Regulations 1981 –will not apply to this investment as there is no transfer of a business, or part of a business, between employing entities.

4.7 Design Specific Information

4.7.1 Design Process

The project team have developed a demand and Capacity Modelling, Schedule of Accommodation, Clinical Brief and 1:200 design using the below methods with clinical, operational, estates and design stakeholders' involvement. These documents have been signed off by relevant Trust key stakeholders, see Appendix C3 for the sign off sheet.

Demand and Capacity Modelling

In order to develop a fit for purpose Emergency Village that meets the demand for now and the future the Trust undertook demand and capacity modelling, described in section 2.9.4. The demand and capacity modelling slides (see Appendix S16) denote the assumptions that were made during the modelling stage to determine the capacity required to meet the demand / activity that is projected for the facility. The modelling has reviewed demand between 2016 – 2021 and takes account of the impact of the pandemic. Drafts of this document have been shared with clinical leads, steering group members and project board members in the form of workshops and written copies to review. Following these reviews updates have been made to ensure the modelling is a true representation of activity. The end result of the demand and capacity modelling is a list of required functional content, essentially a call-off sheet for how

many clinically functional spaces are required for each sub-department. For example, the functional content for the emergency department would include the number of Majors, Minors, Mental Health and Resus rooms. This is used to inform the schedule of accommodation.

Schedule of Accommodation and Schedule of Derogations

The SOA is a detailed list of each room required within the proposed facility. It considers the functional content, identified through the demand and capacity modelling, and provides sizes for those functional spaces based on current guidance. It also includes all of the support spaces required to compliment the functional spaces. The SOA provides the initial brief for the design development. The SOA is an iterative process that is revised to suit specific departmental decisions and local requirements. The SOA includes fifteen different versions, these versions show the history of the scheme's development over time. Version 9 has been developed by a healthcare planner and meets the Health Building Notes (HBNs), Health Technical Memorandum (HTMs) in line with the Demand & Capacity Modelling. Versions ten to fifteen have been developed in line with project constraints and to meet the needs of Trust instructions. The SOA can be found at Appendices C4 and C5..

A Schedule of Derogation has been produced which highlights how the design has deviated away from the HBN and HTM SOA due to site constraints and Trust instruction. The Schedule of Derogation can be found at Appendix C6.

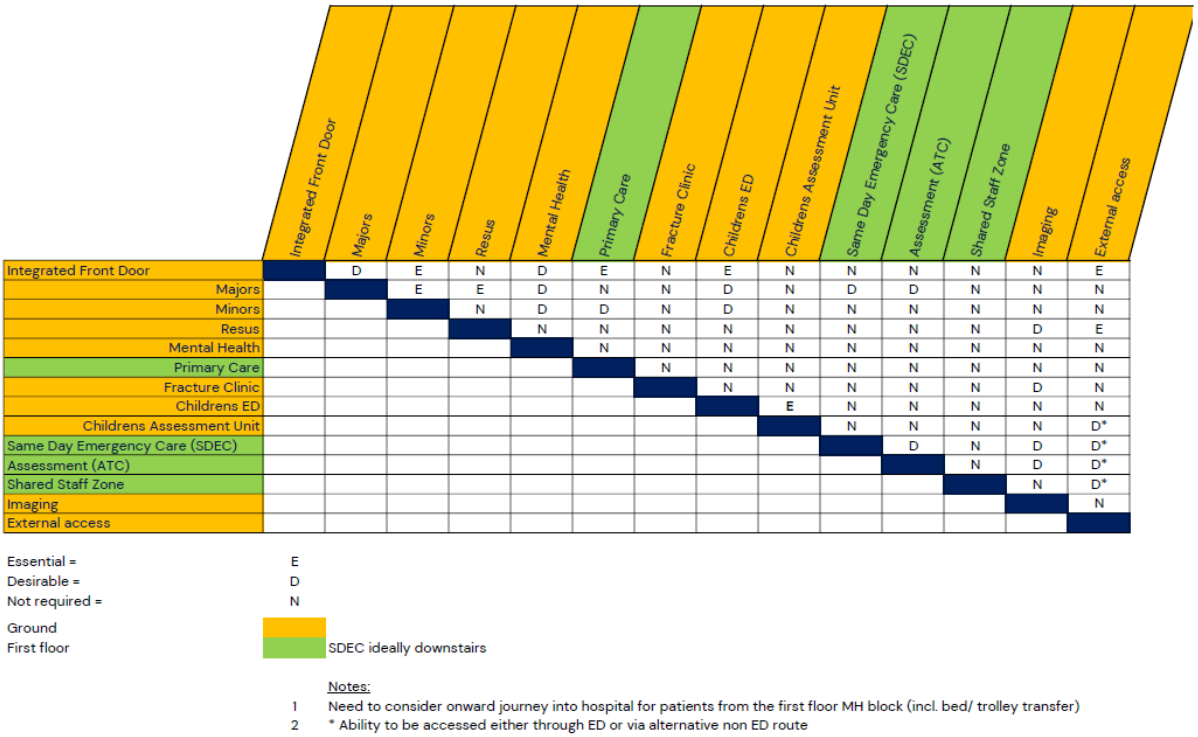
Clinical Brief

The clinical brief is a written description of each service and how it works, including the types of patients that are seen, patient journey, accommodation provision, activity indicators, and specific design and environmental requirements. The clinical brief is informed by the SOA and model of care discussions with the clinical teams. The Clinical Brief can be found at Appendix C7.

Adjacency Diagram Matrix

As part of the development of the 1:200 and other design documents the clinical lead developed the below adjacency diagram which indicates how services should be collocated for effective working.

Figure 22 Adjacency Diagram Matrix



	Integrated Front Door	Majors	Minors	Resus	Mental Health	Primary Care	Fracture Clinic	Childrens ED	Childrens Assessment Unit	Same Day Emergency Care (SDEC)	Assessment (ATC)	Shared Staff Zone	Imaging	External access
Integrated Front Door		D	E	N	D	E	N	E	N	N	N	N	N	E
Majors			E	E	D	N	N	D	N	D	D	N	N	N
Minors				N	D	D	N	D	N	N	N	N	N	N
Resus					N	N	N	N	N	N	N	N	D	E
Mental Health						N	N	N	N	N	N	N	N	N
Primary Care							N	N	N	N	N	N	N	N
Fracture Clinic								N	N	N	N	N	D	N
Childrens ED									E	N	N	N	N	N
Childrens Assessment Unit										N	N	N	N	D*
Same Day Emergency Care (SDEC)											D	N	D	D*
Assessment (ATC)												N	D	D*
Shared Staff Zone													N	D*
Imaging														N
External access														

Essential = E
Desirable = D
Not required = N

Ground
First floor — SDEC ideally downstairs

Notes:
1 Need to consider onward journey into hospital for patients from the first floor MH block (incl. bed/ trolley transfer)
2 * Ability to be accessed either through ED or via alternative non ED route

Drawings

A 1:200 drawing has been produced (Appendix C8) which provides the loose fit initial design and is a visual representation of the schedule of accommodation and the clinical brief. It shows which rooms are next to each other and allows the clinical teams to visualise the space of their department. The drawing has been developed with the involvement of clinicians, fire safety, infection control and ambulance leads to ensure that the design is compliant and suitable for use, it has taken into consideration patient flow, patient pathways, operations of the developments and colocation. The drawing has been through an iterative process that is revised during a series of design workshops with the clinical teams.

Security

The new development will be part of the Bassetlaw Hospital site therefore will benefit from the site wider security measures.

As part of the design process the design team have included methods of safeguarding and security measures to ensure patient safety, these will be further developed as the design process progresses. The key security measures have been included below:

- Co-location of a safeguarding suite for Children's ED and CAU.
- Secondary escape route in the mental health room.
- Direct route to Children's ED which avoids Adults ED.
- Protective barriers on the Children's outdoor play area.
- Discreet entrances.

4.7.2 Clinical Model

In order to address the problems described in the Case for Change, the new clinical model reconfigures services so that:

1. Patients are triaged at the front door and streamed to the most appropriate service for their needs;
2. The currently fragmented U&EC services are brought together in one place, a modern 'emergency village', to transform the patient journey, increase flexibility, achieve critical mass and ensure efficient use of the workforce.

The new patient pathway is illustrated in the figure below.

Figure 23: New Adult Patient Pathway for U&EC Services

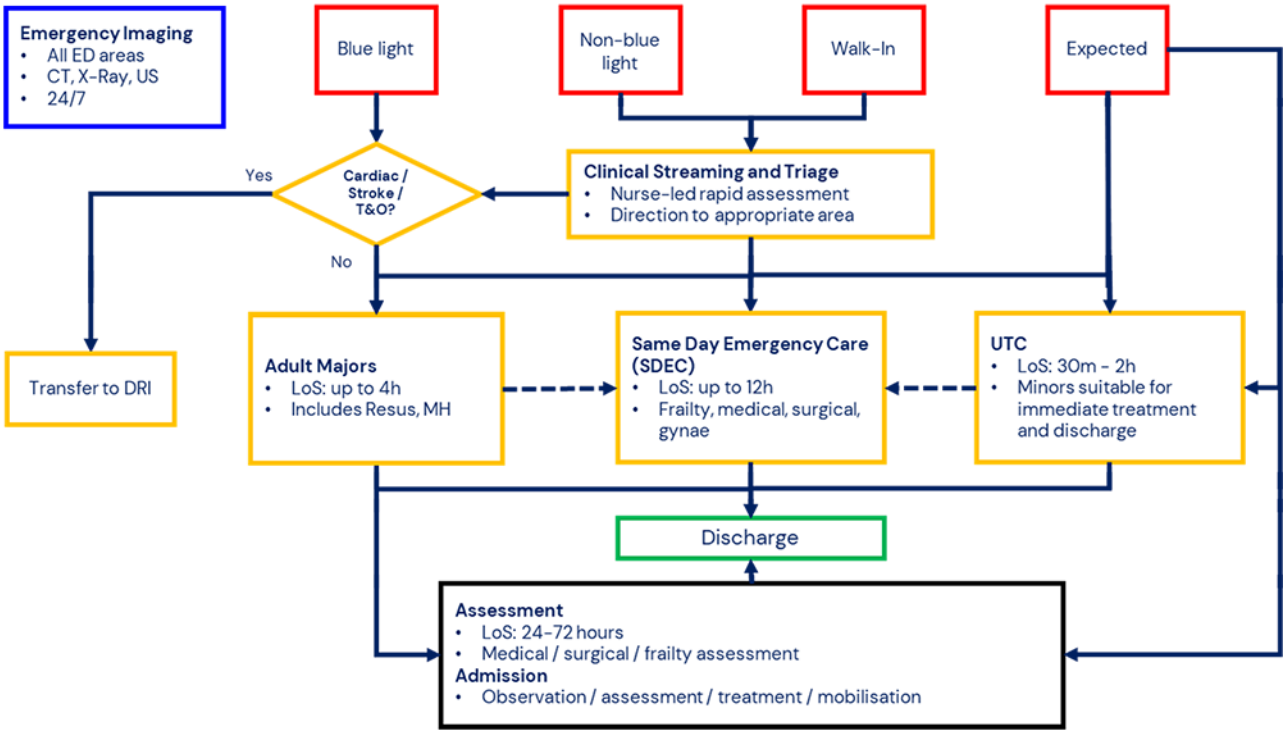
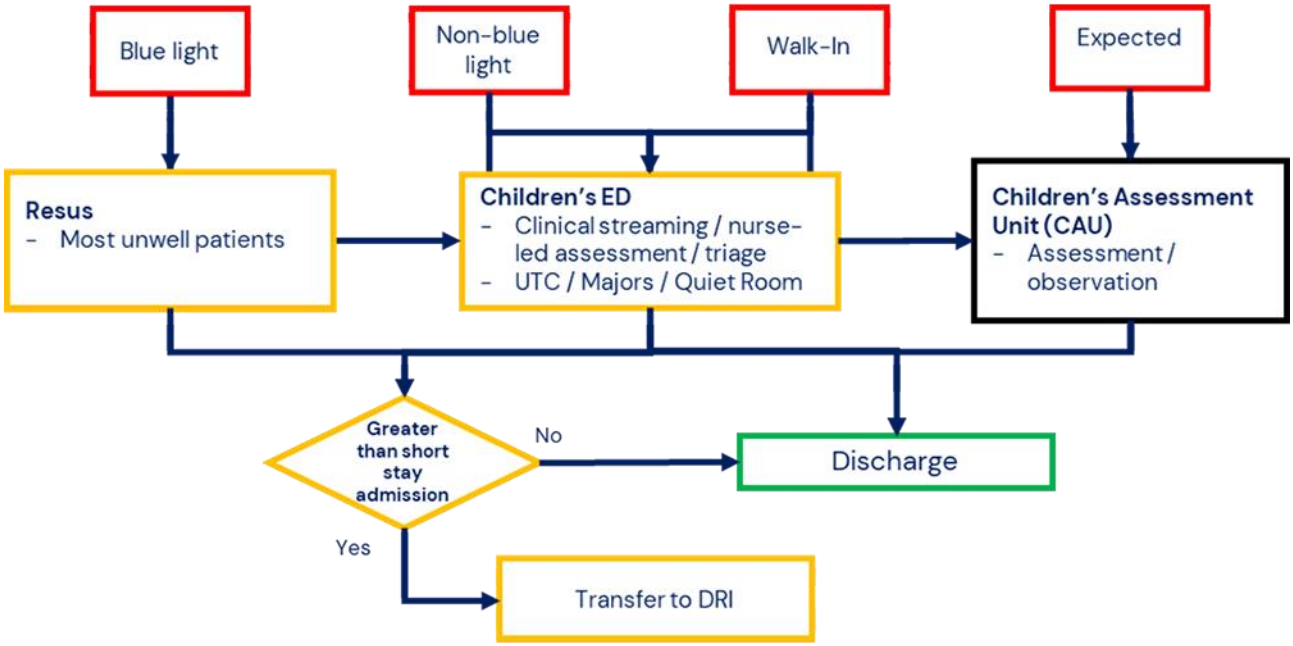


Figure 24 Children's Pathway Model



The aims of the new model are as follows:

- Ambulant emergency patients will be streamed, assessed and treated by the right staff as soon as possible thanks to a holistic vision of urgent and emergency care services, backed up with right-sized and appropriately configured facilities.
- Staff roles will be transformed as part of the Trust's workforce transformation plan (currently in development), ensuring effective partnership working with primary and social care staff.
- A greater proportion of patients suitable for ambulatory emergency care will now receive it, thanks to easier access to dedicated and improved ambulatory emergency care facilities as an integral part of the emergency village; meeting the same day emergency centre targets.
- This will reduce the volume of patients requiring in-patient admission and ease pressure on the inpatient bed stock, as well as returning patients to their homes earlier.
- Both adult and paediatric patients requiring same day emergency care will receive it within a dedicated Same Day Emergency Centre co-located with the urgent and emergency care services, in line with best practice.

Further information on the clinical model and design can be found in the Design Commentary (see Appendix C9) and the Clinical Design Brief (see Appendix C7).

4.7.3 Land Transactions – Acquisitions/Disposals

There are no land transactions included as part of this project due to the fact that:

- The land and buildings on / in which the scheme will be delivered are owned by the Trust.
- All enabling works will take place on Trust-owned and occupied land.

- The scheme is not vacating a stand-alone building or section of a building that could be partitioned off from the main site and disposed of.

There are no acquisitions or disposals associated with the development.

4.7.4 Design Quality Indicator

Design Quality Indicator for Health (DQIfH) was developed by the Construction Industry Council (CIC), as a design quality evaluation tool for all types of healthcare projects whether new or refurbishment. DQIfH is designed to follow the NHS' business case process through Strategic Outline Case, Outline Business Case, Full Business Case, Construction and Post Occupancy Evaluation. A DQI assessment will be complete at FBC stage.

4.7.5 Government Construction Strategy

The Government Construction Strategy (GCS) 2016-20 sets out the Government's plan to develop its capability as a construction client and act as an exemplary client across the industry, GCS 2016-20 builds on the success GCS 2011-15 and will help departments meet the challenges of inflationary pressure in a rising market by driving increased construction productivity. The GCS 2016-20 will assess and improve the functional capacity of central government as a client and improve the understanding of the stages in programmes where efficiencies can be achieved. GCS 2016-20 will also further embed the practices developed under GCS 2011-15.

The Government Construction Strategy has been considered fully as part of the procurement review in order to maximise the benefit to the Trust and the Procurement Strategy has been developed with a key driver to obtain the best possible value for money.

The table below identifies the principal objectives of GCS 2016-20 and describes how the Trust and the new scheme specifically are addressing them.

Table 42 How the Scheme Meets Government Construction Strategy Objectives

Strategy Objective	How the Trust/scheme is meeting the objective
Improve central government's capability as a construction client	The scheme is being procured through Procure 21+ which is fully consistent with government policy including the Productivity and Efficiency Agenda, PCR15, the National Audit Office guidance on centralised frameworks, and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector
Embed and increase the use of digital technology, including the use of digital technology, including Building Information Modelling (BIM) Level 2.	The plan for embedding digital technology within the emergency village is being developed and will be available at FBC (see section 2.7.7). BIM is being managed by IHP using Viewpoint as the software solution for a common data environment and for holding project documentation
Deploy collaborative procurement techniques that: Enable early contractor and supply chain involvement;	The scheme has adopted ProCure 21+, which is a collaborative procurement approach in which the PSCP contributes to the early development of the design solution. There is particular focus on risk and value management to ensure that an optimum solution is achieved that delivers value for money.

Develop skills capacity and capability, including by delivering 20,000 apprenticeships through central government procurement over this Parliament; Promote fair payment.	Competitive tenders will be obtained for sub-contracted packages (eg groundworks, frame, envelope, windows etc). An independent cost adviser will compare costs with benchmarked cost data and provide a statement of value for money to the client prior to instruction. The payment mechanism will comply with the Government Prompt Payment Policy. IHP, the PSCP for this scheme, has a strong local presence and they have already begun to engage local supply chains particularly with regard to labour. They have committed to providing 238 apprentice weeks for the project, and 9 new job opportunities (see section 4.4.5.4 for details). IHP have developed a Government Soft Landings plan and engaged a commissioning agent to develop a commissioning plan and lead on commissioning and handover.
Enable and drive whole-life approaches to cost and carbon reduction across the construction, operation and maintenance of public sector buildings and infrastructure	The project team have considered a variety of MMC construction methodologies. Volumetric modular construction was investigated in detail by both IHP and the Trust. A modular provider was engaged to provide a proposed design based on the OBC design, along with a programme and cost plan. Other offsite construction systems are also being considered and will be included within the final design, such as: modularised MEP equipment and service risers as well as panelised external walls

The GCS 2016-2020 has delivered £1.7 billion of efficiencies by departments achieving improvements in efficiency and capability. The Transforming Infrastructure Performance (TIP): Roadmap to 2030 succeeds the GCS and will sit alongside the Construction Playbook and the National Infrastructure Strategy.

It will end what is seen as an artificial separation between infrastructure and construction and articulate a consistent shared vision for the future of the built environment, including the role that the government plays through its construction projects.

4.7.6 Healthcare Planning

Work was undertaken by the specialist consultancy firm, Archus, to look at current and future models of care, section 4.7.2 and activity levels, section 2.9.4 and how this would impact on the future capacity requirements. As part of the development of the Functional Content Brief was developed Appendix C7, Archus reviewed and updated the capacity requirements for the scheme and developed a HBN/HTM compliant SOA. Further information on this can be found at Appendix C7 Clinical Brief.

4.7.7 DH Consumerism

The design solution for the scheme complies with best practice in accordance with HBN 03-01 except where stated in the derogation schedule, found at Appendix C6.

The design achieves a level of privacy and dignity for patients, whilst ensuring that staff have excellent visibility at all times.

Facilities for families and carers include a family room and beverage area, interview room and WC adjacent to the resus and majors areas. There are also family areas in the CAU.

The needs of children are taken into account through the provision of a covered external play area in the courtyard garden adjacent to the children's assessment unit.

The existing building refurbishment will greatly improve the quality of existing space and its energy efficiency in terms of fabric and M&E systems.

The function of the Emergency Village is primarily to protect and treat vulnerable patients and to provide appropriate levels of privacy and dignity when they are at their most vulnerable. For this reason, there are limited options to provide standard windows. The design must instead look for opportunities to admit daylight without compromising privacy and dignity and this will be achieved by the use of frosted or etched glazing to windows. Functionally the spaces will be predominantly mechanically ventilated so windows will be fixed and non-openable.

4.7.8 HBN and HTM

The 1:200 designs have been developed in accordance with all relevant NHS standards, including HTM, HBN, Firecode and BREEAM compliance and Infection Control approach.

4.7.9 Building Research Establishment Environmental Assessment Methodology (BREEAM)

The BREEAM (Building Research Establishment Environmental Assessment Methodology), first published in 1990, is the leading and most widely used environmental assessment method for buildings and communities. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance. The Department of Health and Social Care requires schemes with a value in excess of £2m (>500m²) to achieve minimum BREEAM 'Excellent' rating for new builds or 'Very Good' rating for refurbishments.

The scheme is subject to two separate BREEAM assessments: one for the new build element and a second for the refurbished areas. The BREEAM Pre-Assessments in Appendices C13 and C14 show that the scheme is on target to achieve the required ratings.

4.7.10 Firecode

The development of the fire strategy for the new development has been based on best practice and the Department of Health requirements for the relevant Fire Codes and relevant HTM. The Fire Strategy for the scheme complies with HTM 05 and will be further reviewed at FBC during the 1:50 design process. A letter confirming compliance at this stage can be found in Appendix C10.

4.7.11 Infection Control

The proposed new healthcare facilities will be designed and configured in compliance with HBN and HTM guidance to provide clean, well designed environments within which clinical services and procedures can be carried out safely. Infection prevention and control measures have been designed into the new building through zoning, with appropriate clinical adjacencies to facilitate clean to dirty flows and the provision of good access for cleaning and

maintenance to take place. Effective ventilation in line with HTM 04-01 is a necessary requirement in a healthcare landscape where COVID-19 has become endemic.

As planned for the design development at OBC stage, the clinical leads have been fully engaged to ensure the needs of users are understood and clearly articulated in the design brief. The Trust's Infection Prevention and Control Team has also been engaged by the Programme Group to inform the detailed designs.

A letter confirming compliance at this stage can be found in Appendix C11.

4.7.12 Resilience

HBN 00-07 provides guidance for NHS-funded providers on designing and planning for a resilient healthcare estate. It aims to help NHS-funded providers to determine appropriate levels of resilience for sites, buildings and installations against a wide range of emergencies, hazards and threats and their impacts and consequences. The guidance focuses on:

- The strategic approach to resilience planning for healthcare estates;
- Procuring resilient healthcare estates;
- Design and planning considerations for a resilient healthcare estate;
- Resilience of building services engineering;

The design and planning of the scheme has been developed in accordance with the guidance contained in HBN 00-07.

4.7.13 Travel Plan

The Travel Plan is currently in development and will be included at FBC stage.

4.7.14 Planning Permission

A request for pre-application advice was submitted to Bassetlaw District Council in June 2022 (see Appendix C12 for confirmation of receipt). The design team is currently awaiting the Council's response. Further updates will be provided in the FBC.

4.7.15 P21+ Assurance

Through all stages of the P21+ process the requirements set out in the ProCure 21+ guide have been followed. The Trust have employed an experienced P21+ project manager to support the project throughout the entire process.

4.8 Modern Methods of Construction

Modern Methods of Construction (MMC) is a wide term, embracing a range of off-site manufacturing and on-site techniques that provide alternatives to traditional building and forms part of the Government's recent policy (2019) for future construction in the public sector. The projects MMC allocation is 71%.

In addition to enabling a reduced on-site component assemble time, due to off-site factory production to a pre-agreed quality standard, MMC also reduces the size of on-site

construction teams, disruption to site, health and safety risk and post-completion defects. MMC can also help in overcoming a skills shortage in the construction industry and should also result in a reduction in project time and cost whilst improving quality throughout the whole of an asset's life.

The P21+ MMC Percentage Utilisation Tool is being used on the project, which includes CIRIA Category 0 Briefing, Scoping and Design to include:

- Standard models of care, schedules of accommodation and layouts;
- Standard grid/storey heights/platforms (e.g. CIH Platform);
- Re-using existing proven project designs (P21+ Project Share makes these available royalty free);
- P21+ Repeatable Room designs;
- P21+ Standard Components & Assemblies.

The government's Infrastructure and Projects Authority (IPA) guidance 'Transforming Infrastructure Performance' (2017) also refers to MMC as 'smart construction' defined under the following three categories which cover a range of techniques with greater levels of activity taking place off site and increased levels of standardisation, underpinned by digital design and engineering.

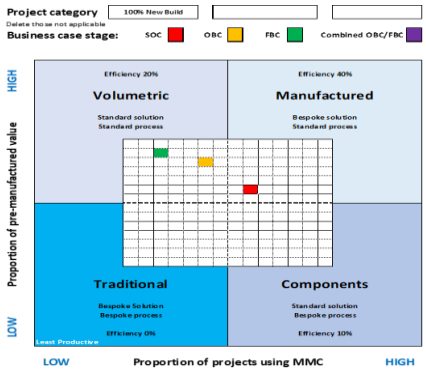
- **Manufactured**: whilst not widely used this offers the greatest opportunity to improve delivery efficiency and boost productivity. This approach enables high levels of customisation by developing and using standard components and assemblies.
- **Volumetric**: for example, fully fitted modules.
- **Components**: for example, standardised design elements (WC/shower 'pods', pre-assembled bed head services etc).

In addition, there is traditional construction: for example, methods that are relatively unproductive, with projects individually designed and constructed with little consistency in either the design solution or construction method, even for similar projects.

The table below presents the outcomes of the MMC assessments:

Table 43 MMC Project Outcomes

#	Heading	Requirement
1	New build GIA/m2	1,572m2
1a	Major refurbishment GIA/m2 (<90% > 65% of new build project average cost £m2/GIA)	1,100/m2
1b	Other refurbishment GIA/m2 (<65% of new build project average cost £m2/GIA)	679/m2
Total project GIA/m2		
2	New build total estimated outturn cost excluding VAT and inflation	£9,919,926
2a	Major refurbishment total estimated outturn cost excluding VAT and inflation	£3,900,933
2b	Other refurbishment estimated outturn cost excluding VAT and inflation	£622,832
Total project estimated outturn cost excluding VAT		

#	Heading	Requirement
3	Which of the following is the trust currently considering and for how much of the total project GIA/m2 and estimated outturn cost excluding VAT and inflation?	
3a	Volumetric	278m2 (£787,296)
3b	Manufactured	3,073/m2 (£7,643,696)
3c	Component	3,073/m2 (1,754,053)
3d	Traditional	3,073/m2 (£4,258,645)
4	What is the likely option or what is the agreed option for procuring these works? The business case will require additional details in the Commercial Case as described the NHSEI Business Case Checklist https://improvement.nhs.uk/documents/459/NHSI_Capital_Regime_Investment_Annex_1_-_V5_final.docx	
4a	Pre-tendered framework:	Use of the Procure 21+ Framework with the appointed PSCP, Integrated Health Projects
4b	Other procurement process:	Details in brief
5	Are the current designs considered to be standardised / repeatable	Yes
5b	If 'Yes' to # 5 provide details of which other NHS organisations have used these designs and when	Use of P21+ repeatable rooms for consult exam rooms, and designs utilised from the North Lincs and Goole NHS Emergency Department schemes at Grimsby and Scunthorpe that the appointed architect, P+HS are working on.
5c	If 'No' to # 5 provide details why 'MMC' options are not being considered and where in the business case there is evidence to support this	Details in brief
6	Trust are required to complete an updated version of the MMC tracker (attached) at each business case stage 	DBTH BECV - MMC Tracker.xlsx

4.8.1 Repeatable Rooms

The proposed drawings and design are based on best practice guidance and clinical and estates engagement. The design has been developed to 1.200 with agreed key adjacencies, room spatial requirements and the totality of accommodation required to meet the clinical brief and operational model.

Technical and design compliance is ongoing throughout all stages of the design and during FBC stages there will be a greater understanding of any derogations that may be required. Where new accommodation (the extension) the target will be full compliance in the design and specification to meet HTM and HBN requirements. Majors and minors cubicles are standardised in their size and content to allow for maximum flexibility in use and familiarity for staff. Where existing accommodation is refurbished and reconfigured, there will be a mixture of major refurbishment, minor refurbishment and redecoration and therefore the level of compliance will vary depending on the nature of works in each area.

The BEV design is based on the SOA (see Appendix C4) and all area differences are denoted on an as drawn SoA (see Appendix C5). The project will be submitted for Planning Approval and Building Regulations approval and therefore will provide compliance with local and national guidelines.

Relevant HBN/HTM guidance that has been reviewed and will continue to be reviewed as part of the ongoing design development are:

- HBN 15-01 Planning and Designing Access and Emergency Departments
- HBN 15-02 Facilities for same day emergency care
- HBN 23 Designing hospital accommodation for children
- HBN 00-09 Infection Control in the built environment
- HBN 00-02 Sanitary Spaces
- HBN 00-04 Designing stairways lifts and corridors in healthcare buildings
- HBN 04-01 Adult in-patient facilities: planning and design
- HBN 11-01 Primary and Community Care
- HTM 05-02 Fire Safety in the design of healthcare premises.

As project is being delivered via P21+ will also review any recommendations from the P21+ suite of documents including (where appropriate) repeatable rooms and standardised approved specifications.

4.8.2 Standard Components

Each repeatable room has a list of standard components that are provided.

4.9 Estates and Facilities Management Targets

A number of estates and facilities management targets have been set specifically for this scheme which are referenced below.

4.9.1 Space

The Carter report indicated that floor space used for non-clinical purposes should not exceed 35%. The scheme achieves this because all floor space is 100% clinical. There is no space for corporate services or space for services not associated with the delivery of urgent and emergency clinical care.

4.9.2 Efficiency

There are improved efficiencies in the building due to the design. A single entrance provides greater efficiencies and improved patient outcomes. A key consideration in the design is the flow of patients and the ability to stream patients from an 'Integrated Front Door' to all areas of the emergency village. The design where possible minimises travel distances for patients and provides excellent visibility and flow for staff managing patients from entrance and reception through to triage, assessment and treatment and, where required, continued monitoring and observation. The benefit of the emergency village concept lies in the many specialities and expertise located in close proximity to one another therefore the layout must support this activity.

The existing building refurbishment will greatly improve the quality of existing space and its energy efficiency in terms of fabric and M&E systems.

4.9.3 Ongoing Maintenance

The condition of estate will be maintained over the long term via the in-house estates team who will provide ongoing maintenance.

4.9.4 Energy and Sustainability Targets

Climate change is recognised as a serious risk to health and wellbeing and the NHS Sustainable Development Unit expects all new builds to gain a Building Research Establishment Environmental Assessment Method (BREEAM) "Excellent" rating, which is the second highest rating possible.

BREEAM sets standards for the environmental performance of buildings through the design, specification, construction and operation phases and can be applied to new developments or refurbishment schemes. Performance is assessed in relation to the procurement, design, construction and operation of a development against a range of targets based on performance benchmarks, with a focus on sustainable value: energy, land use and ecology, water, health and wellbeing, pollution, transport, materials and waste management.

The Trust is targeting a BREEAM 'Excellent' rating in the new build facilities. The sustainability of the proposed new building has been considered in the following ways:

- Aiming to reduce operational energy to RIBA 2030 targets.
- Taking a whole life cycle cost approach.
- Minimum removal of site spoil to landfill by working with site levels to avoid bulk off-site materials removal.
- Preferential selection of materials with responsible product stewardship through a sustainable procurement plan.

- Using construction methods that will reduce site waste.
- Low use of Volatile Organic Compound materials.
- Maximum substitution of cement with up to 30% Pulverised Fuel Ash (PFA) or up to 90% Ground Granulated Blast-furnace Slag (GGBS).
- Use of recycled materials where possible
- Reduction of waste and resources required through resource efficiency workshops.
- Looking at reducing the embodied carbon of materials and systems chosen though lifecycle assessment.
- Low energy light fittings.
- Water efficient sanitary fittings.
- Use of carbon reduction strategies such as good employment of passive design principles, to achieve 'near to zero' net carbon emissions.
- Responsible management of construction.
- Allowing for post occupancy input from the design team (soft landings approach).
- Targeting net biodiversity improvement on the site.
- The construction contractors to demonstrate how they will aim to use a local workforce and small and medium size enterprises.

4.9.5 Sustainability considerations and Net Zero Carbon

Doncaster and Bassetlaw Teaching Hospital Trust is committed to the NHS's Net Zero Carbon ambitions as set out in the Greener NHS programme. The Trust has produced its own Green Plan detailing how it will take a more sustainable approach in its activities (see Appendix S5 'The DBTH Green Plan – Our sustainable path to Net Zero'). The new facilities have been based on the principles of sustainable design and the Trust is aiming to achieve a BREEAM rating of Excellent for the new build element of the scheme (see Appendix C13).

5 Financial Case

5.1 Introduction

The purpose of the financial case is to outline the financial implications of the preferred option and assess affordability. As such it sets out the capital requirements and revenue consequences of the proposed scheme, along with underpinning assumptions. It outlines anticipated funding arrangements and presents the impact on the overall financial statements.

As outlined in the Economic Case, the preferred option involves refurbishing and extending the Mental Health building to create the proposed Bassetlaw Emergency Care Village.

5.2 Capital Requirements

5.2.1 Initial capital costs

It is anticipated that delivery of the preferred option will require capital investment of £17.89m. This has been estimated by the Trust's Cost Advisors, Edge, based on the following main assumptions:

- Schedules of Accommodation and 1:200 drawings in accordance with the level of design required at OBC stage.
- Works costs calculated using Healthcare Premises Cost Guide @ PUBSEC 281 and 100 Location.
- Allowances for fees, equipment costs, planning contingency and optimism bias have been applied as appropriate.
- Standard rate VAT of 20% has been included on all project expenditure with the exception of fees which are zero rated. No VAT recovery on the works costs has been included at this stage. Further advice will be taken from the Trust's VAT advisors at FBC stage.

A copy of the capital cost plan is provided in Appendix E4 and a summary provided in the table below.

Table 44: Capital Costs

	Net £'000	VAT £'000	Total £'000
Construction Costs	10,628	2,126	12,754
Project Fees	771		771
Non-Works Costs	150	30	180
Equipment Costs	886	177	1,063
Planning Contingency	695	139	834
Subtotal	**13,131**	**2,472**	**15,602**
Optimism Bias	1,313	263	1,576
Subtotal	**14,444**	**2,734**	**17,178**

	Net £'000	VAT £'000	Total £'000
Inflation start on site	411	82	493
Inflation to mid-point	257	51	308
Total	**15,112**	**2,868**	**17,980**

5.2.2 Capital funding

It is anticipated that the £17.98m capital will be funded as follows:

- £17.605m provided through Wave 4 STP funding as outlined in the original SOC.
- £0.393m self-financed by the Trust including:
  - £0.186m funded as part of the Trust's wider Mental Health scheme, specifically in this case to provide appropriate Mental Health spaces in ED
  - Work is underway to explore options to fund the remaining £0.207m, such as value engineering to reduce costs as the design of the project matures.

Table 45 Capital Funding Analysis

	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	TOTAL £'000
Funding source:					
Other - Wave 4 STP Funding	1,194	15,955	457		17,605
Trust self-finance - Mental Health Scheme			168		168
Trust self-finance - Other Funding Source			207		207
Total Funding	**1,194**	**15,955**	**832**	**0**	**17,980**
Application of funding:					
Construction Costs	706	9,431	492	0	10,628
Project Fees	51	685	36	0	771
Non-Works Costs	10	133	7	0	150
Equipment Costs	59	786	41	0	886
Planning Contingency	46	617	32	0	695
Optimism Bias	87	1,165	61	0	1,313
VAT	182	2,426	126	0	2,734
Inflation start on site	33	438	23	0	493
Inflation to mid-point	20	274	14	0	308
Total Costs	**1,194**	**15,955**	**832**	**0**	**17,980**
Source less Application	**0**	**0**	**0**	**0**	**0**

5.2.3 Contingency planning

In common with all current schemes, market volatility and price inflation continue to pose a risk to the cost envelope. The Project Board has put in place measures to mitigate this as far as possible. Capital costs include a reasonable contingency for risk based on the costed risk register provided in Appendix M8 and optimism bias calculation provided in Appendix E3. They are based on the schedule of accommodation and design requirements which have been signed off by key stakeholders. A robust change control process is in place to ensure the scope of the design is tightly managed.

5.3 Revenue costs

5.3.1 Non-recurring revenue costs

It is anticipated that transitional costs of £48,515 will be incurred as a result of the moves required to deliver the preferred option.

5.3.2 Recurring revenue costs

Recurring revenue costs have been estimated based on the following:

- Baseline current pay and non-pay costs associated with the ED and ATC teams based on 2022/23 budgets.
- Building running costs based on average cost per m2 from the Trust's 2020/21 ERIC data, uplifted to 2022/23 price base.
- Any efficiencies associated with delivery of new facilities and enablement of the proposed clinical model are considered within the Cash Releasing Benefits section below.

The resulting recurring revenue costs estimates are summarised in the table below.

Table 46 Recurring Revenue Costs

	BAU £'000	Preferred £'000	Incremental £'000
Pay Costs	10,924	10,924	0
Non-Pay Costs	951	951	0
Clinical services	**11,874**	**11,874**	**0**
Cleaning	76	102	27
Utilities	80	109	29
Total FM Costs	246	333	88
Building running costs	**402**	**545**	**143**
Total revenue costs	**12,276**	**12,419**	**143**

5.3.3 Capital charges

Capital charges have been estimated based on:

- A valuation from Cushman and Wakefield, which is provided in Appendix F2, estimates that when the asset comes into use its value will be £12,781,503, resulting in an impairment of £4,135,137.
- At the end of the asset life, it is estimated that the residual value of the building will be £7,430,660.
- Depreciation charges are applied based on straight line depreciation using the following standard useful life:
  - Buildings – 60 years, equating to £89k p.a.
  - Equipment – 10 years, equating to £106k p.a.

- Public Dividend Capital (PDC) dividend payments are calculated using the average cost of net relevant assets each year at the current standard 3.5% rate of return until it is repaid.

5.3.4 Cash Releasing Benefits

Cash releasing benefits of £683k p.a. have been identified based on the assumptions in the table below.

Table 47 Cash Releasing Benefits

Output	Outcome	Assumptions	Cash Releasing Benefits
CAU Overnight	**Fewer children transferred to DRI**	The SOC identified that, as a result of fewer transfers, the service provided by a dedicated PDC crew will no longer be required. Based on 2021/22 activity data it is estimated that this relates to 216 transfers p.a.	**£94k p.a.** DBTH Cost Saving based on 2022/23 costs
Improved adjacencies between ED and ATC	**Rota efficiencies**	The SOC identified that the improved adjacencies will enable more integrated ways of working and reduce rota requirements between ED and ATC as follows: Medical – 1 WTE per shift Nursing – 1 WTE per shift Porters – 0.3 WTE overall	**£575k p.a.** Based on 2022/23 average pay costs
Design efficiencies	**Energy efficiencies**	Based on 2020/21 ERIC data the Trust's current energy consumption is an average of 294 KWH/m2. Aecom's Net Zero Carbon Pathway report (May 2022) identified a target for the scheme to reduce consumption to 250 KWH/m2, with a stretch target to 180.	**£14k p.a.** Based on achieving the target 250KWH/m2 and applying the current average cost per KWH (2020/21 ERIC data uplifted to 2022/23 prices)

5.3.5 Overall revenue affordability

Recurring revenue costs including capital charges and cash releasing benefits have been included in the financial model with appropriate inflation rates applied.

The results are shown in section 5.4.2. and this demonstrates that the scheme is affordable in revenue terms over the whole life of the asset. However, it should be noted that:

- There is an initial cost pressure in the early years of the scheme as new ways of working are embedded and cash releasing benefits established.
- Affordability is dependent on the delivery of the cash releasing benefits identified in section 5.3.4. and further work is required to develop the workforce model behind this at FBC stage.

5.4 Impact on Financial Statements

A copy of the financial model is provided in Appendix F1.

A summary of the impacts on financial statements are provided in the tables below.

5.4.1 Impact on Statement of Financial Position

The proposed accounting treatment for the preferred option is a straightforward capital purchase, funded predominately by Wave 4 STP Funding subject to approval of the OBC and subsequent FBC.

The resulting incremental impact on the Statement of Financial Position (SOFP) compared to the Business as Usual position is shown in the table below.

Table 48 Statement of Financial Position

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000
Property, plant and equipment: Other	13,845	13,672	13,476	13,281	13,085	12,890	12,694	12,499	12,303	12,108
Cash and cash equivalents	-659	-878	-786	-656	-510	-350	-176	12	215	435
Trade and other payables CL	0	-39	-16	-16	-16	-16	-16	-16	-16	-17
Total net assets employed	**13,186**	**12,755**	**12,675**	**12,609**	**12,559**	**12,523**	**12,502**	**12,495**	**12,502**	**12,526**
Financed by:										
Public dividend capital	17,605	17,605	17,605	17,605	17,605	17,605	17,605	17,605	17,605	17,605
Income and expenditure reserve	-4,419	-4,850	-4,930	-4,996	-5,046	-5,082	-5,103	-5,110	-5,103	-5,079
Total taxpayers' and others' equity	**13,186**	**12,755**	**12,675**	**12,609**	**12,559**	**12,523**	**12,502**	**12,495**	**12,502**	**12,526**

5.4.2 Impact on Statement of Comprehensive Income

The incremental impact on the Statement of Comprehensive Income (SOCI) of delivering the preferred option compared to the Business as Usual position is shown in the table below.

Table 49 Statement of Comprehensive Income

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	Remaining Years £'000	Total £'000
Income	0	0	0	0	0	0	0	0	0	0	0	0
Operating expenditure	-50	209	576	589	602	615	628	642	656	670	58,529	63,665
Impairment	-4,135	0	0	0	0	0	0	0	0	0	0	-4,135
Depreciation	0	-173	-196	-196	-196	-196	-196	-196	-196	-196	-9,580	-11,318
Operating surplus / (deficit)	**-4,185**	**36**	**381**	**393**	**406**	**419**	**432**	**446**	**460**	**474**	**48,949**	**48,212**
PDC charges	-235	-466	-461	-459	-456	-455	-454	-453	-453	-450	-32,384	-36,726
Surplus / (deficit)	**-4,419**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**11,486**
Impairment reversal	4,135	-0	-0	-0	0	-0	0	0	0	-0	0	4,135
Adjusted surplus / (deficit)	**-284**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**15,621**

5.4.3 Impact on Statement of Cashflows

The incremental impact on the Statement of Cashflows of delivering the preferred option compared to the Business as Usual position is shown in the table below.

Table 50 Statement of Cashflows

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000
Operating surplus / (deficit)	-4,185	36	381	393	406	419	432	446	460	474
Non-cash income and expense	4,135	212	172	196	196	196	196	196	196	197
Net cash from operations	**-50**	**248**	**553**	**589**	**602**	**615**	**628**	**642**	**656**	**671**
Capital purchases	-17,980	0	0	0	0	0	0	0	0	0
Net cash from investing activities	**-17,980**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Public dividend capital received	17,605	0	0	0	0	0	0	0	0	0
PDC dividend (paid)/refunded	-235	-466	-461	-459	-456	-455	-454	-453	-453	-450
Net cash from financing activities	**17,370**	**-466**	**-461**	**-459**	**-456**	**-455**	**-454**	**-453**	**-453**	**-450**
Increase/(decrease) in cash	**-659**	**-218**	**92**	**130**	**145**	**160**	**174**	**188**	**202**	**221**
Cash at start of period	0	-659	-878	-786	-656	-510	-350	-176	12	215
Cash at end of period	**-659**	**-878**	**-786**	**-656**	**-510**	**-350**	**-176**	**12**	**215**	**436**

5.4.4 Trust wide Statement of Comprehensive Income

A summary of the Trust-wide SOCI including the investment is shown below.

Table 51 Trust-wide SOCI

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	Remaining Years £'000	Total £'000
Income	489,319	498,454	501,401	510,759	520,718	530,838	541,125	551,580	562,209	573,158	40,598,429	45,877,989
Operating expenditure	-496,178	-496,957	-497,775	-492,609	-497,601	-507,272	-517,123	-527,141	-537,315	-547,815	-38,653,797	-43,771,582
Impairment	-4,135	0	0	0	0	0	0	0	0	0	0	-4,135
Depreciation	-13,117	-13,408	-13,550	-13,670	-13,791	-13,914	-14,038	-14,162	-14,288	-14,414	-888,019	-1,026,368
Operating surplus / (deficit)	**-24,111**	**-11,912**	**-9,923**	**4,481**	**9,326**	**9,653**	**9,965**	**10,278**	**10,606**	**10,930**	**1,056,613**	**1,075,905**
PDC charges	-7,477	-8,161	-8,611	-9,046	-9,376	-9,675	-9,976	-10,280	-10,589	-10,901	-1,039,518	-1,133,612
Surplus / (deficit)	**-31,588**	**-20,073**	**-18,534**	**-4,565**	**-50**	**-22**	**-12**	**-2**	**17**	**29**	**17,095**	**-57,707**
Impairment reversal	4,135	0	0	0	0	0	0	0	0	0	0	4,135
Adjusted surplus / (deficit)	**-27,453**	**-20,073**	**-18,534**	**-4,565**	**-50**	**-22**	**-12**	**-2**	**17**	**29**	**17,095**	**-53,572**

5.4.5 Impact on CDEL table

Table 52 CDEL table

	2022/23 £'000	2025/26 £'000	2026/27 £'000	TOTAL £'000
Gross Capex (Approval value)	1,194	15,955	832	17,980
Less NBV of Disposals				0
Less Grants and Donations (must be in the same financial year as the capex)				0
CDEL	**1,194**	**15,955**	**832**	**17,980**

5.5 Affordability

It is anticipated that delivery of the preferred option will require capital investment of £17.89m which will be funded as follows:

- £17.605m provided through Wave 4 STP funding as outlined in the original SOC.
- £0.393m self-financed by the Trust including:
  - £0.186m funded as part of the Trust's wider Mental Health scheme, specifically in this case to provide appropriate Mental Health spaces in ED
  - Work is underway to explore options to fund the remaining £0.207m, such as value engineering to reduce costs as the design of the project matures.

The revenue consequences of this investment include:

- £0.143m of incremental operating costs each year to cover the additional cleaning, utilities, and maintenance requirements incurred as a result of the increased floor area.
- £0.196m of annual depreciation charges, based on a 60-year asset life and applying asset values advised by Cushman & Wakefield.
- Public Dividend Capital (PDC) dividend payments are calculated using the average cost of net relevant assets each year at the current standard 3.5% rate of return until it is repaid.
- Additional costs are largely mitigated by cash releasing benefits of £0.683m p.a.

Recurring revenue costs including capital charges and cash releasing benefits have been included in the financial model with appropriate inflation rates applied.

The results, shown in the table below, demonstrate that the scheme is affordable in revenue terms over the whole life of the asset.

Table 53 Incremental impact on SOCI

	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000	2031/32 £'000	2032/33 £'000	Remaining Years £'000	Total £'000
Income	0	0	0	0	0	0	0	0	0	0	0	0
Operating expenditure	-50	209	576	589	602	615	628	642	656	670	58,529	63,665
Impairment	-4,135	0	0	0	0	0	0	0	0	0	0	-4,135
Depreciation	0	-173	-196	-196	-196	-196	-196	-196	-196	-196	-9,580	-11,318
Operating surplus / (deficit)	**-4,185**	**36**	**381**	**393**	**406**	**419**	**432**	**446**	**460**	**474**	**48,949**	**48,212**
PDC charges	-235	-466	-461	-459	-456	-455	-454	-453	-453	-450	-32,384	-36,726
Surplus / (deficit)	**-4,419**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**11,486**
Impairment reversal	4,135	-0	-0	-0	0	-0	0	0	0	-0	0	4,135
Adjusted surplus / (deficit)	**-284**	**-430**	**-81**	**-65**	**-50**	**-36**	**-21**	**-7**	**7**	**25**	**16,565**	**15,621**

However, it should be noted that:

- There is an initial cost pressure in the early years of the scheme as new ways of working are embedded and cash releasing benefits established.
- Affordability is dependent on the delivery of the cash releasing benefits. and further work is required to develop the workforce model behind this at FBC stage.

6 The Management Case

6.1 Introduction

The Management Case provides a summary of the arrangements which have been put into place for the successful delivery of the scheme in accordance with best practice. It considers other service relocations and operational changes that will be needed to secure the benefits sought through the investment.

This section of the business case sets out the management arrangements required to deliver the preferred option including:

- Project Plan
- Project Management Arrangements
- Project Roles and Responsibilities
- Project Reporting and Monitoring
- Benefits Management
- Change Management
- Contract Management
- Risk Management
- Arrangements for Post Project Evaluation
- Premises Assurance Model (PAM)
- Gateway Review Arrangements
- Contingency Plans

6.2 Project Plan

The anticipated project programme is attached at Appendix M1. High level milestones are set out in the below table. There are no other workstream milestones which will impact the critical path of the project.

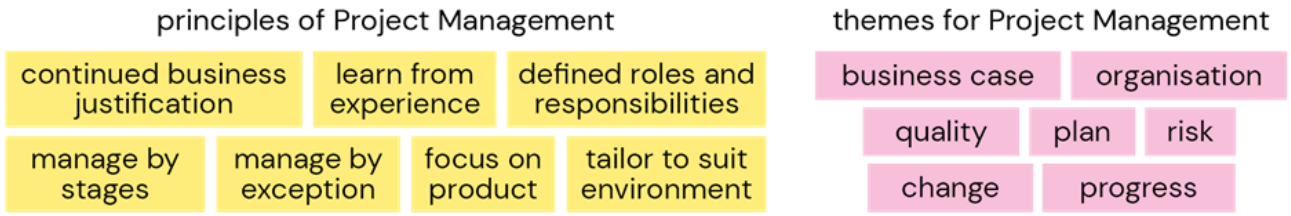
Table 54 Project Milestones

Activity	Start Date	End Date
OBC Production	05/05/2022	26/07/2022
NHSE&I OBC Approval	30/07/2022	21/10/2022
Design Development (RIBA stage 3)	18/07/2022	31/10/2022
Design Completion (RIBA Stage 4 Co-ordinated Design)	11/10/2022	17/01/2023
Market Testing	27/09/2022	28/11/2022
Receipt of GMP	13/12/2022	13/12/2022
Finalisation of FBC	14/12/2022	13/01/2023
Trust Approval	16/01/2023	20/01/2023
Submit FBC to NHSE&I	23/01/2023	23/01/2023
NHSE&I FBC Approval	23/01/2023	31/03/2023
Stage 4 Enabling works	20/02/2023	31/03/2023
Stage 4 Construction Works	03/04/2023	05/04/2024
Handover and Completion	05/04/2024	19/06/2024

6.3 Project Management Arrangements

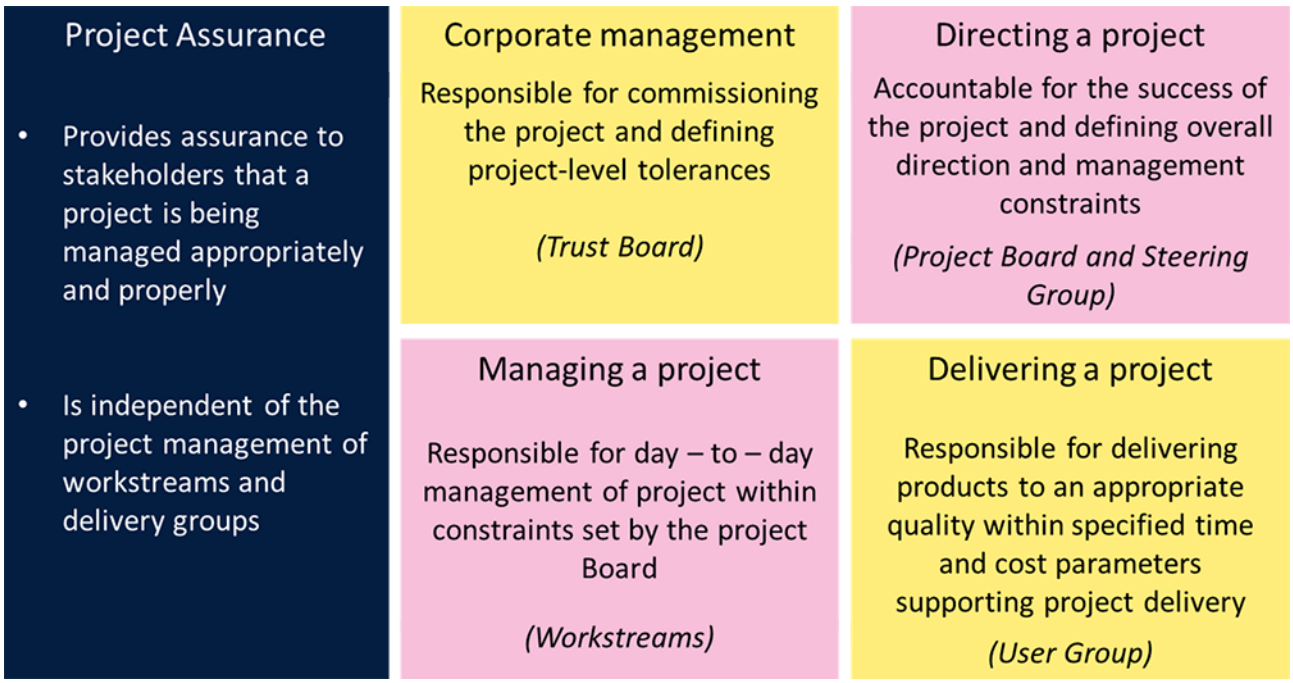
The project will be managed in accordance with PRINCE 2 methodology. The Programme Board (referred to on the below organogram) is responsible for driving forward and delivering the outcomes and benefits of this development. Members will provide resource and specific commitment to support the project manager in respect of the key deliverables.

Figure 25: Project Management Organogram



The project will be organised into the following governance arrangement.

Figure 26: Governance arrangements



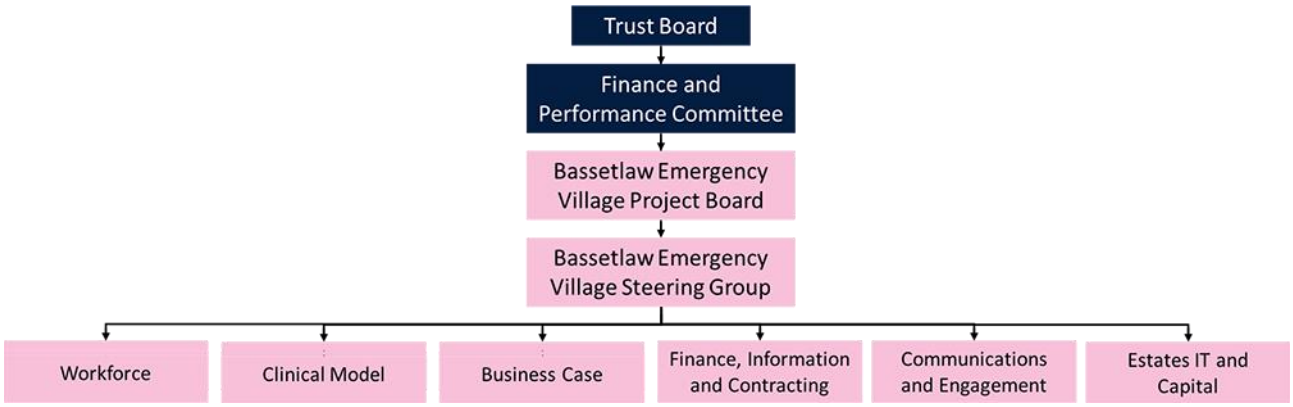
6.3.1 Project Management Budget

Project management costs are included in the capital costs outlined in section 5.2.

6.3.2 Management Structure

The project governance structure has been established to reflect the principles and themes of controlled project delivery. The following governance structure has been approved by the Project Board:

Figure 27 Project Governance Structure



There is a clear demarcation between those groups with a responsibility to produce outputs needed to deliver the project, i.e., workstreams and delivery groups, and those groups with responsibility to check, challenge and approve the outputs ensuring that the project is directed consistently across all subject matters, i.e., governance committees.

The main governance committees are:

- Trust Board;
- Finance and Performance Committee;
- Bassetlaw Emergency village Project Board;
- Bassetlaw Emergency village Steering Group.

All forums and committees included in the governance structure are established with formal Terms of Reference (ToR). Each forum will review their ToRs regularly, not less than at every stage boundary.

6.4 Project Governance

The Project Board, chaired by the SRO, Dr Kirsty Edmondson-Jones, will oversee the delivery of the project through the identified work-streams from conception to completion. The designated Programme Directors (Anna Fawcett & Chris Turner) will provide a consistent approach to delivering the project's objectives and will work with the relevant workstream leads to deliver the required outcomes on time and within budget. Accountability for the outputs of the individual workstreams sits with the respective workstream leads. The key roles of the Programme Board are to:

- Confirm the scope of the project.
- Deliver the project within the parameters set.
- Agree and sign off all major project plans.
- Authorise deviation from agreed project scope.
- Sign-off each stage and associated deliverables and ensure relevant Trust approvals are met.
- Ensure that required resources are available.
- Respond to any escalated issues from work-streams and project team.

- Monitor risks associated with the project and review risk register.
- Sense check and quality assure work-stream outputs.
- Provide high level direction on stakeholder involvement and support and monitoring project level management of stakeholders.
- Provide strategic direction for the project.
- Ensure the requirements for business case approval are met. This will include ensuring that commissioners sign off the business case.
- Identify whether any fundraising opportunities are available for this project and action accordingly.
- Receive and note post project review for lessons learnt.

6.4.1 Trust Board

The Trust Board is the ultimate legal entity responsible for the project. The Trust Board in particular has specific legal duties to discharge in the management and operation of the Trust.

In discharging these duties, they must ensure that all decisions are made to ensure safe operation and financial management. The project will transform the operation and strategic capabilities of the Trust, easing operational safety concerns but adding to financial management pressures. The balance struck between these two factors is ultimately the responsibility of the Trust Board.

The Trust Board delegates responsibility for the delivery of the outputs and necessary decisions. Authority is delegated to the Finance and Performance Committee (FPC) to oversee the project and the FPC provides assurance to the Trust Board on project delivery. However, all major decisions and outputs will be ratified by the Trust Board, including approval of the OBC.

Within the PRINCE2 governance arrangements, this group is classed as part of the corporate management function.

6.4.2 Finance and Performance Committee

The Finance and Performance Committee is a non-statutory standing sub-committee of the Trust Board established to provide advice and assurance to the Board on the effectiveness of financial strategy and planning. The committee provides guidance on Trust operational performance and on the commercial strategy, strategic investments, and development of the Trust infrastructure. The committee is responsible for providing the Trust Board with assurance on all aspects of financial, capital, and estates governance and management structures, systems, processes and controls. Central to the Committee's work is ensuring the effective operational performance of the organisation, with a focus on constitutional standards and appropriate use of resources and assets. It is also responsible for ensuring that the organisation is in accordance with statutory and regulatory reporting standards and requirements, including constitutional standards. The Committee oversees the development and monitoring of strategies including the estates and digital strategies on behalf of the Board.

The duties of the Finance and Performance Committee include:

- Reviewing and monitoring the delivery of strategies within its remit;
- Evaluating financial planning, assumptions and forecasting in relation to budgets, balance sheet (debtors, creditors, and asset valuations), capital, savings and transformation improvement plans and ensuring these are efficiently and effectively managed;
- Assessing and monitoring key performance indicators and constitutional standards following engagement with other assurance committees and reviewing progress;
- Monitoring the outputs of the performance management framework utilising the integrated performance report;
- Providing advice and support on significant financial and commercial policies prior to recommendation at the Board for approval. This includes policies related to costings, revenue, capital, working capital, treasury management, investments, and benefits realisation;
- Monitoring the effectiveness of the Trust's financial and operational performance reporting systems, and KPIs (Key Performance Indicator), ensuring the Board is assured of ongoing compliance through its annual reporting processes and reporting by exception to the Board where required;
- Reviewing and approving business cases in line with the scheme of delegation requirements.

6.4.3 Project Board

The Project Board, chaired by the SRO, who will oversee the delivery of the project through the identified work-streams from conception to completion. The Project Board meets every month to consider, advise and direct the project.

A core function of the Project Board is to determine and inform NHSE/I and DBTH more widely on progress whilst escalating those decisions which require a higher level of authority, i.e., alterations to the project budget, programme or appointments.

In this capacity the Project Board will collate information, prepare the data necessary and make recommendations to facilitate a decision to be made as appropriate. The key roles of the Project Board will be to:

- Confirm the scope of the project;
- Sign off the Project Initiation Document and project plans;
- Deliver the project within the parameters set;
- Agree all major plans;
- Authorise deviation from agreed project scope;
- Sign off completion of each stage and deliverables, ensuring relevant Trust approvals are met;
- Ensure that required resources are available;
- Respond to any escalated issues from work-streams/ Project Design User Group;
- Monitor risks associated with the project and review the risk register;
- Sense check and quality assure work-stream outputs;

- Provide high level direction on stakeholder involvement and support; and monitor project level management of stakeholders;
- Provide strategic direction of the project;
- Ensure the requirements for business case approval are met. This will include ensuring that commissioners sign off the business case;
- Identify whether any fundraising opportunities are available for this project and action accordingly;
- Receive and note post project review lessons learnt.

Project Board terms of reference can be found at Appendix M2.

Table 55 Project Board Attendees

Name	Position
Kirsty Edmondson-Jones	SRO and Chair
Jon Sargeant	Deputy Chair
TBC	Chief Nurse
Dr Tim Noble	Executive Medical Director
Becky Joyce	Chief Operating Officer
Alex Crickmar	Interim Director of Finance
Anthony Jones	Deputy Director of People and Organisational Development (Interim cover)
Ken Anderson	Chief Information Officer
Emma Shaheen	Head of Communications and Engagement
Dr Anu Agrawal	Divisional Director - Medicine
Eki Emovon	Divisional Director – Children and Families
Karen McCreadie	PA to Director of Strategy and Improvement (Minutes)
Victoria McGregor Riley	CCG Representative
Anouska Huggins	Business Case Lead (Archus)
Chris Turner / Anna Fawcett	Project Director (Archus)
Monique Chavda	Project Operational Manager (Archus)

6.4.4 Steering Group

The Bassetlaw Emergency Project Steering Group is responsible for driving the management and delivery of all aspects of the Trust's project. This includes oversight of the delivery of the OBC and the FBC for capital investment, ensuring they can withstand external scrutiny and are underpinned by robust transformation plans.

The group is responsible for the management of resources dedicated to the project, oversees the development and implementation of the stakeholder engagement and communications plan, and ensures the identification and appropriate management of key risks to the project. The Steering Group meets every month to consider, advise and direct the project.

The duties of the Steering Group are as follows:

- Agree the project plan for delivery of business cases at each stage of the process, including the OBC and FBC stages.
- Monitor performance against the project plan, identifying and removing obstacles to its delivery.
- Review sections of the business case as these are developed and approve the final business case for submission to the Project Board, ensuring documentation is developed in line with national guidance and that it aligns with the Trust's agreed strategies.
- Review key documents associated with the project as required and recommend their submission to the Project Board.
- Approve the submission of the hospital designs to the Project Board.
- Agree and oversee the resourcing plan for delivery, including the appointment of external consultants as required to support demand and capacity modelling, economic and financial modelling, estates components, business case authorship and stakeholder engagement and communications.
- Identify and oversee the resolution of ongoing issues to the delivery of the business case, identifying strategies/actions to deprioritise issues.

Steering Group terms of reference can be found at Appendix M3.

Table 56 Steering Group Attendees

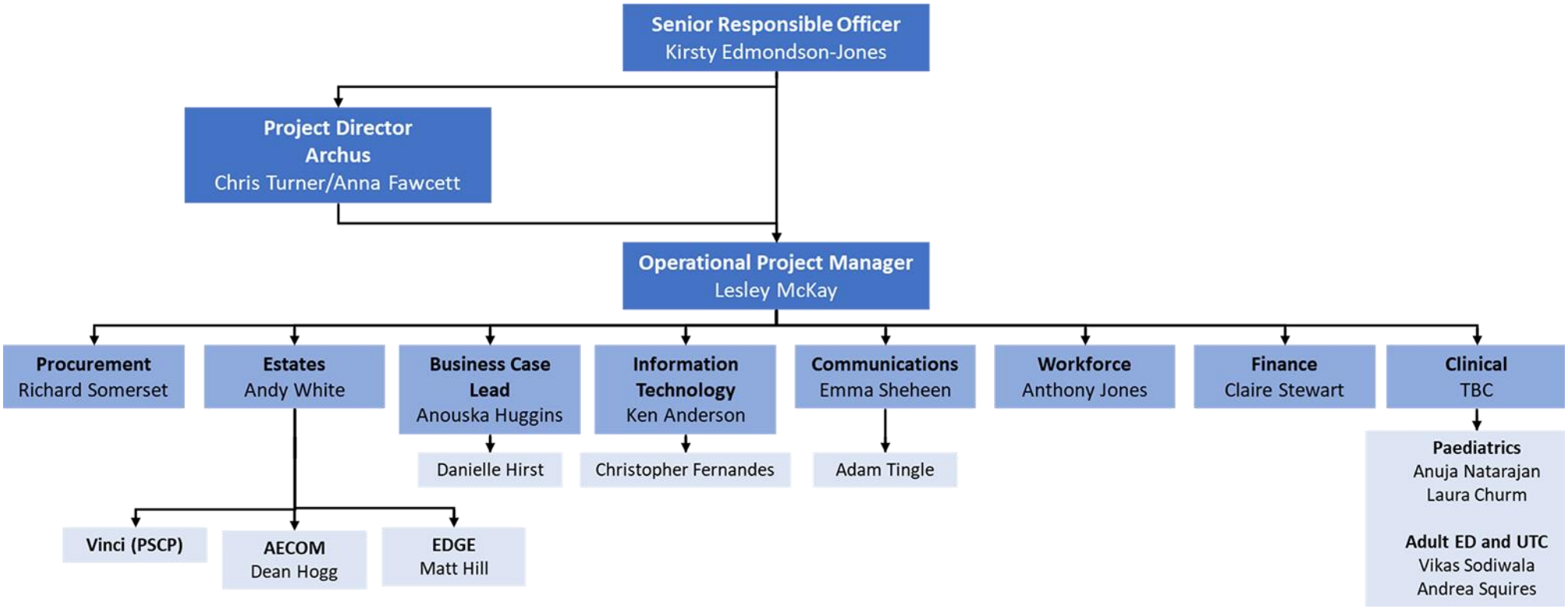
Name	Position
Chris Turner / Anna Fawcett	Project Director (Archus) – Chair
Monique Chavda	Project Operational Manager (Archus) – Deputy Chair
Andy White	Head of Capital Projects
Richard Canetti	Deputy Director of Strategy and Improvement
Anuja Natarajan	Clinical Director - Acute Paediatrics – Children's Division Project Clinical Lead - Paediatrics
Helen Burroughs	General Manager – Paediatrics and TriHealth
Laura Churm	Divisional Director of Operations, Paediatrics
Naushad Khan	Clinical Director & Consultant in Emergency Medicine
Ewen Wilson	Clinical Director (Acute Medicine)
Ranjit Pande	Clinical Director (Trauma and Orthopaedics)
Mazin Delaimi	Consultant (Emergency Department)
Natalie Griffiths	Head of Nursing (Emergency Medicine)
Lesley Mckay	Strategic Programmes Manager
Andrea Squires	Divisional Director of Operations, U&EC
Kate Carville	Divisional Director of Nursing - Medicine
Christopher Fernandes	Head of Digital Programmes
Anthony Jones	Deputy Director of People and OD

Name	Position
Adam Tingle	Communications and Engagement Lead
Claire Stewart	Head of Financial Planning, Commissioned Income & Costing
Richard Somerset	Head of Procurement
Adele Brook	Transformation lead – Elective and Urgent and Emergency Care, Bassetlaw CCG
Karen Mccreadie	PA to Director of Strategy and Improvement
Anouska Huggins	Business Case Lead (Archus)
Dean Hogg	Capital Projects Project Manager (Aecom)

6.4.5 Project Structure

The reporting structure for the project is as follows

Figure 28 Governance Structure



The project will be delivered according to the PRINCE 2 methodology for delivering projects in controlled environments. Each workstream is responsible for delivering key outputs needed to inform the successful delivery of the OBC. These outputs will be scrutinised, challenged, and ratified by the four levels of project governance. To do this, PRINCE methodology sets out a series of key documents, as follows.

Table 57 Reporting Outputs and Frequency

Report	Forum	Frequency
Workstream report	Steering group	Monthly
Project Dashboard	Project Board	Monthly
Written update report	F&P	Monthly
Monthly Report	Transformation Board	Monthly

6.4.6 User groups

Included in the structure are specialist user groups for clinical and non-clinical aspects of the development. These groups are the key interface between the delivery functions and the 'front line' workforce who deliver clinical and operational (non-clinical) services.

In these groups, service delivery staff are required to balance the needs of their specific 'business unit' and the needs of service users. The groups provide feedback and knowledge on their departmental requirements to the project technical delivery experts.

These groups encompass a range of specialties and services within the hospital. Each focus area will have an overarching board controlling the requests and feedback between its subgroups.

Delivery has been separated into themes referred to as workstreams. Each workstream will consist of a main project management forum, in the form of a "steering group" and specialist delivery groups for areas of specific subject expertise and focus.

The delivery functions will be responsible for the delivery of all outputs needed to support a robust and compliant OBC. Where gaps and assumptions are identified, these will need to be made clear and mitigation plans put in place, with appropriate management action plans to address gaps and assumptions at the FBC stage.

The workstreams are:

- Estates;
- Procurement
- Workforce;
- Strategy and Transformation;
- Clinical
- Communication and Engagement;
- Digital;
- Business Case
- Financial.

Within the scope of this project, there are interdependencies with different capital projects. One of the main interdependencies is between SDEC and ATC which are reliant on each other's success as a project.

6.4.7 Design Team

The Design team, which includes AECOM, Archus, IHP and Trust members, meet fortnightly to ensure that all project workstreams are on track and up to date with the status of the project. The design team bring together the outputs from the project workstreams and provide feedback to the Project Board.

The Design Team will:

- Ensure operational delivery of the project to time, quality, and budget;
- Make decisions on matters for escalation to Project Board for escalation to the Trust Board as required;
- Manage risks and issues and escalation of appropriate matters for executive direction / approval; and
- Draw together the outputs of the Working Groups and manage the coordination of cross cutting issues.

Table 58 Design Team Members

Name	Organisation
Andy White	Trust
Richard Canetti	Trust
Tom Garrett	Trust
Liam Swords	IHP
Carey Hadfield	IHP
Andy Whaley	IHP
Phil Bentley	P&HS Architects
Matt Hill	Edge
Chris Turner	Archus
Anna Fawcett	Archus
Anouska Huggins	Archus
Monique Chavda	Archus
Dean Hogg	AECOM
Harry Loftus	AECOM

Senior Responsible Officer

The project SRO for the Doncaster & Bassetlaw NHS Trust programme is Dr Kirsty Edmondson-Jones, Director of Innovation & Infrastructure at Doncaster & Bassetlaw NHS Trust

The SRO is responsible for sponsoring the project within the Trust and will act as the main point of contact with the Trust Board and Executive Directors. As a visible, recognised senior person within the Trust, Kirsty Edmondson-Jones will also take responsibility for managing external messaging and relationships as well as ensuring that the appropriate governance structure is in place to deliver the project objectives, and that the identified benefits are realised.

The roles and responsibilities of the SRO are:

- own the vision for the project and the supporting business case
- provide clear leadership and direction at an executive level throughout the life of the initiative
- have full responsibility and accountability for the outcome of the project and realisation of the benefits
- manage the interface with key senior stakeholders, keeping them engaged and informed
- own the relationship between the project and NHSE/I and DHSC
- maintain the alignment of the project to the organisation's strategic direction
- ensure that the project remains affordable and will improve the quality of care to the target population, and
- establish and ensure that the necessary resources are made available to deliver the scheme
- Ensure that project objectives are met to the agreed time, cost and quality constraints.

Kirsty Edmondson-Jones has completed the Better Business Case training course. Her CV can be found in Appendix M4.

Project Director

The Project Directors for the scheme are Chris Turner and Anna Fawcett. Their role includes:

- Co-ordinates all workstreams to deliver the agreed objectives;
- Monitors progress, resolving issues, mitigating risks, and initiating corrective action as appropriate;
- Provides an overall monitoring and assurance role across the project workstreams, ensuring that project risks and issues and any internal or external dependencies are defined, managed, and escalated where appropriate;
- Ensures appropriate risk, benefits and stakeholder management frameworks are in place for the project;
- Acts as the day-to-day agent on behalf of the SRO for successful delivery of the initiative;
- Owns and reviews the project plan, communicating the impact of any revisions in terms of milestones, timelines, and dependencies;
- Ensures the development of business cases and project documentation;
- Ensures that the initiatives and projects that support the delivery of the project are initiated on a consistent basis with governance arrangements that meet requirements;

- Manages allocated outputs to the required quality within the agreed time and costs constraints;
- Manages and assures the work of project team members;
- Reports regularly to all relevant individuals and groups using standard reporting processes and templates;
- Chairs the Steering Group.

Internal Operational Project Manager

The internal project manager is Lesley McKay. The internal Project Manager's roles and responsibilities include, but are not limited to, the following:

- Ensure the production of the design brief and the project plan.
- Clarify the work scope, responsibilities and relationships.
- Lead and direct the efforts of the Project Team.
- Define the organisational structure and communications plan for the project, including a timetable and ensuring that all adhere to it.
- Ensure that appropriate information is available, or causes it to be collected, and transmitted between the client body and other members of the team.
- Ensure that consultation with stakeholders has been carried out and information collated for the detailed brief.
- Monitor resource availability, decision making and progress, performance quality of the Project Team.
- Ensure adequate procedures are in place to monitor and control costs, time and quality.

Capital Project Manager

The capital project manager is Dean Hogg, facilitated through Trust Capital Planning Unit which is headed by Andy White. The capital Project Manager's roles and responsibilities include, but are not limited to, the following:

- Be the single point of contact for Supply Chain on behalf of the client;
- Assist the Programme Director with option appraisal and final report and prepare business case documentation;
- Develop scheme budget and expenditure plan with cost advisor;
- Ensure relevant operational policies, room data sheets and surveys have been completed. Ensure site's availability and access;
- Implement risk management activities;
- Oversee the contract documentation preparation, agree with PSCP the stage activities and associated costs;
- Operate the scheme contract using the P21+ contract template and proformas;
- Review PSCP programme and expenditure forecast;
- Control early warning and compensation events;
- Oversee final account settlement.

Cost Manager

The cost manager's roles and responsibilities include, but are not limited to, the following:

- Prepare and maintain an elemental cost plan and projects spend profile;
- Monitor and manage change control during the project;
- Value Engineering – advise on construction economies and consideration of a balanced design and optimal selection of materials;
- Provides input into a risk register;
- Advise on the most appropriate form of procurement route and the selection of tenders;
- Prepare contract documents and report on tenders;
- Prepare monthly valuations and out-turn cost forecasts;
- Agree the Final Account with the Contractor.

Principal Contractor

As described in the Commercial Case of the OBC, the Trust appointed IHP as the PSCP through the ProCure21+ (P21+) procurement framework route. P21+ is consistent with the requirements of government policy, including the 'Productivity and Efficiency' agenda, the Government Construction Strategy, the NAO guidance on the use of centralised frameworks, and the Cabinet Office Common Minimum Standard for procurement of the Built Environment in the Public Sector. Crucially, the framework is consistent with the Public Contracts Regulations 2015 and therefore with current EU regulations in respect of public sector procurement.

The PSCP's roles and responsibilities are fully detailed in the appropriate procurement documents but are summarised as follows:

- Development of a safe method of construction in line with Health and Safety legislation and the Trust's Local Rules;
- Review of the design and the provision of buildability advice;
- Development of detailed final design for major components, manufacturing details and components;
- Planning, managing and delivery of the physical construction;
- Providing an integrated supply chain including specialist suppliers and contractors;
- Project management, including managing the design team production timescales;
- Quality control;
- Interface with client departments and users;
- Cost monitoring advice and assistance;
- Final testing and commissioning;
- Snagging and defects management.

Architect

- Receive a detailed briefing from the Client;
- Prepare a schedule of accommodation and room date sheets;
- Carry out feasibility study;
- Prepare outline and detailed designs;
- Apply for all necessary permissions;
- Ensure the design complies with the requirements of CDM;
- Prepare detailed tender information and advise on the selection of contractors;
- Monitor the construction and carry out Contract administration duties;
- Monitor the construction and ensure that work is of the correct quality and liaise with Clerk of Works;
- Resolution of defects and final inspection;
- Prepare snagging list and issue certificate of Practical Completion;
- Resolution of defects and final inspection.

Principal Designer

- Undertake all services required of the CDM Coordinator under the Construction (Design and Management) Regulations 2015;
- Ensure designers consider Health and Safety in the development of their designs and obtain risk assessments;
- Prepare the Pre-Construction Health and Safety Plan;
- Review the Contractors Health and Safety Plan;
- Notify the Health and Safety Executive of the proposed development works and the appointment of the Principal Contractor;
- Collate the Health and Safety File and the O&M Manuals.

Structural and Civil Engineer

- Undertake structural surveys including geotechnical and topographic surveys;
- Assist in the preparation of feasibility studies and the development of an outline scheme design;
- Develop on the basis of the space plan an integrated structural solution that supports the services strategy and provides a cost-effective solution;
- Prepare a detailed design co-ordinated with all other disciplines;
- Develop the detailed design and co-ordinate the overall design;
- Prepare detailed tender information and advise on the selection of Contractors;
- Ensure the design complies with the requirements of CDM Regulations in full;
- Monitor the construction and ensure that work is of the correct quality and liaise with Clerk of Works;
- Prepare snagging lists, resolution of defects and final inspections.

Services Engineer

- Visit the site and carry out and advise on the requirements for details of existing services and undertake detailed surveys of the same;
- Assist in the preparation of feasibility studies and the development of outline scheme designs;
- Develop on the basis of the space plan an integrated services solution that supports the space plan in line with the services strategy for the building/zone;
- Consider and advise on the whole cost, sustainability running and utility costs;
- Ensure the design complies with the requirement of CDM;
- Prepare detailed design co-ordinated with all other disciplines;
- Prepare detailed tender information and advise on the selection of contractors;
- Visit site and ensure that the services co-ordination is effectively managed;
- Monitor the construction and ensure that work is of the correct quality in liaison with the Clerk of Works;
- Develop in conjunction with the Contractor a detailed testing and commissioning programme;
- Prepare snagging lists, resolution of defects and final inspections.

Clerk of Works / NEC Supervisor

- Liaising with Contractors on access, safe working arrangements, agreeing method statements, footpath closures etc.;
- Monitoring and recording progress with the works;
- Monitoring and reporting defects to the Contract Administrator;
- Liaising with the Design Team and Contractor and resolving technical queries;
- Liaising with the users regarding operational matters and resolving these in conjunction with the Project Manager;
- Issuing hot works permits, roof access permits etc. in accordance with the site's local rules;
- Monitoring, testing and commissioning is carried out in accordance with the agreed performance standards;
- Carrying out defect/snagging inspections and advising the Project Manager whether the project is suitable for Handover to the user;
- Reviewing and confirming that the defects have been successfully resolved.

6.4.8 Use of Special Advisers

As outlined above, the 'Emergency village' project requires that the Trust procure the services of a number of specialist advisors to assist with the successful delivery of the scheme. The table below lists the specialist advisors procured to support the delivery of the OBC. Special advisers have been used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisers. External advisers are detailed in the table below:

Table 59 Specialist Advisors

Role	Organisation	Scope Summary
Business Case Support, Health Planning and Operational Project Management Support	Archus	Providing expertise and overall co-ordination of the Business Case development in line with Treasury and NHSEI requirements.
Architects	PH+S	Responsible for the scheme design, massing diagrams, key adjacencies and project phasing.
Engineers	IHP	Provision of M&E, C&S, Transport & Travel and Sustainability engineering advice and design.
Capital Project Management	Aecom	Responsible for the oversight and project management within the P21+ framework.
Cost Managers	Edge	Provide cost management services for the development of the Business Case.

6.5 Project Management

In line with PRINCE2 methodology, there will be clear delegated authority through the project governance pathway. The ultimate authority for this project is the Trust Board, who in line with various statutes have legal accountability for the operational and financial performance of the hospital's activities. The accountability for such obligations cannot be delegated, however, the responsibility for the activities needed to discharge these legal duties can be delegated.

In executing these duties, within the project environment, responsibility will be cascaded to each level of the structure. All financial management obligations will be delegated in line with the Trust's Standing Financial Instructions (SFIs).

It is accepted that the project will be delivered by a large number of highly qualified professionals, through a series of defined stages that align to the RIBA (Royal Institute of British Architects) Plan of Works 2020 version.

In doing this, levels of delegated authority will be reviewed at each key stage boundary. The SRO and Project Director will formally review and accept levels of delegated authority through the project.

These professionals will be required to manage by exception, and whilst there will be a requirement to provide a sufficient detail for the Trust Board to sign off documentation at each stage boundary, the varying levels identified in the governance structure should only be expected to raise issues within their delegated responsibility by exception.

6.6 Stakeholder Engagement

6.6.1 Communication Objectives

The core communications objectives identified below apply for the BEV Programme:

To enhance the reputation of DBTH and the Bassetlaw Emergency Village Project:

- To support the Project Board with communications messages, both internal and external, and to advise on the most appropriate media with which to convey a particular message.
- To inform the Trust, its partners and the public about the nature of the project the progress made at various key stages.
- Recognise and value the work of the Emergency Department, its support services and how the project will provide the perfect base from which they can deliver patient care
- To promote and liaise with local press throughout the preparatory, build and operational process, ensuring maximum coverage, dispelling inaccurate coverage.

To deliver consistent core messages:

- Communicating changes with control and consistency
- Ensuring communications are timely and informative
- Ensuring communication materials support the delivery of key messages at all stages of development
- Promoting and explaining building, how it will change and improve the current facilities for patients and staff and address questions in collaboration with key individuals within the Project Board.

To actively engage with stakeholders, involving real dialogue and a two way process:

- To maximise support for, and minimise opposition to, what is planned
- Help staff through a major change/development by keeping them informed and asking them for suggestions and feedback
- Keep stakeholders informed of all key milestones of the project.

More details on stakeholder engagement and a timetable for communications can be found in section 2.8.5.

6.7 Benefits Management

The Trust is committed to maximising the benefits of this investment in modern healthcare facilities for the people of Bassetlaw. Benefits have been identified and quantified in line with the Green Book and the Treasury Comprehensive Investment Appraisal model. The delivery of benefits will be managed through the Project Board. The benefits of this project are outlined in section 2.10. Benefits were identified and used to inform the economic appraisal as outlined in section 3.6.

An assessment has been undertaken to compare the benefits to the project investment objectives. This has determined that each investment objective has been met by one or more benefits.

The detailed Benefits Realisation Plan will be developed as part of the FBC; based on the most up-to-date information available at that time. This will include all benefits (cash-releasing and non-cash-releasing) and will specify the following for each:

- What enablers are required to deliver the benefit;
- What the outcome of the benefit will be;
- What is the baseline measure of the benefit;
- What the target date is for delivery of the benefit;
- Who is responsible for the delivery of the benefit.

The Benefits Realisation Plan will outline the key actions required to deliver the benefit by the agreed timescale, who is responsible for the action and when the key actions will be completed. Delivery of the overall benefits will be formally assessed as part of the Post-Project Evaluation.

The benefits identified will fall into the following main categories. In each case, the sources and assumptions underlying their use will be explained.

A copy of the project benefits register is attached at Appendix M5. This sets out who is responsible for the delivery of specific benefits, how and when they will be delivered.

6.8 Change Management

Change management associated with the project will be managed through the Project Team and authorising bodies that preside over it, under the chairmanship of the SRO. Change management issues will be escalated and discussed at the Project Board and any resultant contract and/or cost changes will need to be approved accordingly and delegated to the relevant group to manage.

The scheme is not expected to have a significant cultural impact, as it is an expansion of an existing service. The Trust is aware however that the project is a major change for staff working in and around the Emergency Department and therefore its success is predicated on these staff supporting the project. To date, staff have been involved in all aspects of the project and it is envisaged that they will continue to play an instrumental role as the project moves into its next phase.

There will be no change to the organisational structure of the Trust following completion of the redevelopment of the site. There is potential for positive cultural changes following completion to enable staff to work more effectively and efficiently in a newly redeveloped fit-for-purpose building. This can help contribute to higher levels of staff retention over the coming years to improve the working culture for both staff and patients.

Within each stage will be a series of decision points where major documents produced by workstreams will be ratified within the governance arrangements. All documents will be subject to a robust and consistent version control methodology.

The following documents are core to the project at this stage:

- Strategy documents, including the Clinical Services Strategy, Workforce Plan, Estates strategy, etc.;
- Schedule of Accommodation;
- Clinical models of care and patient flow diagrams;

- Clinical briefing documents.

All changes will be subject to a formal change control process. Change is not design development. Change can only occur when strategic, operational policies or functional content quantities are altered from those included in the current approved documents.

6.8.1 Change Control Register

If a change is agreed that impacts upon the PSCP and their work, the following P21+ Change Management procedure is to be followed in line with the contract.

Formal Change Control procedures will begin during the early stages of the Project and will enable the Trust to make informed decisions with a high degree of predictability of outcome in accordance with the P21+ Procurement Framework and associated NEC3 ECC Main Option C Contract.

Change control process and contract matters are managed using, an online contract management platform which has been agreed and implemented by the Trust and PSCP. Sypro provides a live update of all projects, early warnings (EW), acceptance and compensation events (CE). This is used to manage the NEC3 Main Option C Contract required by the P21+ process. It can be accessed by the PSCP, Trust and Trust Advisors, but only the appointed Project Manager is able to provide acceptance in line with the NEC3 Main Option C Contract.

Change instructions can only be notified by the P21+ Project Manager named in the contract and must be in writing. Any variations are dealt with by way of a compensation event and must detail any potential financial and project implications.

No changes shall be implemented that have not been subject to change control and supported by the issue of a formal instruction authorised by the Client.

Each change request will be given a unique ID and linked to the compensation event issued by the PSCP. The impact of the CE on cost and time will be recorded and a date will be given for to note when the Trust formally accepted this change.

6.9 Risk Management

The responsibility for managing the risks of the project resides with the Capital Project Manager, who manages the central project risk register that includes all project risks. Key project risks will be identified and recorded on a Risk Register, where they will be allocated a Risk Manager, who is responsible for managing the risk together with the mitigation measure identified for that risk and each risk will be costed.

The Risk Register has been developed and presented to the Steering Group and Project Board at each meeting. It is a separate stand-alone 'live document' which is reviewed and updated throughout the life of the project to capture new risks, identify those whose status has changed, examine mitigation strategies and close risks which are no longer applicable. The Risk Register currently reflects key risks as well as information gathered from previous Trust projects. The project will identify risk through the use of a 5x5 Risk Matrix as seen in the table below.

Key members of the Project Board, Steering Group or Design Team may be responsible for owning risks highlighted on the Register and carrying out the mitigating actions identified; however it is the Capital Project Manager who is required to manage the Risk Register as a whole, with particular attention to the most significant risks. Risk workshops are to be held at regular intervals throughout the duration of the project and additional risks added as they are identified.

Through a delegated authority, the Capital Project Manager will present the steps that are being taken to minimise exposure to risk on the project. The risk workshop will then determine if the approach is appropriate or if additional action is required to be undertaken.

Table 60 5x5 Risk Matrix

		Likelihood				
		Rare	Unlikely	Possible	Likely	Almost Certain
Consequence	5 - Catastrophic	5	10	15	20	25
	4 – Major	4	8	12	16	20
	3 – Moderate	3	6	9	12	15
	2 – Minor	2	4	6	8	10
	1 – Negligible	1	2	3	4	5

Error! Reference source not found., indicates the top five high level risks for this scheme. A copy of the project costed risk register is attached at Appendix M8. This sets out who is responsible for the each individual risk and the required counter measures.

Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)
Hyperinflation	5	5	25	Predetermine the inflationary consequences and allocate the management of Hyperinflation to the party best able to manage it. Implement inflationary price adjustment formulae's to factor the rise in costs before they occur.	4	5	20
Increase in procurement periods / lead ins & Material shortages	4	4	16	VINCI identify long lead items, which could be ordered in advance to mitigate delay. Identify alternate options	4	4	16
Site Compound / Construction logistics affecting parking & Emergency Services parking and/or traffic / trust operations	5	4	20	VINCI are developing a site logistics plan as part of RIBA 2 which will identify level of reduced parking. Plan to be agreed with Trust	3	4	12
Construction Procurement delays - Early Orders	4	4	16	IHP to identify value of the early orders and required procurement dates. Trust to use CRL monies to fund early orders and confirm the plan is achievable	3	4	12
Mental health Block not being vacated on schedule - may impact the construction start date for the RAAC project and thus the BEV construction	4	3	12	Regular engagement with Nottinghamshire Healthcare to ensure programmes align. Further mitigation strategies are being developed	4	3	12

6.10 Arrangements for Post Project Evaluation

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business case.

The arrangements for PPE have been established in accordance with best practice. This will be a two-stage approach, with the Project Completion Report (PCR) being completed at 6 months of the building being in use; followed by the full post-project evaluation at two years. The two stages of PPE will be of benefit to:

- The Trust – in using this knowledge for future capital schemes;
- Other key local stakeholders – to inform their approaches to future projects;
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively;
- Contractors – to understand the healthcare environment better.

6.10.1Project Completion Report

The review at six months involves completion of NHSI's pro-forma, which includes the project key information, lessons learnt and actions implemented by the Trust, comments from the Trust Board and comments from NHSI on significant findings. In addition there is a detailed set of questions on the following topics:

- Achievement of project start date (as approved at FBC)
- Achievement of project Completion date (as approved at FBC)
- Final project costs compared to FBC
- Fees compared to FBC
- Legal actions or issues
- Assessment of procurement method selected
- Assessment of framework contract
- Conflict and resolution
- Key quality benefits in the FBC and whether they have been achieved
- Delivery of service need
- Key financial benefits in the FBC and whether they have been achieved
- Planned efficiencies and whether they have been achieved
- Project team and whether it was appropriate
- Project 'blockers'
- Confirmation of the timescales for the full PPE (stage 2)
- BREEAM rating
- Independent Design Appraisal
- Post-construction / post-occupancy evaluation by the contractor

The Project Completion Report will be completed by key members of the project team and will be reviewed / approved by the appropriate groups in the governance structure, culminating in the Trust Board.

6.10.2 Full Post Project Evaluation

The scope of the post project evaluation at 2 years will be determined in part by the outcome of the Project Completion Report at six months. However, as a minimum, the following topics will be included:

- Summary evaluation
- Revisiting the strategic context
- The investment decision
- The procurement
- Project management and implementation
- Benefits management
- Outcome and impact
- Organisational impact and change management
- Lessons for future projects
- Post-occupancy evaluation
- Approvers' input
- External support.

Each of these topics will cover a number of questions, as outlined in NHSI guidance document. Additional questions and/or topics may be included based on the outcome of the Project Completion Report at six months.

6.11 Premises Assurance Model (PAM)

The 2014 NHS Premises Assurance Model (PAM) represents a refreshed and updated version of the previous model that is more comprehensive, incorporating 'soft' Facilities Management services, consistent, aligned with Post-Francis regulatory requirements and supports the long-term financial sustainability of the NHS. NHS PAM supports the NHS constitution pledge, 'to provide services from a clean and safe environment that is fit for purpose based on national best practice' and the current regulatory requirements to ensure that 'service users are protected against risks associated with unsafe and unsuitable premises'.

The main benefits of the new PAM are to:

- Allow NHS organisations to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe.
- Provide a consistent basis to measure compliance against legislation and guidance.
- Allow NHS organisations to compare how efficiently they are using their premises.
- Prioritise investment decisions to raise standards in the most advantageous way.
- Better understand the efficiency, effectiveness and level of safety with which they manage their Estate and how that links to patient experience.

The results of the Trust's 2020-2021 PAM can be found in Appendix M6.

6.12 Gateway Review Arrangements

All significant public sector projects are required to complete the Office of Government Commerce (OGC) process of detailed peer review and assessment at key stages or gateways.

The requirement to register a project for formal review is based upon an initial Risk Potential Assessment (RPA). Completion of an RPA results in a project being classified as Low Risk (scoring 30 points or less), Medium Risk (31-40 points) or High Risk (41 points or more). The RPA for this project is attached at Appendix M7; and demonstrates a score of Low Risk which means [that a formal Gateway review is discretionary.

6.13 Contingency Plans

The Trust has a strategy for business/service continuity; and contingency plans are in place which ensures that DBTH can continue to deliver an acceptable level of service for its critical activities in the event of any disruption.

The Trust firms believes that this scheme enables the provision of 'fit-for-purpose' urgent and emergency care that meets national recommendations, supports patient flow and early supported discharge; along with the opportunity to educate people about making their own appropriate choices for urgent care needs.

In the event that funding is not received and therefore this project does not go ahead, then the ED, already not fit-for-purpose, will not be able to cope with demand, develop new care pathways or meet patients' needs. As a consequence of this, the experience the Trust offers to patients will be infinitely poorer and lacking in quality standards. Moreover, the Trust will struggle to attract, recruit and retain the best people who are able to provide high-quality patient care.

If the project does not proceed, there would also be significant impact on the Trust's ability to deliver high-quality care for its patients. The Trust has done everything it can do to maximise available space within the existing building footprint for front of house urgent and emergency care services. If the Trust is unable to secure the funding to expand the building to create additional capacity, improve clinical adjacencies and therefore facilitate new models of care, it will not be able to maximise benefits for patients, staff, and partners within the wider health and social care community.

Appendices

Appendix S1	Board of Directors Approval of OBC
Appendix S2	Commissioners Approval of OBC
Appendix S3	CQC Report
Appendix S4	NHS National Strategies
Appendix S5	DBTH Green Plan
Appendix S6	DBTH Clinical Services Strategy
Appendix S7	DBTH Patient Engagement and Experience Strategy
Appendix S8	DBTH Qii Strategy
Appendix S9a	DBTH People and Organisational Development Strategy
Appendix S9b	DBTH Workforce Plan
Appendix S10	DBTH Digital Strategy
Appendix S11	DBTH Estates and Facilities Strategy
Appendix S12	Front Door Streaming Model
Appendix S13	Project Communications Plan
Appendix S14	Paediatrics Consultation - Public Document
Appendix S15	Paediatrics Consultation - Analysis Report
Appendix S16	Activity and Capacity Modelling
Appendix S17	Equality and Health Impact Assessment
Appendix S18	DBTH Strategic Direction 2017-2022
Appendix E1	Options Framework
Appendix E2	CIA Model
Appendix E3	Optimism Bias Calculation
Appendix E4	OB forms
Appendix C1	Procurement Strategy Report

Appendix C2	High Level Information Pack
Appendix C3	Design Sign Off Sheet
Appendix C4	Schedule of Accommodation
Appendix C5	Schedule of Accommodation As Drawn
Appendix C6	Schedule of Derogations
Appendix C7	Clinical Brief
Appendix C8	Detailed Drawings (to include 1:200)
Appendix C9	Design Commentary
Appendix C10	Fire Letter of Confirmation
Appendix C11	Infection Control Letter of Confirmation
Appendix C12	Planning Permission Pre-Application
Appendix C13	BREEAM pre-assessment NEW BUILD
Appendix C14	BREEAM pre-assessment REFURBISHMENT
Appendix C15	MMC Utilisation Tool
Appendix C16	Cost Advisor's Report
Appendix F1	Long Term Financial Model
Appendix F2	Valuation Report
Appendix M1	Project Programme
Appendix M2	Project Board Terms of Reference
Appendix M3	Steering Group Terms of Reference
Appendix M4	SRO's CV
Appendix M5	Benefits Register
Appendix M6	Premises Assurance Model
Appendix M7	Gateway Risk Potential Assessment
Appendix M8	Costed Risk Register

UK Company Registration No. 6937095

Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts

Annex 1: Business case core checklist

November 2016

NHS Improvement publication code: CG 14/16

Guidance for use

This checklist, prepared by the Department of Health (DH), NHS Digital (formerly the Health & Social Care Information Centre (HSCIC)), NHS England, NHS Improvement and other stakeholders, is for use by both NHS trust and foundation trust project teams and NHS Improvement in reviewing and providing assurance on capital investment and property transaction business cases. It comprises a 'core' generic checklist. NHS Improvement has added a bespoke clinical quality checklist – this should be completed for all business cases with a patient-facing or clinical aspect.

It should be noted that the format and content of the core checklist may vary in practice to suit the needs of the individual reviewing organisation. However, the core numbers and items in this core checklist will be common to all business case checklists.

Project teams should treat the checklist as a combination of guidance on material which must be included in a business case, and advice on various issues. For example, a business case should be submitted by the senior responsible officer (SRO) (checklist reference 1.1.2 in the checklist below), to show project ownership. If guidance is needed on any point, the project team should consult its case reviewer/approver lead.

Note that the checklist represents the **minimum** content of a business case. HM Treasury's *Green book*[1] and related five case model guidance should be used to produce a complete business case.

The checklist should be submitted with the business case, filled in to indicate whether or not a requirement has been complied with and where it is referenced.

Business case reviewers should then use the checklist in one or both of two ways:

- at the start, to check that the necessary basic material is present
- when the review work is complete, as a formal sign-off of the case, using Table 1 below.

Table 1: Checklist control table

	Name	Initial check (date)	Case submission/review complete (date)
Submitting organisation			
Reviewer			

[1] www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

Assurance summary

This section should highlight where further assurance is required and should be linked to the NHS Improvement recommendation report (Table 2).

Table 2: Assurance summary

Business case	Areas where further assurance is required	Recommendation
Strategic case		
Economic case		
Commercial case		
Financial case		
Management case		
Clinical quality		
Completed by:		

r

1. Strategic case

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Approvals and support				
✓	✓	✓	1.1.1	Has the business case been approved by the relevant board or governing body?	Provide minutes of the board/governing body meeting approving the business case. The board/governing body has approved all parts of the business case, eg strategic fit and the financial/operational impact.	N	2.3.1 Appendix S1
✓	✓	✓	1.1.2	Has the business case been submitted by the senior responsible officer (SRO)?	If there is more than one SRO/approving body, then the senior or lead responsible officer should take responsibility for submitting the case. The business case should go initially to the 'junior' approving body, eg NHS Improvement, if both NHS Improvement and DH are involved. It is important at this stage that the SRO shows ownership and formally signifies the start of the review/approval process.	N	
			Rationale and objectives				
✓	✓	✓	1.2.1	Has a clear rationale for the scheme been set out?	What requirement is being met, or what risks or problems are being solved? Is the proposed scheme sufficiently large and standalone to form a project or would it be more sensibly undertaken as part of another programme or project? The rationale should include the strategic priorities and alignment with clinical, workforce and estates strategies where relevant. The link between the rationale and activity, financial and workforce assumptions should be demonstrated.	Y	2.8

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.2.2	Have SMART objectives for the proposed investment/spending been identified?	SMART = specific, measurable, achievable, realistic and time bound. Objectives should be consistent with the benefits identified in the strategic and economic case and should be included in benefits realisation plans as appropriate.	Y	2.8.3
✓	✓	✓	1.2.3	Are the investment/spending objectives clearly linked to associated benefits?		Y	2.10
✓	✓	✓	1.2.4	Is it clear what health service needs are supported by the objectives?		Y	2.8.4
✓	✓	✓	1.2.5	Is there evidence of how the lead commissioning organisation has engaged its patients and/or users, stakeholders, wider public/ population and governors (as appropriate) in setting the clinical and service priorities that led to the scheme design and objectives?	For build projects, the case should show that patient group(s) are actively involved in informing development of the plans. For IT projects, discovery and alpha phases will precede the SOC and inform the direction of the project. For service change and reconfiguration proposals subject to the NHS England assurance process described in the NHS England guidance *Planning, assuring and delivering service change for patients*, has the SOC been informed by sufficiently mature analysis contained in the pre-consultation business case (PCBC) and the decision-making business case (DMBC)?	Y	2.8.5 Appendices S13, S14, S15

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	1.2.6	Have there been any changes to the original scope or objectives?	Are the previous case spending objectives and planning assumptions still valid? Do the services to be procured/does the recommended deal still provide synergy and best fit with other parts of the organisation's business strategy? Cost changes from those presented at OBC stage should be disclosed and explained.	Y	2.9.8
			Strategic and policy context				
✓	✓	✓	1.3.1	Has the strategic context been documented?	Where relevant, an organisation overview with details of structure, financial position, services provided, population and commissioners served could be useful. This should also take account of the wider context in which the organisation sits, eg the local health system (for builds), the UK as a whole (for national IT projects).	Y	2.4-2.7
✓	✓	✓	1.3.2	Has the impact on existing service configuration and the wider health economy been assessed? Is the rationale consistent with local/regional strategic priorities?	This applies primarily to builds, eg the organisation's vision, strategic priorities, clinical strategies and/or commissioning intentions (where appropriate) should be checked against what is known about service configuration priorities and other health priorities. Full details should be given of the consequences for other services, clinical networks and the local health system/health organisations.	Y	2.4.7, 2.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.3.3	Is there evidence of support from other relevant bodies, eg project sponsors and commissioners (where applicable)?	The project sponsor and/or commissioners should provide written approval of the business case (if applicable). Commissioners or other relevant bodies with a material interest in the scheme should provide written confirmation supporting the future activity and financial assumptions (if applicable), these being consistent with those of the investing body. The local health and wellbeing board should be consulted and written evidence provided of its support (if applicable).	N	2.3.2 Appendix S2
✓	✓	✓	1.3.4	Is the rationale consistent with government policy and strategic priorities? Any specific policies/ priorities should be listed.		Y	2.5
✓	✓	✓	1.3.5	Did the project comply with relevant Carter efficiency recommendations?	The case should refer to Lord Carter's 2015 report: *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*, and identify the recommendations being delivered by the project.	Y	2.5, 4.9
✓	✓	✓	1.3.6	Is the rationale consistent with the organisation's strategic priorities?	These should be aligned as needed with key external bodies, eg trusts with clinical commissioning groups (CCG).	Y	2.7
✓	✓	✓	1.3.7	Where local sensitivities and/or opposition have been identified, have possible mitigating actions been considered?		Y	2.9.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.3.8	Is there evidence of the extent to which the proposal promotes integrated working between health, social care and public health?	If parallel investments are necessary or being made in other organisations, these should be shown as a dependency.	Y	2.9.3
✓	✓	✓	1.3.9	Does activity and capacity planning in the investment proposal demonstrate consistency with related service planning?	Activity/capacity modelling and assumptions should be consistent with the activity requirements of the local health system and wider capacity plans, including alignment to workforce plans, organisational service developments and efficiency programme (if applicable). For build schemes, a utilisation schedule should be included to justify the scale of the proposed investment. This should provide evidence of the use of the facility (frequency of use in relation to days per week, hours per day/by speciality/user). The method for establishing this need should be included, as well as evidence of how utilisation targets have been arrived at.	Y	2.9.4 Appendix S16
✓	✓	✓	1.3.10	Does the scheme support greater patient choice on where and how to access care, and/or improved quality and safety of service provision?	See *Operational guidance to the NHS extending patient choice of provider*	Y	2.9.5

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.3.11	Is there confirmation that any equality and diversity impact has been assessed and addressed?	The proposal must pay due regard to the public sector equality duty in line with the principles and requirements of the NHS Constitution and with current legislation and guidance.	Y	2.9.6 Appendix S17
✓	✓	✓	1.3.12	If the scheme involves changes to services, have the four key tests for service reconfiguration been met? Evidence of this should be provided.	The four key tests for service reconfiguration were set out in the NHS England guidance *Planning assuring and delivering service change for patients* published in November 2015. These are: • strong public and patient engagement • consistency with current and prospective need for patient choice • clear, clinical evidence base • support for proposals from commissioners. This guidance is a good practice guide for anyone involved in service change or reconfiguration proposals, including trusts. The guidance sets out the required assurance process commissioners should follow when service reconfigurations are being considered.	Y	2.9.7

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	1.3.13	If there have been any strategic or organisational changes, have these been adequately explained and their effects on the investment described? Are the demand assumptions in support of the size and scope of the investment still valid?	Does the recommended solution still provide all the required services – both current and future?	Y	2.9.8
	✓	✓	1.3.14	Has a post-project evaluation relating to the current service been attached?	This applies where the business case is for a reprocurement or further development of an existing service. Any evaluation that has been carried out should be appended, and referred to in the case. In particular, it should show how: • it has informed objectives • lessons learned have informed the development of options • lessons learned have informed management.	N/A	
			Risks, constraints and dependencies				
✓	✓	✓	1.4.1	Has the strategic case summarised the main risks of the proposed investment project?		Y	2.11

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.4.2	Has the business case identified the main constraints and dependencies of the proposed investment project?	This is particularly important if there are any interdependencies, especially benefits, with other investments/procurements.	Y	2.12

Strategic case: Build schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
✓	✓	✓	1.5.1	Is there evidence of a board- or governing body-approved estates strategy (or equivalent) that articulates the need for this capital investment?	The estates strategy should cover a defined period in the future. The starting point for developing the strategy is to identify the current and future healthcare service needs of the local population and the current condition of the healthcare estate. An estates strategy cannot be developed in isolation from service planning and should integrate with local commissioning and service strategies. The estates strategy should also address the backlog maintenance and costs in relation to the existing estate. The business case must show and quantify how the proposal put forward will contribute to reducing the backlog maintenance for the buildings involved and the NHS estate as a whole. See the DH 2005 best practice guide *Developing an estate strategy*.	Y	2.7.8 Appendix S11

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
✓	✓	✓	1.5.2	Does the estates strategy contain board or governing body-approved development control plans (DCP) for the developments proposed in that strategy?	The business case should include a health organisation board or governing body-approved DCP if the site development is complex. For less complex developments, site plans detailing access and relationships with other properties may suffice.	N No DCP but a Clinc ial Site Serv ices Strat egy will be avail able at FBC	2.7.8
✓	✓	✓	1.5.3	Is the rationale consistent with the mandatory government construction strategy?		Y	4.7.5

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	1.5.4	Is there evidence of a board or governing body-approved sustainable development management plan which sets out clear milestones to measure, monitor and reduce direct carbon emissions?	This will include the impact of new build and refurbishment projects associated with the estates strategy. For further guidance, see *Sustainable development in the NHS*.	Y	2.7.9

Strategic case: IT schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
✓	✓	✓	1.6.1	Is there a summary of the organisation's current IT capability? Does this identify the starting point for development of the IT scheme?	An annex may include, for example, the configuration of current systems, existing level of integration, extent of paper-based systems and level of IT (information processing) expertise.	N/A	
✓	✓	✓	1.6.2	Is the 'gap' in IT provision – between the current position and the identified objectives supporting health service delivery – known?		N/A	
✓	✓	✓	1.6.3	Does the programme demonstrate awareness of the relevant government standards and policies for technology? How does it ensure these will be met?	The Technology Code of Practice and Digital by Default Service standard always apply.	N/A	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓		1.6.4	Is the options analysis of the delivery approach supported by adequate analysis of user, as opposed to stakeholder, needs?	Services that are driven by policy without appropriately meeting user needs are far less likely to deliver the claimed benefits due to low adoption rates.	N/A	
✓	✓		1.6.5	Has the programme established the criteria to be met by the minimum viable product (MVP)?	The MVP is the minimum IT support necessary to deliver a service. If the MVP is undefined, then scope-creep and consequent negative impact on value for money (VfM) in particular are more likely. A service that is unable to articulate MVP criteria is unlikely to have completed sufficient analysis of user needs.	N/A	
✓	✓	✓	1.6.6	Is the programme or any component within the scope of service assessments? If so, at what stage and what were the outcomes?	Service assessments are mandatory at alpha, beta and live stages of programmes. Failure to pass these can prevent the programme continuing to the next stage or even live deployment.	N/A	
✓	✓		1.6.7	Do the options analyses consider technical decisions and justify the preferred option?	Buy versus build, proprietary versus open source, co-location or in-house provision versus cloud hosting, etc.	N/A	

2. Economic case

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
				Options appraisal			
✓	✓		2.1.1	Has a wide-ranging, long list of options (including 'do nothing' or 'do minimum') for achieving the investment objectives been drawn up?	Options should be identified using a range of parameters. Suitable parameters may include scope, implementation approach, timing, scale. Use of a feasibility study is recommended. See *Green book* pp.17–18.	Y	3.3.1
✓	✓		2.1.2	Have the critical success factors/criteria/steps for options appraisal been identified?	Critical success factors should be identified. These should be essential (rather than just desirable) factors and set at a level which does not exclude important options. All criteria should be clearly derived from the SMART (specific, measurable, achievable, realistic and time bound) objectives set out in the strategic case. The reasons for their relative weightings should be set out.	Y	3.2
✓	✓		2.1.3	Is the preferred way forward outlined? This should comprise a shortlist of options with sound reasons for their inclusion.	Options should be clearly weighted, scored and ranked in line with *Green book* guidance. A SWOT (strengths, weaknesses, opportunities, threats) analysis is recommended.	Y	3.5

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.1.4	Has the preferred option been described sufficiently well to enable a quantified assessment of costs, benefits and risks? Can wider impacts be assessed, eg sustainability, competition, regulatory impact?	If, unusually, there is more than one preferred option, the reason for this should be explained.	Y	3.5
			Costs				
	✓	✓	2.2.1	Have all relevant capital and running costs been identified and properly assessed?	The costs should cover the whole life of the investment for all IT projects and most build projects, where possible. They should take into account (if appropriate): lifecycle costs (building-related and equipment/IT replacements), residual values, monitoring and evaluation costs, health organisational development costs, opportunity costs, second-round effects, avoided costs and costs borne by others. Care should be taken not to double-count costs. See *Green book* pp.20–23. Cost sources should be identified for all costs, including where these are estimates. Note that costs must be assessed on a 'bottom-up' basis: that is, the case must show the total costs of each option, not just costs incremental above existing levels of expenditure. Descriptions of how all costs have been quantified should be available along with supporting spreadsheets.	Y	3.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.2.2	Have all key assumptions underlying the costs analysis been stated?	For example, the assumptions about the life of an asset. Reference the source documents underpinning these assumptions.	Y	3.6
	✓	✓	2.2.3	Are costs shown in real term, constant (uninflated) prices, with the base year clearly specified and the current year shown as Year 0? Has the correct discount rate been used?	See *Green book* pp.25–28	Y	3.6
	✓	✓	2.2.4	Have sunk costs, transfer payments, VAT, capital charges, depreciation and other non-resource costs been excluded from the net present costs (NPC)?	Sunk costs are those already incurred, eg project management. Transfer payments include redundancy payments, VAT and local authority rates. Only income from non-government (third-party) organisations should be included.	Y	3.6
	✓	✓	2.2.5	Is the appraisal period appropriate to the life of the asset generated by each option?	A view from the technical advisor should give the economic life of the asset generated by each option and must be stated. Where the appraisal period is different for alternative options, discounted costs must be expressed as equivalent annual costs rather than NPC.	Y	3.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Benefits				
	✓	✓	2.3.1	Have appropriate and credible benefits been identified?	The benefits should be identified through consultation with stakeholders, eg through a benefits workshop. These may include cash-releasing, non-cash releasing or non-quantifiable (qualitative) benefits. See *Green book* pp.21–23. Benefits should be consistent throughout the case; that is, strategic, economic, financial and management.	Y	3.6.8
	✓	✓	2.3.2	Have all key assumptions underlying the benefits analysis been stated?	For example, the assumptions about why a benefit might vary from one option to another, or be treated as non-cash releasing rather than cash-releasing. Reference the source documents underpinning these assumptions.	Y	3.6.8
	✓	✓	2.3.3	Is evidence provided that the benefits are consistent with the SMART objectives identified in the strategic case?		Y	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.3.4	Have benefits been quantified in line with HMT's *Green book* guidance? Non-cash releasing benefits (CRB) should be monetised where possible. Is there a costed profile of benefits?	Care should be taken not to double-count benefits. Non-CRB are very similar to CRB, although the key difference is the former monetises in monetary terms whereas the latter monetises in financial terms (that is, CRB should be considered actual savings, while non-CRB are more usually efficiencies or increases in productivity). Staff time is a common non-CRB in capital investments, eg for digital pens: time saved typing up patient notes = 15 minutes per day, hourly salary = £15 0.25 x 15 = £3.75 per day productivity saving per employee If benefits are owned by other organisations, their input should be sought where possible, and their ownership shown (eg of an IT project) in the benefits realisation plan.	Y	3.6.8
	✓	✓	2.3.5	Where it is not possible to quantify a benefit, is it explained why this is so and have benefits been separately qualitatively evaluated where possible?	Where benefits cannot be valued or quantified, a weighting and scoring exercise should be undertaken. The shortlisted options should then be ranked according to their benefits score. There should be evidence that weights and scores for qualitative benefits have been sufficiently justified for non-quantified benefits.	Y	3.6.8
	✓	✓	2.3.6	Have quantified benefits been discounted over the period of appraisal?	The discount rate should be 3.5% if benefits are valued in real terms or 1.5% if quality-adjusted life years have been used in valuing benefits. For projects with very long-term impacts (over 30 years), a declining schedule of discount rates should be used (see *Green book* Annex 6).	Y	3.6.8

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.3.7	Have the values of benefits been stated in constant (uninflated) prices and are they consistent with the cost assessment?	See *Green book* pp.25–28	Y	3.6.8
			Risks				
✓			2.4.1	Have potential risks, constraints and dependencies been identified?	Risks, constraints and dependencies should be consistent with the strategic case – where they should have been described.	Y	3.6.9
	✓	✓	2.4.2	Have the risks associated with the preferred option been appropriately identified across the whole lifecycle of the project?	These risks should be set out in a risk register (see also management case). Whole lifecycle refers to the life of the project. This is normally the construction period plus 60 years of operational life for new-build investments. Refurbishment schemes are shorter, typically 25–30 years, depending on the anticipated life of the anticipated buildings. IT projects tend to be evaluated over a short time period (7–10 years or even less), with allowances to renegotiate or extend the current contract.	Y	Appendix M8

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.4.3	Have the risks been quantified and costed? These should be presented in a matrix showing: • which party is responsible for managing risks • the probability of the risk • the impact of the risk • the expected cost of each risk (probability x impact).	A narrative should explain the method for the quantification of risks and how the probability has been derived.	Y	Appendix M8
	✓	✓	2.4.4	Have the assumptions underlying the identification, timing and potential impact of the risks been explained?	These should be covered in the risk register.	Y	Appendix M8
			NPV, optimism bias and sensitivity analysis				
✓			2.5.1	Is there evidence of the proposed method for the calculation of the net present value (NPV) for shortlisted options, including identification of the required data?	An appropriate discounted cash flow model should be used, such as the GEM (soon to be replaced by the CIA) for build cases, or the NHS Digital (formerly HSCIC) template for IT cases.	Y	3.6 Appendix E2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.5.2	Have costs, benefits and risks been adjusted for optimism bias?	Optimism bias and mitigation have been assessed in accordance with the optimism bias guidance on DH (NHS build specific) and/or HMT websites. Adjustments should be empirically based (eg using data from past projects or similar projects elsewhere). See *Green book* pp.29–30 and the *Supplementary green book guidance on optimism bias*.	Y	3.6 Appendix E3
	✓	✓	2.5.3	Have the costs, quantified benefits and quantified risks been combined to establish the NPV for shortlisted options? Investment proposals should provide evidence of the triangulation of demand and capacity modelling, workforce strategy, service development and efficiency programme across the lifetime of the scheme.	For approval of capital investment schemes greater than £35 million, and service reconfiguration business cases, the valued benefits must exceed risk-adjusted costs by a ratio of 4:1. This represents the absolute VfM threshold in health spending. However, achieving the threshold is not a simple pass/fail test and each business case will be assessed individually basis. DH economists advise that this is not used as a strict benchmark (that is, some cases fall below the 4:1 threshold, but have other important qualitative/strategic benefits).	Y	3.6 Appendix E2
	✓	✓	2.5.4	Has an appropriate sensitivity analysis of costs, benefits and risks been carried out?	This should be undertaken to demonstrate either switching values, with the likelihood of the switch explained, or percentages chosen and the basis for selection explained. It should include the worst case scenario. See *Green book* pp.32–33.	Y	3.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	✓	2.5.5	Has a cost-to-benefit ratio been calculated for all the shortlisted options, following the formula shown in the guidance?	Formula: Total non-CRB (non-CRB plus societal benefits)/ total opportunity costs (total discounted costs plus retained risks – CRB). As a minimum, all projects are expected to show a ratio of 1:1; that is, the expected amount in quantifiable benefits is at least equal to the amount being invested. It should normally be the case that the ratio is higher than 1:1, but this will vary depending on the type of project. The business case should justify the ratio for the project. The quantified benefits used should be credible, with their delivery capable of being assessed. The 4:1 ratio used by the NICE in assessing new medications should be used as a comparator. Projects which are patient facing are more likely to approach this ratio, and those more concerned with infrastructure are more likely to be further away from it. The ratio achieved should be commented on.	Y	3.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Summary				
		✓	2.6.1	Is there a summary of the OBC option appraisal, showing the long and short lists, result of the economic appraisal (including benefits and risks) and sensitivity analysis? If the assumptions, scope or costs have changed since the OBC, does the FBC demonstrate either that the original preferred option remains valid, or that a new preferred option can be demonstrated to be so on VfM grounds?	At FBC stage, the OBC economic appraisal should be reviewed to ensure it is consistent with the FBC. The economic appraisal undertaken at OBC stage needs to be undertaken again at FBC stage if: • there has been a significant change in the scope of the preferred option and/or • capital costs have increased by more than 5% or revenue costs have increased by more than 10%.	Y	3.6
	✓	✓	2.6.2	Is there a conclusion and clear recommendation for a preferred option? Are the reasons for selecting this option clearly stated?		Y	3.6.11
	✓	✓	2.6.3	Is the preferred option consistent with the results of the cost, benefits and risk appraisals? If not, why not?	The option that generates the lowest risk-adjusted NPC, or the highest risk-adjusted NPV, or equivalent annual cost (EAC) is the preferred ('best') option as it represents the most economically advantageous option. VfM should be based on risk-adjusted cost per benefit point (where best VfM = max NPV) or is there any evidence to suggest that the preferred option was not selected on the basis of the appraisal process? Eg was another option selected solely because it had the lowest cost? See *Green book* pp.37–39.	Y	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.6.4	Are there any decisive unquantified costs, non-beneficial areas and/or benefits, and are these assumptions clearly explained?	See *Green book* pp.34–35.	N	
	✓	✓	2.6.5	If distributional analysis is needed to highlight who benefits and who pays, has it been completed?	See *Green book* pp.24–25.	N/A	
		✓	2.6.6	Has the high level assessment and valuation of benefits and risks in the OBC been fully developed for the preferred option in the FBC, including a detailed risk log/register and benefits realisation plan?	See *Green book* p.44 (benefits realisation) and pp.80–82 (risk register log).	N/A	
	✓	✓	2.6.7	Is all supporting evidence (eg in annexes) consistent with the results in the main text?		Y	

Economic case: Build schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
✓	✓	✓	2.7.1	Is the proposal compliant with NHS estates design and costing requirements, including taking account of proposal 'abnormals'?	Costs to be set out in accordance with the *Healthcare premises cost guide* (HPCG) on OBC and FBC forms and latest Department of Business, Innovation and Skills (BIS) PUBSEC index (which has superseded MIPS). In addition, there should be: • a reasoned contingency sum • inclusion of any consequential planning costs, eg s106.	Y	
	✓	✓	2.7.2	Cost indices and regional location factors – cost advisors employed by NHS organisations are required to subscribe to BIS Construction Price and Cost Indices online to gain access to full data and share project data to ensure indices and location factors are sustainable.		Y	
	✓	✓	2.7.3	NHS Capital investment manual (CIM) cost forms; 1, 2, 3 and 4. Only CIM standard cost forms must be used and completed to reflect DH costing method and agreed costing indices, etc.	CIM forms can be found in the CIM *Business case guide* pp.46-47.	Y	
	✓	✓	2.7.4	If PF2 is involved, is tax properly treated and is risk transfer clearly achieved?		N/A	

Economic case: IT schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.7.5	Are tax/subsidy treatments non-distorting between options?	Check if there's any possibility of state aid if there is distortion between options. See *Green book* p.56.	N/A	
✓	✓		2.7.6	Have any discovery or preliminary works been carried out? If so, have the relevant spend control approvals and conditions been attached to the case?		N/A	

3. Commercial case

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Commercial feasibility				
	✓		3.1.1	Has a suitable range of procurement options been considered? Is the proposed procurement route appropriate for the project?	For public capital the Open, Restrictive, Competitive Dialogue or Negotiated procedures can be used provided the particular route adopted is justified. For PFI, Competitive Dialogue must be used. Has a managed service been considered as an alternative to a capital purchase with a revenue 'tail'? Does the case demonstrate understanding of the objectives, requirements and implications of a managed service, and is this reflected in the risk allocation matrix and risk transfer mechanisms?	Y	4.4 Appendix C1
	✓	✓	3.1.2	Is there confirmation that the organisation and relevant project advisers (eg lawyers) consider the proposal commercially feasible and deliverable?		Y	4.4.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.1.3	Does the proposal allow sufficient time and resources for the completion of all identified procurement tasks, eg completion of necessary procurement documents and supplier negotiations?	A realistic and credible timetable should be provided. The timetable must meet all applicable legal requirements, eg of the Public Contracts Regulations 2015. Legal minimum durations for procurement stages must not be breached. Procurement documents which may need to be completed include: OJEU, PQQ, ITT/ITPD, evaluation criteria, all output specification schedules for works and services, contract and/or payment mechanisms. If a call-off from a framework is proposed, then the authority must show that it is entitled to participate in the framework and that its requirements are in scope of that framework.	Y	4.2.1
			Scope				
	✓	✓	3.2.1	The business case should clearly describe the subject matter of the procurement. For example, has the business case clearly set out the buildings, land, equipment, technology, goods and/or related service streams to be included in the scheme?	The business case should be clear about the output to be procured, including specification of required outputs and requirements to be met (essential outputs, phases, performance measures, quality attributes). The business areas, stakeholders and customers affected by the procurement should also be set out, along with any future possibilities (potential developments and further phases). The process should be properly classified for the purposes of the procurement rules. It should be clear that the organisation can afford to commission or run the clinical services that are already in the building.	Y	4.3

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.2.2	Does the business case include a strategy for any specialised procurement, eg equipment, with a project plan identifying the timeframes and costs?	The equipment strategy should set out: • any existing equipment to be transferred • new equipment being procured in advance of the scheme • equipment being procured as part of, or in parallel with, the scheme • specialist equipment. The business case must confirm which organisation: • procures the equipment • funds the equipment • will own, operate and maintain/replace the equipment.	Y	3.6.3, 5.2 (costs) Equipment schedule being developed, will be 31nclduding at FBC
			Procurement strategy				
✓	✓		3.3.1	Has a realistic and robust procurement strategy been identified?	Clear, realistic procurement key milestones and delivery dates should be set out. Supplementary questions could focus on managerial capacity to deliver to timeline. Caution should be exercised in relation to overly optimistic timelines which have no contingency for slippage. The experience of capital procurement processes generally is that they invariably take longer than anticipated.	Y	4.4 Appendix C1

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.3.2	Does the procurement strategy comply with EU procurement law? Assurance of compliance with procurement legislation should be provided by legal advisors, and updated at FBC stage as appropriate.	For example, all procurement stages must be of at least the minimum duration required by law, which depends on the EU process followed. Where relevant, a copy of the OBC, ITT and draft OJEU advertisement should be included. The content of any sign off from legal advisors will be assessed. It is unlikely to be an unconditional endorsement. The reviewer will assess the degree of scrutiny that has been applied to the process; if this is considered inadequate, then the legal assessor will comment accordingly.	Y	4.4
	✓		3.3.3	Has the procurement strategy been chosen because it can provide an outcome that delivers VfM?	Consideration should be given to how to incentivise those involved with the scheme to provide VfM. This should be reflected in the chosen payment mechanism.	Y	4.4.2
	✓		3.3.4	Has an assessment of market interest been included together with any market soundings to date? Any factors that may have a detrimental impact on market interest are discussed and mitigation strategies included.		Y	4.4.1-4.4.2 Appendix C1

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
		✓	3.3.5	Is there confirmation that no material changes have been made to the procurement strategy? Or if there material changes have been made, have these been detailed and adequately justified?		N/A	
			Procurement process				
		✓	3.4.1	Was a suitable range of responses/bids elicited in response to the tender process to ensure robust competition?	If, for example, only one or two responses/bids have been received (raising the risk of a poor VfM outcome), this situation must be explained, including how it will be mitigated.	N/A	
		✓	3.4.2	Was any shortlisting of supplier responses carried out in the appropriate way, in accordance with the Public Contracts Regulations 2015?	An appropriate assessment of each shortlisted supplier (eg Dunn and Bradstreet reports) should be attached to the business case. This should form part of the wider evaluation of the suppliers which should be documented in the case.	N/A	
		✓	3.4.3	Has an adequate summary of the evaluation process and outcome been included? Does it identify and clearly define all the pros and cons of each shortlisted bid, including the preferred bid? Has the selection of the supplier been carried out fairly and in accordance with the Public Contracts Regulations 2015?	The FBC must demonstrate that the appropriate procurement procedures have been followed as required by EC Directives. A copy of the published OJEC notice should be included in the FBC.	N/A	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
		✓	3.4.4	Is there a clear recommendation for the preferred bidder from the procurement?	The recommendation should be supported by the procurement evaluation report, where relevant. It is good practice to append this report to the business case. The preferred bidder's offering should be clearly described.	N/A	
		✓	3.4.5	Is there a statement of any additional benefits offered by any higher cost supplier?	This is to confirm that the bid with optimal VfM has been selected.	N/A	
	✓	✓	3.4.6	Is the accounting treatment of the potential deal set out?	This section should provide details of the intended accountancy treatment for the potential deal and confirm on whose Statement of Financial Position, formerly known as the balance sheet (public, private or both sectors), the assets underpinning the deal will sit. Where the scheme is novel, contentious or repercussive, or the accounting treatment is unclear, the organisation should obtain written agreement from its external auditors on the proposed accounting treatment.	Y	4.4.3
			Key contractual issues				
	✓	✓	3.5.1	Is there a summary commentary on all key scheme-specific commercial and legal issues?	As appropriate for OBC/FBC stages of business case development.	Y	4.4.5

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.5.2	If the procurement is using a standard contract, have any alterations or derogations been signed off?	The legal reviewer/assessor normally signs these off.	N/A	
	✓	✓	3.5.3	If the procurement is not using a standard contract, does the case indicate what contract will be used? Suitable commentary should be provided. Is the rationale for this structure convincing?	Provision of appropriate detail is necessary to enable full scrutiny of the proposed commercial terms. Details should be provided in relation to the duration of the contract, key roles and responsibilities, proposed liabilities, change control, arrangements for remedies for breach (eg due to delays, poor quality, price, etc), treatment of intellectual property, compliance with appropriate regulations, dispute resolution arrangements, operational and contract administration, proposed breakpoints, provisions for contract extension and options/arrangements at the end of the contract. Any derogation from standard form documents should be highlighted. The contract should tie into the risk analysis. The DH/Treasury Task Force (TTF) guidance on the contractual provisions for PFI/public private partnership (PPP) deals must be followed.	N/A	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.5.4	Are there clear and realistic contractual key milestones and delivery dates?	The following examples of different payment mechanisms may be helpful: • fixed price • reimbursement of costs plus agreed margin • payment on the delivery of agreed outputs. Any available deductions should be clearly described, eg: • availability and performance deductions • liquidated damages for delay. Any incentive payments or gain share arrangements should be clearly described.	Y	4.4.4
		✓	3.5.5	Has the payment mechanism been clearly set out? Is it appropriate?	The payment mechanism should be appropriate to the type of scheme, eg publicly-funded/PFI. These examples drawn from PFI-type schemes may be helpful to other types as well. The payment mechanism for the: • pre-delivery phase could be fixed price/costs or payment on the delivery of agreed outputs • operational phase could be availability payment, performance payment, transaction/volume payment, incentive payment, cost of change or third-party revenues • extension phase (if any) could be technological obsolescence or contract currencies.	Y	4.4.5

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Risk				
	✓	✓	3.6.1	Has the identified risk (see economic case) been appropriately allocated between public and private sectors?	The business case should include a risk allocation table. The governing principle is that risk should be allocated to the party best able to manage it, subject to relative cost. For PFI/PPP: there should be a sound risk allocation matrix for the preferred option showing how risks are to be apportioned between the public and private sectors. Shared risks should be excluded. Ideally, a percentage allocation should be recorded between the categories of public, private and shared risk. If this is not feasible, then a 'tick' system can be used at OBC stage. Has account been taken of potential private sector risks, eg bankruptcy of service provider?	Y	4.5.1
	✓		3.6.2	Is a timetable set out to revisit and evaluate the risk allocation matrix?		Y	4.5.1
		✓	3.6.3	Is the mechanism for effecting risk transfer described? Are the risks identified as transferable to the suppliers reflected in the contract?		N/A	
			Personnel				
	✓	✓	3.7.1	Does the OBC state explicitly whether the scheme has any implications for personnel? Does the FBC confirm this?		Y	4.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.7.2	Are any staff likely to be transferred? If yes, will TUPE apply? If it does, have all the provisions been complied with?	TUPE – Transfer of Undertaking, Protection of Employment Regulations 2006 (and as updated since). This protects the employment conditions of public sector staff transferring to the private sector.	No staff will beTUPEd	4.6
	✓	✓	3.7.3	Is there confirmation that plans accord with current guidance and requirements on retention of employment (RoE) as related to pensions, and that there are plans for consultation in accordance with the law/guidance?	TUPE protection does not include pensions, and DH developed RoE to cover these. Its use is now specifically restricted to soft facilities management in PFI schemes. If it applies, a copy of the legal advice received must be provided, as well as whether the health organisation's HR director accepts or disagrees with it and why.	N/A	

Commercial case: Build schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.1	Have numbered and dated 1:200 (or electronic equivalent in terms of level of detail) drawings been included?	These should: • include site plans and elevations, where appropriate • be numbered and dated, not loaded and with m^2 net internal area (NIA) shown • be consistent with the Schedule of Accommodation/Derogation.	Y	4.7.1 Appendix C8
		✓	3.8.2	Have numbered and dated 1:50 (or electronic equivalent in terms of level of detail) drawings been included?	These should be: • be numbered and dated, loaded and with m^2 NIA shown • consistent with the Schedule of Accommodation/Derogation.	N/A	
	✓	✓	3.8.3	Has a schedule of accommodation/derogation been provided?	This should be in Excel spreadsheet format on a room-by-room basis with any derogation to statutory/mandatory/DH standards highlighted. To support cost forms, drawings and infection control, fire safety, etc certificates of compliance should be attached. See archive publications and DH health building notes.	Y	4.7.1 Appendix C4, C5, C6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.4	Detail any land transactions that are necessary to enable the scheme, together with any conditions that are attached to those transactions, including any constraints relating to the site. If there are conditions, are they built into the options appraisal?		Y	4.7.3

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.5	Is there confirmation that design/project solutions are appropriate and, in addition, will actively support healthcare outcomes?	This may be achieved using one or a combination of the following design toolkits: • **Design review: ASPECT**: deals with the way the healthcare environment can impact on the levels of satisfaction shown by staff and patients, and on the health outcomes of patients and the performance of staff. ASPECT can be used as a standalone tool, but should be used to support DQI (see below) and provide a more comprehensive evaluation of the design of healthcare environments. • **Design review: External review panel**: owner organisation should consider external design review panel, particularly for high value/complex projects as it could be related to planning permission requirements or other internal/external influences • **Design review: Design quality indicator (DQI)**: an established design quality assessment method updated for health use with the support of DH to succeed AEDET. DQI focuses on the quality of projects under three headings: functionality, build quality and impact, and engages a wide range of stakeholders. There are five assessments stages, led by an independent accredited DQI facilitator: briefing; mid design; detailed design; ready for occupation; in-use. Projects must undertake all five stages of assessment to be DQI health accredited. The briefing stage DQI should be held early in the briefing process and must be completed before the end of the SCO.	N Agreed not until FBC	4.7.4

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.6	Does the scheme demonstrate commitment to the government construction strategy?	Evidence to be provided of commitment to government construction strategy including: • cost reduction c15% • procurement reform • building information modelling (BIM) • government ‘soft landings’ • benchmarking. Applies to all construction including local improvement finance trust (LIFT) schemes.	Y	4.7.5
	✓	✓	3.8.7	Has a healthcare planner been appointed to the design team and have they actively contributed to the planning and evaluation process?	The proposal should include a description of the service model backed by plans/drawings demonstrating clinical/non-clinical adjacencies.	Y	4.7.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.8	Is there evidence that the design solution complies with relevant DH consumerism requirements for healthcare buildings?	These requirements include: • acceptable levels of privacy and dignity at all times • gender-specific day rooms • high specification fabric/finishes to reduce lifecycle costs • natural light and ventilation • zero discomfort from solar gain • dedicated storage space to support high standards of housekeeping and user safety • dedicated storage for waste awaiting periodic removal • inpatient bed configurations of >50% single en-suite and >5 bed bays with separate en-suite WC and shower facilities with 3.6-metre bed centres • single-sex washing and toilet facilities • safe and accessible storage of belongings including cash • immediate patient access to call points for summoning assistance • patient control of personal ambient environmental temperatures • lighting at bed head conducive to reading and close work • patient bedside communication and entertainment systems • elimination of mixed-sex accommodation (2011). There should be formal confirmation from the responsible person that compliance with regard to single-sex accommodation and privacy and dignity is achieved, quoting drawing numbers (where appropriate)/date of review. See *Adult in-patient facilities: planning and design* (HBN 04-01), archive publications and DH health building notes.	Y	4.7.7

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.9	Does the scheme comply with health building note (HBN) requirements?	HBN give 'best practice' guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. They provide information to support the briefing and design processes for individual projects in the NHS building programme. They should be complied with; however, where they are not, the deviation from guidance should be included in the derogations.	Y	4.7.8
	✓	✓	3.8.10	Does the scheme comply with health technical memorandum requirements?	Health technical memoranda (HTM) give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. Healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. The HTM series provides best practice engineering standards and policy to enable management of this duty of care. They should be complied with; where they are not, the deviation from guidance should be included in the derogations.	Y	4.7.8

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.11	Does the scheme comply with the building research establishment environment assessment model (BREEAM) assessment?	DH requires, as part of the business case approval, that all new builds achieve a BRE 'Excellent' rating and all refurbishments achieve a BRE 'Very Good' rating under BREEAM Healthcare with schemes of value in excess of £2 million (>500 m^2). A BREEAM pre-assessment completed by a registered BREEAM assessor and demonstrating the required target score should be provided at OBC. A BREEAM interim design certificate demonstrating the required target score issued by BRE should be provided with FBC/stage 2 submissions.	Y	4.7.9 Appendix C13, C14
	✓	✓	3.8.12	Does the scheme comply with the Fire Code?	Formal confirmation that Fire Code compliance is achieved should be provided by the person in the organisation responsible for fire precaution compliance, quoting drawing numbers/date of review.	Y	4.7.10 Appendix C10
	✓	✓	3.8.13	Does the scheme comply with infection control?	Letters of compliance should be provided by a consultant microbiologist and/or infection control lead. Healthcare buildings must be designed with appropriate consultation with specialists to ensure the design facilitates good infection prevention and control (IPC) practices and has the quality of design (including finishes and fittings) that enables thorough access, cleaning and maintenance to take place. See HBN 00-09: *Infection control in the built environment*.	Y	4.7.11 Appendix C11

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.14	Does the scheme meet DH energy and sustainability targets?	Evidence is provided to show that the submitting organisation has applied the revised energy drafting and principles in accordance with DH's principles paper (final version issued February 2005) or (if the energy plant at the new facilities is expected to be regulated by the recent CRC Regulations) the submitting organisation has adopted drafting which reflects similar principles and has been approved by a private finance unit (PFU). Alternatively, if there is a project-specific reason why neither of the above approaches is suitable (eg there is already a long-term contract with an existing energy management supplier), the treatment of energy issues in the draft contract has been approved by PFU. See also HTM 07-02, DH health building notes and Sustainable Development Unit.	Y	4.9.4
	✓	✓	3.8.15	Is there confirmation that the NHS facility is resilient to a range of threats and hazards?	Resilience is the ability of the building and its services to withstand the impact of an incident or emergency. HBN 00-07 provides: • a strategic approach to resilience planning • technical guidance on measures to enhance resilience.	Y	4.7.12

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.16	Does the scheme comply with the relevant health organisation travel plan?	Evidence of the current board- or governing body-approved travel plan.	N Agreed not available until FBC	4.7.13
	✓	✓	3.8.17	Has a summary of the necessary planning permissions been provided?	The elements of the scheme that require planning permission or change of use approval should be detailed. If no permission is needed, a statement to that effect should be included to show that planning has been considered.	Y	4.7.14 Appendix C12

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.18	Has outline planning permission been obtained for all the developments described in the business case?	Outline planning permission should be sought to identify any issues relating to planning. Early involvement of the planners can avoid the need for costly redesigns during later stages of development. On schemes where, exceptionally, planning permission cannot be achieved at OBC, the organisation submitting the OBC must be able to demonstrate that planning authorities have no major objections to the scheme. The form of that assurance will be considered on a case-by-case basis. Evidence which may be considered/required includes: • evidence of sign off from the organisation's planning advisors • the strategy to engage the local planning authority to minimise forward risks • the impact of any significant conditions included in the planning permission or communications with the planning authority • details of any additional planning requirements.	N (pre-app advice request submitted)	4.7.14

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.19	Is a copy of the planning application, letter of approval from the local authority and schedule of any planning conditions and costs provided?	An FBC will not be approved without planning approval (where this is required) or change of use approval (where this is required). Evidence must link with risk register and cost forms for affect/compliance with s106, s278, etc requirements. This item should also include reference to any judicial review period that may apply and NHS England's expectation that works will not commence until any judicial review period ends.	N (pre app advice request submitted)	4.7.14 Appendix C12
	✓	✓	3.8.20	Does the business case identify any acquisitions or disposals associated with the proposed development?	The business case contains the details justifying the disposal/acquisition in line with the recommendations found in the NHS estate code.	None identified	4.7.3
	✓	✓	3.8.21	For P21+ schemes, is there assurance that the requirements set out in the ProCure 21+ guide and detailed selection process have been properly observed?	P21+ should be the default option for construction projects.	Y	4.7.15

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.22	If procurement is via a call-off contract from a framework agreement, including but not limited to P21+, identify that the framework agreement evidences: • your entitlement to call-off • that what is being called off falls within the framework agreement's scope • that the call-off procedures of that framework agreement have been followed.	Although calling off from a framework agreement is an alternative to running an EU procurement law compliant-specific process, this is only so if the provider is entitled to call-off from the framework, the call-off is within the scope of the framework and the call-off procedures of the framework are followed. The call-off requirements are likely to be the most problematic. Most multi-operator frameworks will require mini-competitions between all capable providers on the framework. Such mini-competitions can face many of the same problems of fairly distinguishing between bidders as a full competitive process.	N/A	
	✓	✓	3.8.23	For P21+ schemes, have repeatable rooms been used? If not proposed, this needs to be justified.	P21+ repeatable rooms provide evidence-based high quality design as part of a standardised solution. They represent significant cost reduction and therefore must be considered in all cases. They are available to all NHS organisations, irrespective of the use of the ProCure21+ framework.	Y	4.8.1
	✓	✓	3.8.24	For P21+ schemes, have standard components been used? If not proposed, this needs to be justified.	P21+ standard components are exclusive to P21+ schemes and should be specified on the basis of significant cost reduction with justification if not. All components are compliant with current HBN or have approved derogation.	Y	4.8.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.8.25	Where P21+ is not used, has sufficient justification been provided as to why, as this alternative approach contributes to the aims and outcomes of the government construction strategy?	If Procure21+ is not the preferred option, the reason for this must be given in the options appraisal.	N/A	
	✓	✓	3.8.26	Any capital development commissioned for primary/community care and procured under LIFT using a lease plus agreement (LPA) or land retained agreement (LRA) should be tested for VfM against the LIFT procurement process. Where LIFT is deemed best VfM, LIFT procurement should be followed.	Go to Community Health Partnerships for latest NHS LIFT documentation.	N/A	

Commercial case: IT only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	3.9.1	Is any IT provision in line with DH policies?	Evidence to be provided that IT provision is in line with DH policies. A project plan should identify the timeframes and costs, and any critical IT with reference to the relevant organisation's IT strategy (or equivalent).	N/A	

4. Financial case

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
		Affordability				
ü	✓	4.1.1	Is a clear statement of capital and revenue affordability for the procuring organisation included in the business case, with any key assumptions highlighted?	This should be presented in nominal terms (taking into account inflation) and show the normalised position once the scheme is complete. A 'bridge' statement should be provided indicating how it is proposed the incremental cost of the scheme for the first full year of the operation is funded (eg efficiency saving, capital charges savings, application of existing budgets, etc). A clear statement should be provided describing the impact of the project on the organisation's ability to meet statutory financial duties. Has the organisation clearly stated the financial implications of not continuing with the project? This statement should include an assessment of any project costs incurred ahead of business case approval at the organisation's own risk. Have the cash and revenue impacts of any double running costs or decant costs associated with the scheme been considered? Have significant financial risks associated with the project been clearly stated and any mitigating actions considered? Eg where assumed savings are not delivered.	Y	5
✓	✓	4.1.2	Does the business case show the sources of the costing data and how these have been built up?		Y	5.2 and 5.3

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
✓	✓	4.1.3	Have any of the financial models used been appropriately quality assured?	The National Audit Office's (NAO) *Framework to review models* provides guidance on quality assuring modelling.	Y	5.4 Appendix F1
✓	✓	4.1.4	Have different funding options and their implications been considered?	The cost of any funding option should be included.	N/A	
✓	✓	4.1.5	Is there evidence that a source of (capital and revenue) funding has been confirmed?	The proposal must quantify and identify the (a) type of capital funding and (b) source of funding. This must be confirmed by all relevant parties, along with their agreement with the need to invest and with the preferred solution.	Y	5.1
✓	✓	4.1.6	Have any elements to be funded from external sources been identified, with the profile of funding/spend by year?	External sources include borrowing, public dividend capital, charitable, external grants and other non-provider sources. Confirmation in writing by the external provider of the funding must be evidenced.	Y	5.1
✓	✓	4.1.7	Where borrowing is assumed, has the amount of loan, assumed loan term, assumed interest, prudential borrowing assessment and repayments been clearly stated?	A statement showing the effect of the loan on the organisation's financial position and (where appropriate) financial risk ratings before and after the loan need to be modelled and should be included in the business case.	N/A	

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.1.8	Are any efficiency savings as a consequence of the scheme based on reasonable assumptions?	Relevant assumptions include those relating to income, expenditure, cost improvement programmes (CIP), quality, innovation, productivity and prevention (QIPP) savings, other efficiency savings, inflation, growth and any reductions in backlog maintenance. Details of the organisation's performance at delivering its CIP plans for the previous two years, analysed between recurrent and non-recurrent schemes, should be shown. On the income side, the review will be based on payment by results (PbR) tariff assumptions (national/local, including primary and community care sector pricing) versus activity levels. PbR assumptions should be consistent with commissioner assumptions, and activity assumptions/commissioning intentions should be valid. On the expenditure side, the validity of the efficiency assumptions through new ways of working, eg clinical safety and acceptability, will be checked. The measures proposed should be sanctioned by the relevant board and responsibilities for delivery should have been assigned.	Dependency on workforce model which will be delivered as part of FBC	5.3

ü	✓	4.1.9	In summary, is there evidence that the scheme is affordable year on year and in total to the procuring organisation?	Has the scheme been included in the organisation's financial plan, as appropriate? For NHS schemes there should be evidence that the scheme is affordable within the health system. Is it included in the DH/CCG/NHS England financial plan and/or is it consistent with commissioning plans and/or aligned with local/regional QIPP plans (as appropriate)? It must cover the capital and revenue consequences (including recurrent and non-recurrent consequences) over the life of the project. Financial interdependencies with other projects are identified and explained. Where the organisation/local health system is in financial deficit, the business case must explain how the scheme will contribute to the recovery plan. The recovery plan should be robust and supported by the relevant authorities. Where QIPP savings are required to deliver affordability or recovery arrangements are required to ensure robust finances: • the measures proposed have been sanctioned by the relevant board • responsibilities for delivery have been assigned and likely amounts quantified • monthly outturn on existing programme is provided. Contingencies should also be identified.	Y	5.4 Appendix F1
		Statement of Comprehensive Income/Statement of Financial Position				

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.2.1	Has a projected Statement of Comprehensive Income (I&E) been provided for the procuring organisation? This should cover the underlying/normalised financial position for the past two years, the current year's forecast and at least a five-year projection.	The year-on-year impact of the investment on the organisation's cash flow, Statement of Financial Position (SoFP) and Statement of Comprehensive Income (SoCI) over the whole life of the investment should be included in the business case. The accounts should be accompanied by appropriate commentary and notes which cover all key underlying assumptions, including inflationary assumptions, and income and activity assumptions. These accounts should fully include all anticipated operational developments. Non-recurrent support, income and costs should be identified and correctly accounted for. Sources of income need to be clearly described (including non-recurrent, transitional, third-party, provider resources, land sales, etc). SoCI (I&E account) projections should be shown gross and net of any one-off impairment charges, so that the underlying financial performance is clear. Ongoing maintenance commitments should be included, as well as any impairments, deferred assets and residual interest charge. Workforce implications are clearly described and costed in £ and work-time equivalents (WTE). Any CRB included in the accounts should be clearly described, including how it has been derived, its value and how it is phased over different financial periods to show its impact on the organisation's SoCI.	Y	5.4 Appendix F1

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.2.2	Has the incremental impact of the proposal on the procuring organisation's cash flow, SoFP and SoCI been included?	The costs profile in the business case should be compared with the existing baseline costs. A projected cash flow statement is provided for the same period as for the SoCI and demonstrates there is sufficient cash flow to cover running costs and debt servicing in the transition/double running period and beyond.	Y	5.4 Appendix F1
✓	✓	4.2.3	Is the anticipated SoFP (balance sheet) treatment of the scheme set out, showing impact on the procuring organisation? Any unusual risk factors should be fully analysed and discussed.	Where alternative accounting treatments are possible, evidence should be provided of adherence to the relevant accounting standards to justify the approach taken. This should be supported by written confirmation of agreement to the treatment from the organisation's external auditors.	Y	5.4 Appendix F1
	✓	4.2.4	Where assumed accounting treatment is open to interpretation, is there written confirmation from the director of finance, the procuring organisation's external auditor and the organisation's financial adviser stating that (in their opinion) the assumed treatment is correct?		N/A	
		Technical checks				
✓	✓	4.3.1	Is the split of costs between revenue and capital in line with the current capitalisation policy?		Y	5.3

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.3.2	Where the business case includes the purchase or creation of capital assets, is it clear which organisation will own the assets and whose asset register they will sit on?		Y	5.4
✓	✓	4.3.3	Are there recharges to other organisations as a result of the business case? If so, has the recovery of costs or income being generated been factored into the case? Are the mechanisms for these recharges clear?		N/A	
✓	✓	4.3.4	Have the procurement costs been clearly set out, including the basis for internal costs of the project team and the costs of advisers and technical support?	These should be included in the forward I&E projections. Any funding provided by commissioners or others for these should also be included in the SoCI. There should be commentary on the sources of funding, the agreements to provide funding and any conditions attached.	N/A P21 +	
✓	✓	4.3.5	Where leases are being purchased, have these been correctly accounted for as finance or operating leases in accordance with the applicable accounting standards?		N/A	

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.3.6	Has the treatment of VAT been clearly set out?	Appropriate independent expert advice should have been sought on the treatment and impact of VAT, VAT on land, etc on the scheme. This should be clearly laid out in the financial models and spreadsheets. For some larger schemes, a ruling from Customs and Excise confirming recoverability of VAT may be required at FBC stage.		5.2
✓	✓	4.3.7	Have all contract resources been split out from staff costs and shown as separate line items with correct treatment of VAT?		Y	5.3
		4.3.8	Is the treatment of stamp duty, corporation tax or any other taxes compliant with relevant legislation?		N/A	
✓	✓	4.3.9	Is the indexation assumption accurate and appropriate?	The choice of the most appropriate index will depend on what is being indexed. The business case should explain the choice of the index/indices used.	Y	Appendix F1
	✓	4.3.10	Has the financial analysis been updated to take account of any changes in costs, and to show the effect of the proposed contractual payments?		Y	5.4 Appendix F1

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
		Contingencies				
✓	✓	4.4.1	Are contingency plans described, eg for alternative sources of funding, if assumptions turn out to be wrong or insufficient? Is there flexibility to fund any additional revenue requirements or to absorb any affordability gap? Are there any contingent liabilities?	There should be adequate proposals for managing a shortfall. There should be written stakeholder support for the plans where relevant. For example, if the commissioners are covering the gap, is this cover clearly shown, including amount and timing? Is there evidence that the commissioners understand what the organisation is doing?	Y	5.2
✓	✓	4.4.2	Have the assumptions underlying the financial appraisal (including cost of risk mitigation) been analysed for their robustness?		Y	5.2

OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
ü	✓	4.4.3	Has sensitivity analysis been carried out on the relevant variables in the affordability analysis?	Sensitivity analysis has been carried out on the relevant variables in the affordability analysis that may have an impact on the overall commissioning plan, eg PbR modelling from an activity and price perspective. Switching analysis on the following key variables should be completed to assess the maximum and minimum for each under which the scheme remains affordable (keeping other variables as per the base case): • activity charges • efficiency gains • cost improvements • income/PbR parameters • pay costs • drugs and other running costs • construction inflations.	Y	3.6
✓		4.4.4	Is optimism bias set at the correct level, in accordance with the HMT *Green book*?	Individual elements may be non-applicable or replaced by specific risks.	Y	Appendix E3
	✓	4.4.5	Have all elements of optimism bias been replaced by specific risks and set to zero if appropriate?		Y	Appendix E3 and M8

Financial case: Build schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	4.5.1	Has a costed equipment schedule been provided?	Information must be consistent with costs provided in the business case and cost forms.	N Being developed for FBC but appropriate allowance included	
	✓	✓	4.5.2	Does the business case demonstrate that, where appropriate, the organisation has considered the option and potential for releasing any surplus land in line with the central government requirement?	Accelerating the Release of Public Sector Land for Development for housing is a central government initiative announced in 2011. *Disposal of surplus public sector land and buildings protocol for land holding departments* *Accelerating the release of surplus public sector land*	N/A	

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	4.5.3	Are any land transactions necessary to enable the scheme (disposal/acquisition) detailed, together with any conditions attached to those transactions? Have costs of those transactions been incorporated into the case?	The business case contains details justifying the disposal/ acquisition in line with the recommendations found in HBN 00-08: *The efficient management of healthcare estates and facilities*. In some instances, this may require a separate business case if funding/timescales cannot be aligned to the main business case. Risk around funding/cost and timescale should be clearly identified and costed in the risk section.	N/A	
	✓	✓	4.5.4	Where land sale proceeds are to be used, does the business case set out the valuation basis, timing for sale and a contingency for downward market movements?	Has the valuation been based on the advice of a suitably qualified and experienced valuation surveyor? Use of land sale proceeds should be agreed with all relevant parties, eg NHS Property Services, DH. Any cost benefits or non beneficial aspects to the sponsoring NHS organisation(s) linked to the acquisition or disposal of land as part of the business case must be clearly stated, and the net financial impact on them made explicit in the financial modelling and affordability analysis. See Annex 3 (Land and buildings) of the *Green book*.	N/A	
	✓	✓	4.5.5	Has the organisation taken appropriate advice regarding asset impairments?		Y	5.4 Appendix F2

Financial case: IT schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
		✓	4.6.1	Have the costs of implementation and business as usual (BAU) been included in the analysis? Over what timescale?		Y	

5. Management case

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Project plan				
	✓	✓	5.1.1	Is there a project plan with delivery plans, dates and detailed milestones?	The project plan should cover key milestone dates, including approvals, future contract management and operational plans. It could take the form of, or be accompanied by, a management control plan.	Y	6.2
	✓	✓	5.1.2	Is there a robust contract management plan?		Y	
	✓	✓	5.1.3	Are other workstream milestones and their interdependencies with the proposal clearly set out?	Other workstreams may include workforce, equipment, training, benefits delivery. Clear delivery dates and detailed milestones should be provided.	N/A	N/A
	✓	✓	5.1.4	Is an Office of Government Commerce (OGC) gateway risk potential assessment (RPA) attached?	The outcomes of the RPA should be shown. In some cases, eg when required by HMT, it may be appropriate to include the full report.	Y	6.12
	✓	✓	5.1.5	Once the OGC gateway RPA has been completed, are there clear arrangements for peer reviews?	Confirmation should be provided that recommendations, in particular high priority recommendations, are being addressed. Schemes with high RPA scores of 41+ will require a gateway review. Medium scoring schemes may be subject to gateway review at the discretion of the SRO.	Y	6.12

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.1.6	Are plans and a budget in place for post implementation monitoring and post-project evaluation (PPE)?	Is there a clear definition of the scope of the PPE, approaches to be adopted (eg the Magenta Book), timescales and specific milestones reviews? Plans should be consistent with the benefits identified in the economic case and in line with overall objectives. What is the resource for this? Are costs for PPE included in the project cost? Participation in wider aggregate research may also be appropriate and beneficial. Note: a Stage 5 in-use design quality indicator (DQI) assessment is classified as an element of PPE. The DQI PPE supports the benefits realisation PPE requirement of the CIM and government mandatory BIM (Building Information Modelling) 'soft landings' process for 2016 (government soft landings).	Y	6.10
			Project management				
	✓	✓	5.2.1	What is the project management budget?	A breakdown of the budget should be provided. The budget should incorporate appropriate contingencies (and provide a rationale for these) and be consistent with the financial case.	Y	6.3.1
✓	✓	✓	5.2.2	Is there a summary of the project management structure?		Y	6.3.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.2.3	Does the project structure give assurance that the project has sufficient backing and commitment from senior executives and user groups to underpin a successful project? Has the chief executive or equivalent signed off the PBC/SOC, OBC and FBC, and is board support explicit?		Y	6.4 Appendix M4
	✓		5.2.4	Has the project management method been defined?	The recommended project method is PRINCE 2 (Projects IN Controlled Environments), which is the de facto standard in use in the public sector in the UK.	Y	6.3

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓		5.2.5	Is the membership of the project team set out?	Details of the following should be set out. For large schemes/builds, it would be appropriate to see all of: • the amount of dedicated project/programme resource, that is, number of full/part-time staff and their roles • roles and responsibilities of team members • a management structure indicating communication links and reporting responsibilities • evidence that the extent of senior management and clinical time has been assessed and factored into resource requirements • CVs of the project manager and 'benefits and change manager' (or job descriptions if not yet appointed). For smaller schemes, the first four items on the above list can be useful for providing assurance of competence in these key posts. In IT schemes in particular, it is important to have an adequate resource for benefits management and skilled personnel.	Y	6.4 Appendix M2 and M3

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.2.6	Is there sufficient and adequately skilled resource available to successfully manage the procurement, implementation and operational stages?	The skills set of the team and any skills gaps are identified. Plans are set out on how skill gaps are to be filled, including any plans to use advisers. Who will be responsible for contract management? How does their work fit into the overall project management structure? The role of advisers is set out, including the terms on which they have been appointed, confirmation of the breadth of their appointment, and arrangements to manage their fees.	Y	6.4.7 Appendix M4
	✓	✓	5.2.7	Have adequate management arrangements been put in place to manage the bids, preferred bidder appointment and contract?	These should be clearly set out.	Y	6.4.5
			Project reporting and monitoring				
	✓	✓	5.3.1	Have the reporting structure and monitoring arrangements been set out?	This should identify who is involved in reporting and monitoring, when and how this takes place and the anticipated cost.	Y	6.4
	✓	✓	5.3.2	Does the plan include full details of the membership and terms of reference of the project board and subgroups in the project management structure?	The case should include an organogram or other representation of the project structure and governance (including links to the organisation's board).	Y	Appendix M2 and M3

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.3.3	Has the senior responsible owner been identified?	The SRO is the person who is made ultimately accountable for the success of the programme by the lead/procuring organisation and is usually a member of the management team of that organisation.	Y	6.4.7
			Benefits management				
	✓	✓	5.4.1	Is there a benefits realisation table and plan?	At OBC stage the benefits strategy should be outlined. At FBC stage a detailed plan should be included. These should cover all benefits, CRB and non-CRB, and should reconcile with the economic benefits identified and valued in the economic case. The benefits should be quantified and measurable. There should be a clear plan to ensure monitoring and evaluation of the quantified benefits. This needs to include a timeframe and accountable owner, and ensure that the criteria for measurement have been identified.	Y	6.7
		✓	5.4.2	Is it clear what benefits are to be realised by whom, eg suppliers, stakeholders, etc.?	Responsibility for monitoring and achieving benefits delivery should be assigned to named postholders. How will delivery of benefits by suppliers be monitored?	N/A	N/A
		✓	5.4.3	Does the detailed benefits realisation plan separate CRB from non-CRB and identify how qualitative benefits are to be measured?	The case should demonstrate how cash is to be released and efficiencies achieved, and should identify which budgets will be impacted.	N/A	N/A

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Change management				
	✓	✓	5.5.1	Has the organisational and cultural impact of the preferred option been considered/described? Have the necessary measures been put in place to manage the organisational and cultural changes arising from the impact of the scheme?	For example, the identified impact of deployment should be consistent with wider organisational strategies such as human resources, estates or clinical services.	Y	6.8
		✓	5.5.2	Is there a detailed, resourced and robust change management plan which also shows interdependencies? What is the resource for this?	The change management plan should include a transition plan and details of any necessary training programmes.	N/A	N/A
	✓	✓	5.5.3	Does the business case demonstrate that users fully support the project and are committed to it? Does the business case include detailed plans for user involvement in the planning and implementation of the project?		Y	6.8

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Risk management				
	✓	✓	5.6.1	Is there a comprehensive, costed risk register/log?	The business case should set out at least the top ten highest risk items for delivery of the preferred option. The full risk register should be appended. Is the nature of the risks clearly explained, together with their timing and their potential service and financial impact? Is understanding of their implications demonstrated?	Y	6.9
	✓	✓	5.6.2	Has a risk management plan been provided in which risks are appropriately identified, mitigated and managed?	Contingency plans should be set out and risks allocated to the most appropriate party. Potential cost overruns are provided for in the affordability analysis.	Y	6.9
		✓	5.6.3	Is updated information provided about the nature of the risks, their timing and their potential service and financial impact? Is the risk management strategy sufficiently comprehensive and detailed, covering all identified risks?		N/A	N/A
			Other				
		✓	5.7.1	Arrangements are in place to make the FBC and any addendum public within a month following FBC approval, with the executive summary (at least) available on the relevant health organisation's website.	Publication of the case should be borne in mind from the start so that, for example, the project team is clear about what areas may be commercially confidential (seeking legal advice as needed) and bidders are aware that the case will be published. Care should therefore be taken in organising the case and in its wording.	N/A	N/A

Management case: Build schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.8.1	Where applicable, external advice on design, build, health and safety, the Fire Code, estate issues and information technology has been sought and evidenced in the business case.		N/A	N/A
	✓	✓	5.8.2	Is the business case submission accompanied by a completed NHS premises assurance model (PAM) standard assessment questionnaire for the health organisation and evidence to demonstrate that this has been approved by the organisation's board or governing body?	The NHS PAM promotes the sharing of best practice and lessons learned across NHS providers with the aim of improving the performance of premises. PAM 2014 allows NHS organisations to better understand the efficiency, effectiveness and level of safety with which they manage their estate, and how that links to patient experience and is compliant with relevant legislation and guidance. It provides a single method that is nationally consistent, peer comparable and aligned with the wider NHS management landscape.	Y	6.11

Management case: IT schemes only

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	5.9.1	Is there an outline training programme for all relevant staff, both users and project team members?	Detail should be provided about whether the organisation already has a training infrastructure, how training will be developed and who will develop it.	N/A	N/A
		✓	5.9.2	Has a detailed, costed and resourced training programme been worked up, covering the training requirements of all relevant staff, both users and project team members?	Detail should be provided about how training is being developed and delivered, and by whom.	N/A	N/A
	✓	✓	5.9.3	Does the programme have a delivery plan incorporating the transition to live running/BAU?		N/A	N/A
	✓	✓	5.9.4	Is there evidence that security and confidentiality have been addressed in accordance with information governance principles?		N/A	N/A

6. Clinical quality (see Annex 2 for guidance)

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Clinical strategy and commissioning intentions				
✓			2.1	Describe how the scheme will support the delivery of the organisation's clinical strategy and is aligned to commissioning intentions.	See strategic case – checklist reference 1.2.1.	Y	2.7.2
			Design and buildings				
	✓	✓	2.2	Describe the purpose of the building and the suitability of the design and layout to the proposed scheme, with particular attention to patient, staff and visitor needs. Have the following clinical quality aspects been considered in the purpose, design and layout of the proposed scheme (see clinical quality – checklist reference 2.2.1–2.2.8 below):	Describe the purpose of the building and the suitability of the design and layout to the proposed scheme. Provide a description of the service model, backed by plans/drawings demonstrating clinical/non-clinical adjacencies. There is evidence provided of ongoing engagement with patients and frontline staff in designing the model of care and the environment(s) in which it will be delivered? Confirm that the health organisation has appointed a healthcare planner as part of the design team and this person has actively contributed to the planning and evaluation process. Refer to the HBN appropriate to service type. DH publications DH health building notes	Y	2.9 4.7 Appendix C7, C9

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.2.1	Use of the facility: • model of care • patient need • privacy and dignity • workflows and logistics • adaptability • security.	There is evidence that consideration has been given to future proofing the investment/facility/capacity/ capability. Will the design be appropriate for patient need? Has the importance of privacy and dignity to individuals been considered?	Y	4.7.2 Appendix C9
	✓	✓	2.2.2	Describe and set out the access requirements for patients, staff and visitors.	Consider way finding and signage, patients with disabilities, parking, goods and vehicle separation, and pedestrian access and exits.	Y	4.7.1 Appendix C9
	✓	✓	2.2.3	Describe space in the facility – patient space standards.	Describe and set out the arrangements for public clinical areas.	Y	4.7.1 Appendix C9
	✓	✓	2.2.4	What is the impact of estates derogation on clinical care?	Derogations must be approved by the medical and nurse directors of the organisation.	Y	4.7.1 Appendix C9

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.2.5	What is the impact of clinical adjacencies in the scheme design? What consideration has been given to the impact of clinical and non-clinical adjacencies in the scheme design?	Confirm that the health organisation has appointed a healthcare planner as part of the design team and this person has actively contributed to the planning and evaluation process. Describe the service model, backed by plans/drawings demonstrating clinical/non-clinical adjacencies. DH publications HBN core elements	Y	4.7.1, 4.7.6 Appendix C7, C9
	✓	✓	2.2.6	What consideration has been given to: • provision of carer and parent accommodation • meeting needs of staff and patients.		Y	4.7.1 Appendix C7, C9
	✓	✓	2.2.7	Have frontline staff and patients been involved in the design of the care environment?	How have patients, the public, staff and other stakeholders been involved in shaping proposals?	Y	4.7.1 Appendix C7, C9

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.2.8	Describe how the capital scheme proposal will improve the organisation's patient-led assessment of the care environment (PLACE scores).	PLACE assessments give patients and the public a voice on local standards of care.	To be developed as part of FBC	
	✓	✓	2.3	Does the IT system integrate with other systems for the purposes of patient quality and safety? There is evidence that the organisation has considered: • system integration • impact on patient safety and clinical quality • clinical engagement • clinical knowledge and use of the system • clinical benefits realisation.	Demonstrate how the IT system will integrate with other systems for the purposes of patient quality and safety. Describe and present the findings and outcome of the risk assessment and the impact on quality, including risks identified and the mitigation plan? Present the added clinical benefits of the new system. Provide evidence of clinician engagement and involvement in the project governance process.	N In development, will be available at FBC	2.7.7 Appendix C7
Leadership and stakeholder engagement							

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.4	Can the organisation demonstrate engagement with clinical leaders, frontline clinical and non-clinical staff, and other key stakeholders in shaping investment proposals. The business case and supporting evidence demonstrates the aspects described in clinical quality – checklist reference 2.4.1 to 2.4.3.	Describe how executive clinical leaders, frontline clinical and non-clinical staff, and other stakeholders have been involved in shaping and influencing proposals, including eliciting and acting on patient feedback.	Y	2.8.5, 6.6
	✓	✓	2.4.1	Describe stakeholder engagement: • involvement • shaping developments • high level of engagement with clinical staff.		Y	2.8.5, 6.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.4.2	Clinical leadership, engagement and oversight: • oversight from executive clinical leaders • oversight of planning and ensuring clinical quality and business continuity • leadership resource and capacity to deliver • engagement with patients, the public, staff and other key stakeholders • engagement with appropriate experts, clinical or other stakeholders • clinical experts are involved in shaping proposals.	Has the organisation met its duties under s242 of the NHS Act 2006 to involve and where necessary carry out a full public consultation with patients, the public and other stakeholders? The outcome of this involvement has been considered and where appropriate has informed the business case.	Y	2.8.5, 6.6 Appendix S14,S15
			Design and building				
	✓	✓	2.4.3	Describe the interface with community partners and development/ understanding of patient pathways.		Y	4.7.1-4.7.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Patient experience and safety				
	✓	✓	2.5	The organisation describes how the project will improve the quality of care and the experience of patients. The organisation has carried out a full quality impact assessment using a nationally approved tool and can evidence that the proposal will enhance the quality of patient care and experience. Where any negative impact has been identified, measures to mitigate this have been included in the business case (see clinical quality – checklist reference 2.5.1 to 2.5.7 below).	Describe specifically how the scheme will benefit patients, that is, improve patient experience as a consequence of the new build. Describe how the organisation intends to continue to involve people in shaping the scheme's development. Describe how tools/methods or approaches have been selected by the trust to ensure proposals improve safety, clinical outcomes and patient experience. Describe how the design of the building will aid therapeutic objectives, engender wellbeing and raise patients' and visitors' spirits? Describe arrangements for business continuity during the build period, eg access for staff, patients and the public takes account of the major incident policy and emergency planning.	Y	2.7,4, 4.7.1, 6.13
	✓	✓	2.5.1	Quality, safety and affordability: • there is a clear and credible approach to enhancing the delivery of patient care, quality of care and care outcomes • are the quality, safety, productivity, affordability and VfM considerations robust?		Y	2.7.6, 4.7.1-4.7.2

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.5.2	Patient experience: • How specifically will the scheme benefit patients, that is improve patient experience as a consequence of the new build? eg: ○ aiding recovery ○ quality of environment ○ patient involvement.		Y	4.7.1-4.7.2
	✓	✓	2.5.3	Consideration has been given to the safety, design and flow of the building, including the use of patient safety indicators – safe design.		Y	4.7.1-4.7.2 Appendix C7, C8, C9
	✓	✓	2.5.4	Does the design optimise infection prevention and control? Has the organisation demonstrated compliance with HBN 00-09: *Infection control in the built environment*.	HBN 00-09: *Infection control in the built environment*.	Y	4.7.11

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
	✓	✓	2.5.5	Where the capital scheme involves medicines ensure: • pharmacist involvement and senior pharmacist sign off of plans • involvement of the medicines optimisation lead.		N/A	
	✓	✓	2.5.6	Describe what facilities have been made available for carers, including consideration of carers' requirements, including those caring for others with learning disabilities, mental health and long-term conditions.		Y	Appendix C9
	✓	✓	2.5.7	Describe the business continuity during the build period, eg major incident policy and emergency planning.		Y	6.13

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Workforce				
	✓	✓	2.6	How have national drivers for workforce been incorporated in the proposal, including: • 7-day services • safer nursing care tool, safer staffing tool and NICE guidance • technology advance and utilisation • workforce-to-patient ratios • Francis report and response from the government's *Hard truths* report • learning from the staff survey • appraisal and pay progression – opportunity for improving workforce and rewarding success • weekend workforce and mortality • attraction and retention of staff • evidence of national benchmarking and use of workforce analytical tools to meet current and future delivery • training and development in new ways of working.	Describe how national drivers for workforce have been considered and incorporated into the proposal? Describe arrangements for training and development in new ways of working.	Partial Workforce plan in development for FBC	2.7.6

SOC	OBC	FBC	Ref	Item	Guidance	Org Y/N	Case ref
			Sustainability				
	✓	✓	2.7	Have sustainability, demand and capacity modelling been carried out across the lifetime of the scheme?		Y	2.9.4, 4.9.5
			Learning and continuous improvement				
	✓	✓	2.8	Does the organisation have arrangements in place to evaluate lessons learned and opportunities for continuous improvement?	Describe how the effectiveness of the scheme will be evaluated and shared as lessons learned for future scheme developments.	Y	6.10

Bassetlaw Emergency Village
OBC trust internal approval

Presented to Finance and Performance Committee - 21 July 2022

Why Bassetlaw Emergency Village?

- Fragmented approach to urgent & emergency care delivery at Bassetlaw due to poor service adjacencies, i.e., ED paediatric spaces away from CAU, SDEC away from ED
- Insufficient capacity for current and future demand
- Current footprint and aged infrastructure **doesn't** lend itself to improved models of care & clinical streaming, better adjacencies, increased capacity capability nor addressing CQC safety concerns

Why continued...

INFRASTRUCTURE	BACKLOG MAINTENANCE
CAPACITY	CANNOT MEET DEMAND & NO ROOM FOR EXPANSION
CONFIGURATION	POOR CLINICAL ADJACENCIES

STAKEHOLDERS WANT CHANGE URGENTLY

Investment Objectives

1. Health Outcomes & People centred Environment
2. Innovation
3. Environmental Sustainability
4. Community Connections
5. Economic & Financial Sustainability
6. Social Impact

Activity & Capacity Modelling Assumptions

ED assumptions	
Occupancy rate	Resus 45.0% Majors 70.0% Minors 70.0% Paediatrics 70.0%
Treatment times (minutes)	Resus: 180 Majors: 120 Minors: 30 Paediatrics: 60
SDEC and ATC assumptions	
Operational parameters	SDEC Operating hours: 12 ATC Operating hours: 24 Operating days: 7 Operating weeks: 52 Utilisation rate: 85.0%

The assumptions upon which the modelling has been carried out are set out in the adjacent table.

Activity & Capacity Modelling Assumptions

Fracture clinic assumptions	
Operational parameters	Operating hours: 9 Operating days: 5 Operating weeks: 48 Utilisation rate: 85.0%
Appointment time (minutes)	First: 30 Follow up: 20
Activity and growth assumptions	
Baseline activity	Feb 2019-Jan 2020
Growth	Age adjusted based on DBTH demand growth and market share
Projection date	2034/35
ED modelling	80% peak period activity model applied

The assumptions upon which the modelling has been carried out are set out in the adjacent table.

Schedule of Accommodation (SOA)

Summary Floor Areas		Project
Department		**V15**
Integrated Front Door		191.10
Emergency Department		1029.00
Primary Care		inc
Paediatric Emergency & Assessment		927.86
Shared Staff Zone		386.13
Total GDA		2534.10
Whole Facility Allowances		
Communication (12%)		304.09
Plant (20%)		506.82
Gross Internal area		**3345.01**
Not included in overall area		
Same Day Emergency Care (SDEC)	290.78	436.59
Assessment (ATC)	584.91	644.60
Fracture Clinic	169.32	98.49

Functional Content	Existing	Project
Department		**V15**
Integrated Front Door	N/A	N/A
Mental Health	1	1
Emergency Department		
Majors	9	19
Minors	7	0
Resus	3	4
Primary Care	4	4
Fracture Clinic	11	as existing
CDU	N/A	0
Paediatric Emergency & Assessment		
Emergency	3	4
Assessment	10	16
Same Day Emergency Care (SDEC)	0	12
Assessment (ATC)	21	16
Shared Staff Zone	N/A	N/A

Options Framework Summary

	Do Nothing	Do Minimum	Intermediate			Do Maximum
Scope	**1A:** Continue with current clinical model Carry forward	**1B:** Implement Paediatrics model Carry forward	**1C:** Implement Paeds + Front Door + Right-Size ED PWF	**1D:** As 1C + deliver new ATC Discount	**1E:** As 1C + deliver new ATC + SDEC Discount	**1F:** As 1C + deliver new ATC + SDEC + Fracture Clinic Discount
Solution	**2A:** Ongoing maintenance Carry forward	**2B:** Refurbish existing facilities + deliver Paeds Carry forward	**2C:** Refurbish + New build (SOA v1) PWF	**2D:** New build (SOA v12) Carry forward		
Delivery	**3A:** Existing Carry forward		**3B:** Procurement framework (P21+) PWF	**3C:** Full procurement Discount	**3D:** Development partner Discount	**3E:** PPP/ Joint venture Discount
Implement	**4A:** Continue existing Carry forward		**4B:** Phased programme PWF	**4C:** Single-phased build Discount		
Funding	**5A:** Continue existing Carry forward	**5B:** CRL Funding Discount	**5C:** PDC funding of £17.6m Carry forward	**5D:** Combination of PDC + CRL funding PWF	**5E:** Alternative funding models Discount	

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See Appendix 2 for further information

Shortlisted Options

BAU: Continue with current clinical model. No initial investment but continue with existing arrangements for ongoing maintenance.

Do Minimum: Minor changes to clinical model: Adult ED model remains largely unchanged, proposed Paediatrics clinical model (ED and dedicated CAU), enable interfaces with new ATC and SDEC where possible. This would be a refurbishment to existing facilities.

Preferred Way Forward: Deliver proposed clinical model and right-size to meet forecast demand: Integrated front door (Combined primary care + ED triage + streaming), Majors, Minors, Resus, Mental Health, Primary Care, Paediatrics ED and dedicated CAU, Enable optimum interface with new ATC (to realise associated benefits), Enable optimum interface with new SDEC during a different phase. This would be a refurbishment to the Mental Health building and deliver new build extension.

More Ambitious Preferred Way Forward: Deliver proposed clinical model and right-size to meet forecast demand: Integrated front door (Combined primary care + ED triage + streaming), Majors, Minors, Resus, Mental Health, Primary Care, Paediatrics ED and dedicated CAU, Enable optimum interface with new ATC (to realise associated benefits), Enable optimum interface with new SDEC. This would involve demolishing the Mental Health building and creating a new build facility.

Economic Case - CIA Model

	Option 0 – BAU	Option 1 – Do Minimum	Option 2 – Refurbish and Extend	Option 3 – New Build
	Continue with existing arrangements	Refurbish existing + deliver Paediatrics model	Refurbish and extend MH building to create Emergency Care Village	New build Emergency Care Village
Capital investment	-	£17.2m	£17.98m	£35.3m
Incremental costs	-	£(14.9)m	£(17.8m)	£(28.4)m
Incremental benefits	-	£4.8m	£79.7m	£80.0m
NPSV	**-**	**£(10.1)m**	**£61.9m**	**£51.4m**
BCR	**-**	**0.32**	**4.48**	**2.81**
Benefits	-	Overnight CAU Some estate improvement	Integrated Front Door, ED flow, Paeds ED + CAU adjacencies ATC adjacencies	May deliver optimal adjacencies
Risks	Does not address any of the clinical model requirements	Suboptimal adjacencies and clinical flow Complex phasing – delay risks	Minor compromises compared to new build solution	Capital affordability
Lifespan	Does not increase ED capacity to meet future demand	Does not increase ED capacity to meet future demand	Provides capacity to meet predicated demand to 2035	Provides capacity to meet predicated demand to 2035
Rank	**4**	**3**	**1**	**2**

No benefits, does not achieve spending objectives

Limited benefits required for similar investment

Preferred Option
Best value for money

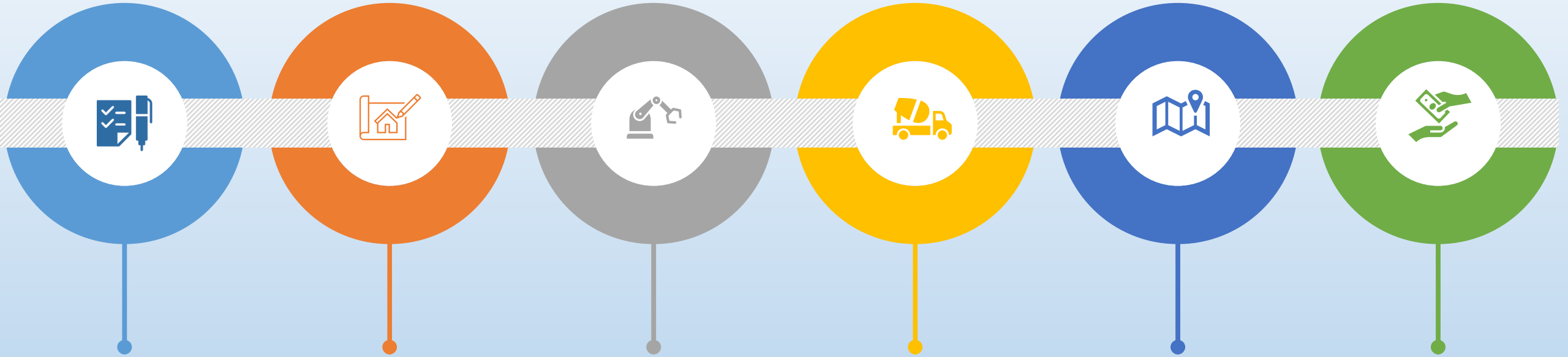
Delivers less value for money and unlikely to be affordable

Economic Case - Conclusion

Option 2 (PWF) delivers BCR of **4.48** from £17.98m capital investment by:

- ✓Providing CAU overnight facilities = Fewer children transfer to DRI
- ✓Improving adjacencies between ED and ATC= Integrated ways of working and rota efficiencies.
- ✓Implementing integrated front door and improving clinical flows = Reduces time in ED
- ✓Improving the working environment and clinical model = Opportunities to improve workforce resilience and reduce agency usage
- ✓Providing modern efficient facilities = improved energy consumption
- ✓Delivering social value

Commercial Case



Professional Services

- Architects
- Project Mgt.
- Engineers
- Health Planning
- Cost Consultants

Design

- 1:200 Design
- Schedule of Accommodation
- Clinical Brief
- DQI

Equipment

- Schedules
- Capabilities
- IT & Digital Fit
- Clinical
- Operational
- Infrastructure

Construction

- MMC
- Sustainability
- Demolition
- Construction
- Decant space
- Site Management

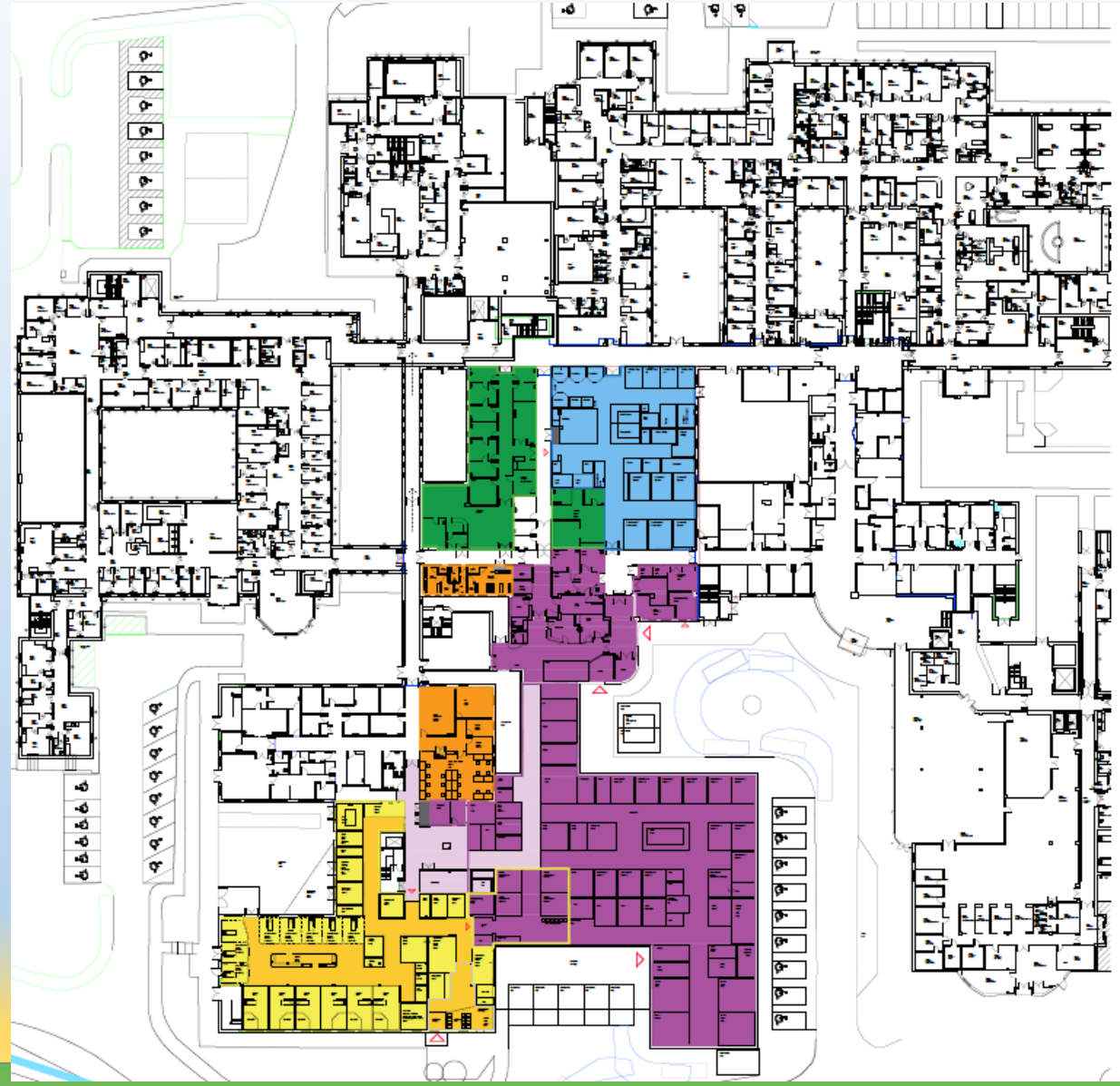
Standards

- HBN and HTM
- BREEAM
- Firecode
- Planning Permission
- Infection Control

Contract

- Procurement Strategy
- Procure 21+
- Risk Transfer Matrix
- Key contractual Issues
- Milestones

Design Development



PWF

Key:

- SDEC
- Fracture Clinic
- ED
- Paeds CAU
- Central Support
- ATC
- PLANT

First Floor Plan

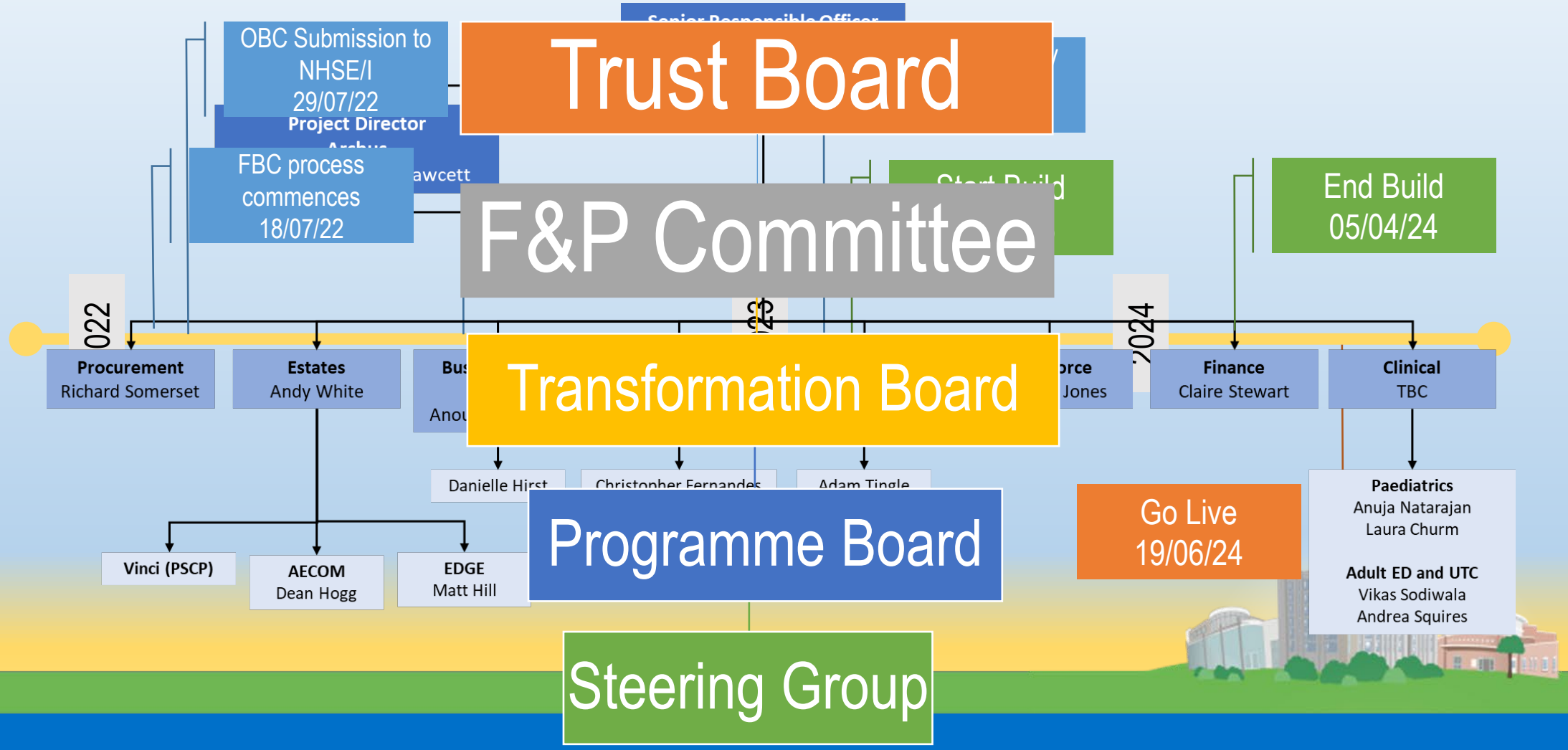
Financial Analysis

- LTFM demonstrates affordable over the long term
- Dependent on delivering cash releasing benefits:
  - Delivery of RAAC scheme critical to ensure ATC adjacencies can be unlocked
  - Work required at FBC to develop workforce analysis that supports

Capital Costs	£'000
Wave 4 STP funding	17,605
MH spaces in ED	186
Other (e.g. Value engineering)	207
Total Capital Cost	**17,980**

Revenue Consequences	£'000
Additional Estates costs (p.a.)	143
Depreciation (p.a.)	196
PDC (Year 1)	466
Cash releasing benefits (p.a.)	(683)
Incremental Revenue Impact Year 1 (excluding inflation)	**122**

Management Case



Next Steps

Activity	Start Date	End Date
OBC Production	05/05/2022	26/07/2022
NHSE&I OBC Approval	30/07/2022	21/10/2022
Design Development (RIBA stage 3)	18/07/2022	31/10/2022
Design Completion (RIBA Stage 4 Co-ordinated Design)	11/10/2022	17/01/2023
Market Testing	27/09/2022	28/11/2022
Receipt of GMP	13/12/2022	13/12/2022
Finalisation of FBC	14/12/2022	13/01/2023
Trust Approval	16/01/2023	20/01/2023
Submit FBC to NHSE&I	23/01/2023	23/01/2023
NHSE&I FBC Approval	23/01/2023	14/04/2023
Stage 4 Enabling works	20/02/2023	31/03/2023
Stage 4 Construction Works	03/04/2023	05/04/2024
Handover and Completion	05/04/2024	19/06/2024

Q & A

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	**G1**
Report Title:	**Corporate Risk Register**		
Sponsor:	Jon Sargeant - Interim Director of Recovery, Innovation & Transformation		
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary		
Appendices:	CRR July 2022		
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:	<u>Key changes to the CRR this period:</u> • No new corporate risks rated 15+have been added or escalated from Management Board • Currently there are 91 risks logged rated 15+ across the Trust and were tabled at the May 9th Trust Executive Group (TEG) for review • 12 of these risks are currently monitored via Corporate Risk register (CRR) • Risk ID2472 – (COVID1) - World-wide pandemic of Coronavirus-management. Risk rating increased from 15 to 20 (5Cx4L). Rationale for increase: current infection rates increase last 2 weeks with "return to living with COVID" guidance being implemented. Increased staff absence re covid infection. Elective work slowly recovering. Bed occupancy with COVID increased again. <u>Action required</u> • Continuous review of existing risks and identification of new or altering risks through improving processes. • Ensure link to key strategic objectives indicated within the Board Assurance Framework. • The current risk management review the Trust commissioned has completed. Recommendations considered from the report are being monitored via software solution *Monday.com* and using the new project governance structure via the Executive Team. • The key enabler for the implementation of the recommendations will be the new Risk Management Board to be introduced and chaired by the Executive Medical Director. Draft ToRs agreed by TEG and all recommendations for the risk management processes to be facilitated via this group including the validation of the 91 risks logged 15+.		
Recommendation:	• The Board is asked to note the Corporate Risk Register information and the acknowledgement of the review outcomes being facilitated by the new Risk Management Board and governance structure previously discussed via the Interim Director of Recovery, Innovation & Transformation which should improve and strengthen the Trusts risk management processes.		

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:	TEG & Executive Team – (15+ risks)						
Date:	TEG 9 th June 2022	**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:	Risks rated 15+ Detail & Overview papers discussed at TEG 9/5/2022						

Appendix 4 (Level 4 detail)

Corporate Risk Register Summary July 18 2022

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	30/05/2022	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 - Knock on disruption of procurement and logistics teams sometimes delaying response Updated: 18/12/2020 Trust has been explicitly instructed by NHS E & DoH not to take no 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 -	Wilson, Rachel	**Dec/21** -Covid 19 pandemic related supply issues have now eased but national allocation arrangements remain in place for some key medicines. EU exit impact has been minimal to date but medicines shortages continue due to a combination of other issues. (A Barker). Trust has been explicitly instructed by NHS E & DoH not to take no 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.	Extreme Risk	15	High Risk	Apr-22	⟺
2664	PEO3	27/08/2022	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	**24/6/22** vcf approved, recruitment ongoing Can reduce risk rating once recruited**30/11/21** Risk grading decreased from 20 to 16 with new controls in place. Full action plan in place. Substantive consultant appointed and commenced in post(dec2021). Locum post appointed for 12 months and starting early 2022. Mutual aid secured from STH from January 2022. Second offer of mutual aid being explored. Full set of wider actions focusing on short-term workforce, environment, and longer term training and workforce model.Some support from general anaesthetists and external locums. **7/5/21** Mutual from Sheffield commenced (covers approx. 5 shifts per week during the day -DRI site.). planned for 2 existing consultants to	Extreme Risk	16	High Risk	Jun-22	⟺
2472	COVID1	17/08/2022	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	Trainer, Abigail	**18/7/22** risk increased due to increased prevalnece and numbers . increased bed occupancy and staff absence, mask reintroduced . **17/5/22** risk reduced. visiting reinstated as current infection rates reduced and "return to living with COVID" guidance. Elective work slowly recovering. Bed occupancy with COVID reduced (AT) **20/3/22** existing controls in place and recovery plans monitored via COO and delivered to F&P & Board. New IPC guidance in place to allow 1mrule to support elective recovery. Updates regularly to CQC via engagement meetings.ay	Extreme Risk	20	High Risk	Jul-22	↑
11	F&P1	23/09/2022	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	Alex Crickmar	**24/3/22** full discussionre new plans to F&P 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	Jun-22	⟺
7	F&P6	31/07/2022	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	Debbie Pook,Gill Marsden	**30/11/21 -** Controls still applicable as in March. Refreshed board performance report in progress to reflect H2 priorities and to improve transparency of performance against key metrics. Improved benchmarking approach in place using data from NHSE/I, nationally published data and dashboards. Trust wide engagement approach with consultants/SAS and Divisional leaders regarding H2 requirements including UEC roadshow.[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	Extreme Risk	16	High Risk	Jun-22	⟺

Corporate Risk Register Summary July 18 2022

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
19	PEO1 (Q&E1)	02/08/2022	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	Anthony Jones	**2/12/21** -Regular updates provided to Partnership Forum and JLNC in respect of service and Trust level changes being planned. Deputy Director of P&OD has weekly meetings with staff side chair and secretary and attends the staff side meetings and the Director of P&OD meets regularly with the LNC Chair. The Communications team share regular updates using Facebook, general and targeted emails and posting on the Trust website and The Hive to ensure all colleagues in the Trust are updated on key issues - recent examples include during the Covid pandemic. In addition the monthly team brief sessions have moved on line with a recording of the Chief Executive being posted on facebook and The Hive. The Executive Team meets weekly with the Head of Communications in attendance; in addition there are monthly Trust Executive Group meetings and quarterly senior leadership meeting with the Chief Executive. The Chief Executive holds regular listening events with all Divisions and directorates virtually to which all staff are invited.[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	12	Moderate Risk	Jun-22	⟺
12	F&P4	29/10/2022	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	Howard Timms	**[29/03/2022** Howard Timms] Implementation of Maintenance Strategy Review (7 Point Plan) FY 22/23 £16.7 Million Capital Investment identified for 22/23 Project Team working on Development of new Hospital Build for Doncaster. **[16/11/2020** 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	Mar-22	⟺
1410	F&P11	22/08/2022	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 (4) Disaster recovery and business continuity testing (5) Control of device (not user) access to the network (6) Configuration management and process documentation) (7) Backup management and storage capacity (8) Logging and retention of log information (infrastructure) (9) Failure to wholly implement patch management (10) Visibility of networked devices and systems as they relate to notified vulnerabilities (e.g. CareCERT advisories) As a result the above could lead to temporary closure of systems access, infection of key software and/or related operational issues. This would need significant remedial work and might require forensic response that would need to be funded from cyber liability insurance. Negative press coverage would follow and investigation by national bodies would be likely.	Anderson, Ken	**7/2/22 -U**pdated ordering of risks to reflect work done on patching, asset management and log retention and analysis, which has reduced risk in these areas. More work remains on those points, but other risks now have a greater priority. Work is ongoing to update unsupported software in the organisation, with further investment requested in 22/23 to continue the work needed. Investment has also been requested in the top 2 risk areas and other identified areas of risk identified.**[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	Feb-22	⟺
16	PEO2 (F&P8)	02/08/2022	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	Anthony Jones	**02/12/2021** - Regular reports to the People Committee in relation to vacancy levels and training plans. Refreshed Trust level workforce plan being developed detailing hot spot areas and planned actions. Electronic workforce planning tool being investigated to support divisional/specialty workforce planning. Workforce planning forms part of business planning process. Apprenticeship group in place which reports through the Training and Education committee to the People Committee. Workforce Planning committee now in place with representation from divisions and key staff groups to explore how we maximise our recruitment and training opportunities.**[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	Jun-22	⟺

Appendix 4 (Level 4 detail)

Corporate Risk Register Summary July 18 2022

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
1807	**F&P20 / Q&E12**	28/10/2022	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	Howard Timms	[**29/03/2022** Howard Timms] Lift Refurbishment Programme delayed due to COVID. Lift Refurbishment Project for EWB Lift 3 and 7 commenced March 22. Further Lift Refurbishment Planned 22/23 including South Block Lifts 3 and 4, W and C Lifts 1 and 2 and Mexborough Pain Management. [**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	Mar-22	⟺
1412	**F&P12**	29/10/2022	Estates and Facilities	Not Applicable (Non-clinical Directorate)	**Risk of fire to Estate**	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	Howard Timms	[**29/03/2022** Howard Timms] EWB and W&C Block Fire Enforcement Notices Rescinded and replaced with Fire Action Plans Fire Improvements W&C investment 21/22 £4.1 million Further Fire Improvement Works scheduled investment 22/23 £3.0 million **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	Mar-22	⟺
13	**ARC01**	29/07/2022	Directorate of Finance, Information and Procurement	Not Applicable (Non-clinical Directorate)	**Risk of econmic crime against the Trust by not complying with Government Counter Fraud Functional Standard GovS 013**	Risk of econmic crime against the Trust by not complying with the Government Counter Fraud Functional Standard GovS 013 – Counter Fraud leading to (i) Impact on Trust's finance (ii)Negative impact on reputation (iii)action from Cabinet Office re failure to comply with standard	Alex Crickmar	[**04/04/2022**] Regular communication via ARC and Trust Counter Fraud champion and CF Specialists. Trust assessed against the standards and documented for compliance in (LOCAL FRAUD RISK ASSESSMENT Version 11 (Valid from 1st April 2022 until 31st March 2023. Submitted and approved at ARC via the Counter Fraud Operational Plan 24th March 2022. Individual risk assesment attached to risk. Actions added to individual risk owners. 12 is highest risk attahced to Bank madate fraud (i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR (v) Staff fraud questionnaire. (vi) Board level awareness, October 2018.	**Extreme Risk**	**12**	High Risk	Apr-22	⟺

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	G2		
Report Title:	**Trust Annual Report 2021/22 including Annual Governance Statement, and Annual Accounts 2021/22**				
Sponsor:	Alex Crickmar, Acting Director of Finance				
Author:	Matthew Bancroft, Head of Financial Control				
Appendices:	Appendix A – Trust Annual Report 2021/22 including Annual Governance Statement and Annual 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 2021/22 including Annual Governance Statement, and Annual Accounts was presented at the Audit and Risk Committee on 17 June 2022. Following discussions at the Audit & Risk Committee it was agreed the accounts would be approved, with delegated authority from the Trust Board, subject to a satisfactory audit outcome from Ernst & Young. The Committee agreed that should any non-material changes be identified as part of the external audit, the Chief Executive, Acting Director of Finance and the Chair of the Audit & Risk Committee would sign off to allow submission. At the confidential Board of Directors meeting on 28 June the Acting Director of Finance confirmed that some minor, non-material disclosure changes had been made to the annual accounts, none of which affected the surplus, cash position or primary statements. The final accounts were submitted to NHSE/I on 24 June, a final copy of which was received by the Audit & Risk Committee on 17 July and shared with Board today for ratification.				
Recommendation:	The Board is asked to note the approval of the Annual Report and Annual Accounts by the Audit and Risk Committee				
Action Required:	~~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:	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:	17/6/2022 14/7/2022	**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.	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2021/22

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

The past 12 months mark one of the most challenging periods within the history of Doncaster and Bassetlaw Teaching Hospitals (DBTH). Despite this, we have, with the support of all colleagues, made great strides forward. We are moving to a position where our recovery can start to begin in earnest, not just to restore services to where they were, but enhancing them, taking what we have learnt throughout the pandemic and moving forward.

In our previous Annual Report, we reflected upon a period of transition for the Trust. We outlined the major changes we made to make our sites as COVID-19 secure as possible, and we detailed how we had coped with the initial waves of COVID-19. However, 2021 and 2022 have been very different in this respect. It has been a period where we have had to learn to live with COVID-19, whilst providing all of the services expected of us, and befitting of our communities. It has meant that we have faced times of great hardship, particularly as we have experienced numerous further waves of COVID-19, with the Omicron variant taking its toll on staff absence, however, we have persevered and we believe that, together, we have so much to be proud of, and a lot to look forward to.

As is detailed in this report, in 2021/22, we have cared for an additional 2,491 COVID-19 patients, and this in addition to 783,461 episodes of care which have taken place within our hospital sites. Our activity this year has far outstripped that seen the year previous, and brings us on parity, if not a little bit beyond, activity in 2019/20 prior to the pandemic.

Since March 2020, we believe Team DBTH has often been ahead of the curve on the important decisions related to COVID-19. Along with the tenacity, determination and can-do attitude of all colleagues, this proactive approach has put us in the best position possible to address the challenges of the pandemic, and we believe this same outlook will help us as we look to recover and move on from these times.

For very different reasons, and while there is cause for optimism, the coming years are going to be equally as challenging as the prior two. Throughout the rest of 2022 and into 2023 and beyond, it is our aim to recover strongly from the impact of the coronavirus, delivering high quality care for our patients and trying to move closer to our goal to be considered to be outstanding.

Additionally, as the overall governance and organisation of the NHS has changed, we also now find ourselves as a crucial part of two Integrated Care Systems in South Yorkshire and Nottinghamshire respectively – one of only a handful of trusts in such a position. The impact of this means that we now have to build stronger relationships with Nottinghamshire colleagues and continue to develop the collaborations in two 'Places' and two Integrated Care Boards (ICB).

Therefore, and as referenced earlier, we believe it is important that we try to get ahead of the curve once again, organising ourselves in such a way as to best deal with these

upcoming challenges, as well as maximising the opportunities that will undoubtedly present themselves.

Much of this work will be driven by our Directorate of Recovery, Innovation and Transformation, and this team will help to identify and remove barriers and challenges. Crucially, the Directorate will look to ensure that divisions and directorates are supported to recover services, so that our clinicians are able to make significant improvements in the services we deliver to our patients to ensure that they receive the very best care and treatment.

Innovations we will further expand upon will include projects such as the Rapid Diagnostic Service, to reduce waiting times for patients, we will also continue to move forward with our ambitious capital programme, with significant investment to be made within Emergency and Urgent Care, as well as keep pushing on in our goal to build a new hospital in Doncaster. To bring these, and many other projects to fruition, we will need the support of all colleagues, and it is our intention to draw upon the collective expertise, dedication and skill of all of Team DBTH to help us in this vision.

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, as well as the ambitions we have. 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 2021/22, along with our plans for 2022/23. 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
22 June 2022

Richard Parker OBE
Chief Executive
22 June 2022

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 in 2022) 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

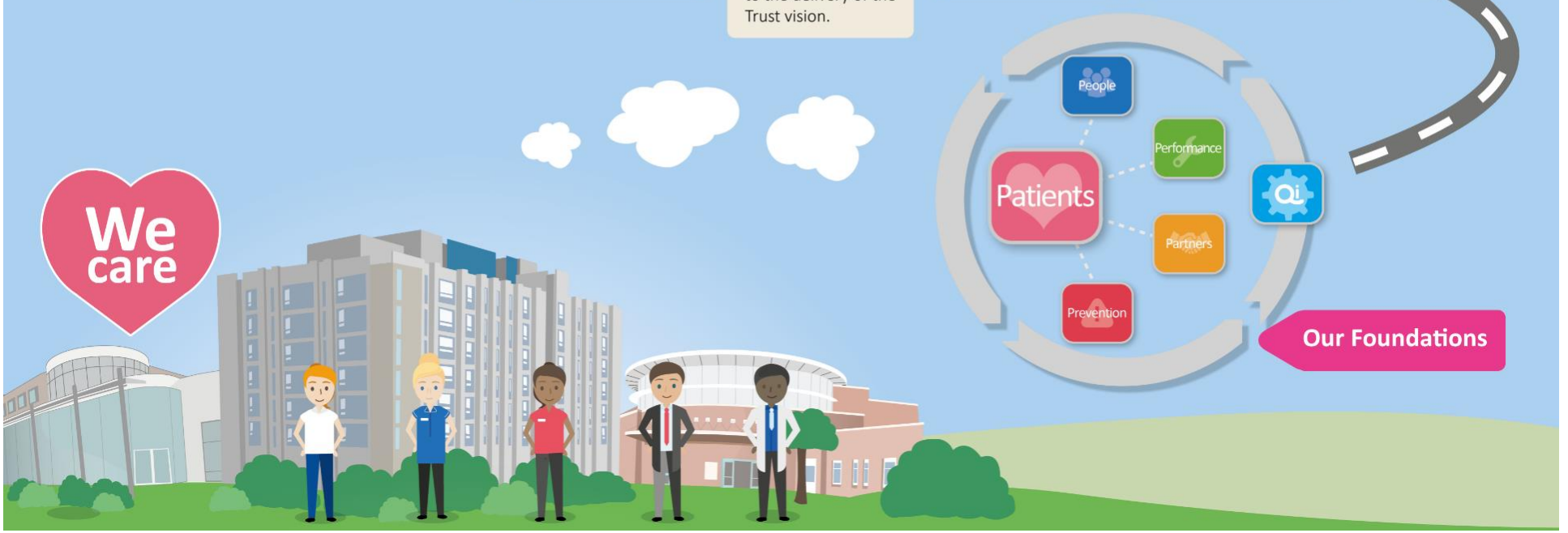
To be the safest trust in England, outstanding in all that we do.

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:** The Trust is in recurrent surplus to invest in improving patient care

Breakthrough
How we will move to deliver our True North in **2021/22**.

- **Objective one:** Achieve measurable improvements in our quality standards and patient experience.
- **Objective two:** 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.
- **Objective three:** Team DBTH feel valued and feedback from staff and learners in top 25%.
- **Objective four:** Every team achieves their financial plan for the year.



A timeline of our year

A brief summary of achievements, milestones and developments within our hospitals throughout 2021 and 2022.

April 2021

- **Easing of certain visiting restrictions:** Following a period of restricted visiting, we revised this slightly to allow partners to join mothers in the attendance of 12 and 20 week ultrasound scans.
- **New CT Scanner:** To aid with diagnostic test waiting times, we took delivery of a new CT scanner at Bassetlaw Hospital.
- **Further easing of visiting restrictions:** Further guidance was eased, with parents able to attend antenatal doctors appointments together.
- **Introduction of the Holistic Care team:** The Trust launched the Holistic Care Team, a service made up of a range of health professionals to further improve the care given to patients with complex needs.
- **COVID-19 vaccination programme:** Came to an end at the end of April, with colleagues offered the opportunity to receive the first and second dose of the vaccine.
- **Water leak at Doncaster Royal Infirmary:** The Women's and Children's Hospital suffered a large water leak on 27 April. A large part of the building was rendered inoperable and repair works began shortly after.

May 2021

- **Digital letters:** A new system launched moving correspondence from the Trust to the 'DrDoctor system' which is also used for appointment reminders. Those who are not comfortable with electronic devices can still opt for paper communications.
- **Five year forward:** The Trust launched a consultation asking local people to share their views to help develop the organisation's strategy for the next five years.
- **Building works begin as part of the Women's and Children's Hospital repair and refurbishment:** Following the water leaks earlier in the year, work begins in earnest on a new theatre unit and two inpatient ward areas to the rear of the existing building.

June 2021

- **Easing of adult visiting restrictions:** Following a period of restricted visiting, two adults were allowed to attend for up to two hours a day.
- **DBTH Members' Lecture Series:** The Trust debuted its very first lecture series, focused on the Trust's response to COVID-19.
- **Appointment of Chief Information Officer:** Following a robust recruitment process, Ken Anderson was named Chief Information Officer at the Trust.
- **Digital Transformation:** Phase two of the Trust's Digital Transformation programme began to further enhance the care and treatment of patients.

- **Rainbow Garden at Doncaster Royal Infirmary:** The Trust opened a memorial garden to those we have lost to COVID-19.
- **Visiting restrictions heightened:** As a result of increased COVID-19 activity, visiting restrictions changed to one visitor, for an hour, each day.

July 2021

- **Chief Allied Health Professionals (AHP) appointed:** Following a robust recruitment process, Jodie Roberts was named Chief Allied Health Professional.
- **Bassetlaw joins the Nottingham and Nottinghamshire Integrated Care System:** The district of Bassetlaw now aligns with the Nottingham and Nottinghamshire Integrated Care System (ICS), moving it from the South Yorkshire and Bassetlaw ICS.

August 2021

- **DBTH Pride:** The Trust hosts its inaugural 'Pride Week' celebrating LGBTQ+ colleagues.
- **Over 100,000 COVID-19 tests completed:** Using in-house facilities, over 100,000 tests are undertaken within DBTH to detect coronavirus.

September 2021

- **Trust is first to achieve RACE accreditation:** DBTH is named the first NHS organisation to qualify to use the RACE (Reporting Action Composition Education) Equality Code Quality Mark, following assessment.
- **'Thank you' event for all staff:** The Trust partners with Yorkshire Wildlife Park to host a special event for colleagues.
- **Flu campaign gets underway:** The organisation's inaugural flu vaccination programme begins, with 1,000 colleagues opting for the jab in the first 24 hours.
- **COVID-19 booster programme begins:** Ultimately, 90% of all colleagues will opt for the top-up vaccine.

October 2021

- **Trust secures part of £3 million funding to transform diagnostic care:** The Trust is named as one of two providers in South Yorkshire to secure funding to enhance diagnostic testing at Montagu Hospital and create a Community Diagnostic Centre.

November 2021

- **The Trust is accepted into a national Electronic Patient Record Programme:** DBTH was named as one of only seven hospitals within the country to be accepted into the 'Digital Aspirant Plus' programme.
- **50 nurses joined the Trust as part of international recruitment efforts:** The health professionals joined primarily from India as we looked to fill workforce gaps.

December 2021

- **Self-service system launched within the Emergency Department:** This helps the sign-in process for patients attending the urgent service.
- **Consultation begins to secure the future of 24/7 paediatric services within Bassetlaw Hospital's Emergency Department**: Ultimately just under 2,000 local people had their say on this matter.
- **New theatre and ward areas open within Women's and Children's Hospital:** The project began in May and initially housed paediatric services.
- **Due to an increase in COVID-19 activity, visiting is restricted:** Only in specific circumstances can patients receive visitors during this time.

January 2022

- **Montagu Hospital's Community Diagnostic Centre enters phase one:** During this time a CT and MRI scanner are placed within the site.

February 2022

- **Appointment of Chief People Officer:** Following a robust recruitment process, Zoe Lintin was named Chief People Officer, replacing the existing position held by the Director of People and Organisational Development, Karen Barnard who retired.
- **Serenity Appeal launches:** The scheme seeks to raise to £150,000 to help develop a maternity bereavement suite.
- **Visiting restrictions eased:** Following an easing in COVID-19 activity, visiting restrictions are eased once again.
- **The Trust is visited by Sajid Javid MP, Secretary of State for Health and Social Care:** The Government official toured Doncaster Royal Infirmary and met local residents at Montagu Hospital.
- **Montagu Hospital's Community Diagnostic Centre's phase one is completed:** This follows the successful installation of MRI and CT scanners and over 3,000 diagnostic tests undertaken.
- **Rebecca Joyce, Chief Operating Officer, steps down:** A robust recruitment process to appoint a successor is on-going at the time of writing this report.

March 2022

- **First ever Professional Nurse Advocate is appointed:** The newly created post works with colleagues to offer restorative clinical supervision.
- **Due to an increase in COVID-19 activity, visiting is restricted once again:** Only in specific circumstances can patients receive visitors during this time.
- **Pat Drake, Non-Executive Director, retires:** The former member of the Board of Directors served more than 50 years in the NHS.

Overview of our activity and performance in 2021/22

A note on COVID-19

Covid-19 data (as of 31 March 2022):

- Current Covid-19 patients: **151**
- Total Covid-19 patients in Intensive Care: **Three**
- Total Covid-19 discharges: **4,446**
- Total number of patients who have died: **1,088**
- Total number of patients who have been admitted: **5,717**

Broken down by month:

In total, the Trust cared for an additional 2,491 patients with COVID-19 in 2021/22, this is just 735 fewer than was seen in the previous year, at a time when the majority of services have been restored to near business as usual levels.

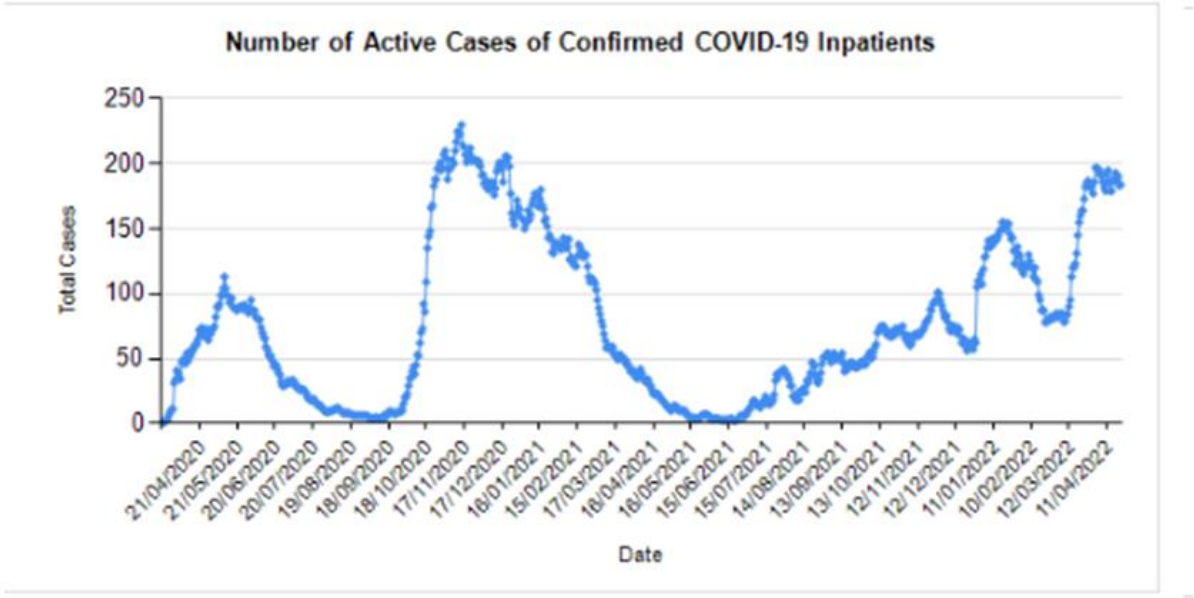


Figure one: Total number of COVID-19 inpatients from March 2020, to April 2022.

Our operational response:

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 another year of challenge and upheaval.

In 2021/22, colleagues worked hard to restore, as much as possible, business as usual within the Trust. This work was made more challenging by the various waves of COVID-19 we

faced, reflected within the fact we had to regularly restrict and ease our visiting guidance, as well as re-prioritise our workload.

To manage this process, the Trust stood up our 'Enhanced Operations Group' at intervals throughout 2021 and 2022 and this was to manage periods of acute activity and pressures. This group consisted of senior managers and health professionals, and met thrice-weekly - this was in addition to usual site management and on-call arrangements.

We also maintained many of the policies and ways of working implemented during the first year of the pandemic - details of which can be read in 2020/21's Annual Report.

In 2021/22, we experienced staff absence and sickness even more acutely, and this resulted in the reduction of certain services for a short-time, and a focus on urgent and emergency work, as well as work related to cancer. As such, this had a knock-on effect on our overall performance, however the process was tightly managed and activity scaled up as soon as possible.

Infection prevention and 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, much of which has been maintained through 2021/22.

From March 2020, 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 Personal Protective Equipment (PPE), and everything in between. This position was routinely monitored and developed as we went through the year, with many restrictions and ways of working still in place.

As has been the case throughout the pandemic, 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 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.

Our teams have also innovated, finding 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 devised and put into operation a system for redeploying colleagues into areas experiencing work force shortfalls, or those under increased strain. This service was set-up

early on during the pandemic and has been maintained ever since and was particularly important in helping with shortfalls that were felt most acutely in March 2022.

As has been already mentioned within the report, with intermittent periods of increased activity, we took the decision at several points throughout the year to restrict all visiting. This also meant maintaining remote working arrangements for, largely non-clinical colleagues, something which will, more than likely, be rolled into business as usual plans once the pandemic passes.

Until further notice, the Trust will continue to work to current arrangements, with senior managers making the appropriate decisions, in conjunction with our Infection Prevention and Control team to ease, or heighten, restrictions.

Vaccination and testing:

The Trust worked, primarily, with NHS Doncaster Clinical Commissioning Group and Primary Care Doncaster in order to deliver our vaccination campaign.

With a long-established record for successful vaccination campaigns, the COVID-19 vaccination programme was no different, and we achieved the following rates of vaccination amongst colleagues within the Trust:

- 97% of all professionals within the Trust received the first dose (Pfizer and Astrazeneca offered).
- 94% of all professionals within the Trust received the second dose (Pfizer and Astrazeneca offered).
- 90% of all professionals within the Trust received the booster dose (Pfizer offered).

Those who opted to not take the vaccine were largely exempt for one reason or another.

Similarly, to aid with efforts to reduce nosocomial COVID-19 spread within our services, all colleagues were, and still are, asked to complete twice-weekly tests for coronavirus using lateral flow devices and to input the results into a bespoke in-house system to monitor any trends and act on any potential outbreaks.

The Trust also implemented specific guidance for colleagues who suspect they have COVID-19, or have tested positive, as follows (at the time of writing this is still Trust policy):

The isolation timetable

- **Day zero** – This is the day your symptoms began, or if asymptomatic the day your positive test was taken.
- **Day one to four** – You do not need to do anything.
- **Day five** – Undertake your first lateral flow test.

- **Day six** – Undertake your second lateral flow test. If the first test is negative, and the second is also, you can return to work on this day. If one is positive, you need to continue until you receive two negative tests two days apart.
- **Day 11** – If you haven't managed to test negative 24 hours apart, regardless you can return to work on this day if you feel well enough to do so.
- **When you are ready to return** – Let your line-manager know and ring **0300 30 45 550** to close down your absence.

If unvaccinated: Colleagues are asked to see out the full 10-day isolation period.

Furthermore, the Trust continued with efforts to screen all tests for COVID-19 in house. As the pandemic began in March 2020, the Microbiology team, which is housed at Doncaster Royal Infirmary, initially sent tests to their counterparts at Sheffield Teaching Hospitals who kindly undertook limited screening on behalf of the Trust. However, given challenges to capacity at the time, and increasing numbers of patients presenting with symptoms of the novel illness, this only allowed for around 50 swabs to be checked per day, and as cases rose so did the pressure on the testing systems.

As a result of efforts within our Microbiology team the first test for coronavirus took place on site on Thursday 9 April 2020. Since that time, we have tested more than 243,000 samples for COVID-19, with colleagues testing more than 700 samples a day during peaks of activity.

The service continued to innovate throughout the pandemic, with colleagues able to utilise in-house testing for the illness, enabling them to return to work quicker if a negative result was achieved. Additionally, the team began to work with Abbott in January 2021 to install rapid testing stations, creating extra screening capacity with results returning in around 13 minutes.

Our activity through 2021/2022

We cared for around **110,051** inpatients

[Last year 86,111]

We cared for approximately **473,932** outpatients

[Last year 337,950]

We cared for approximately **194,994** emergencies

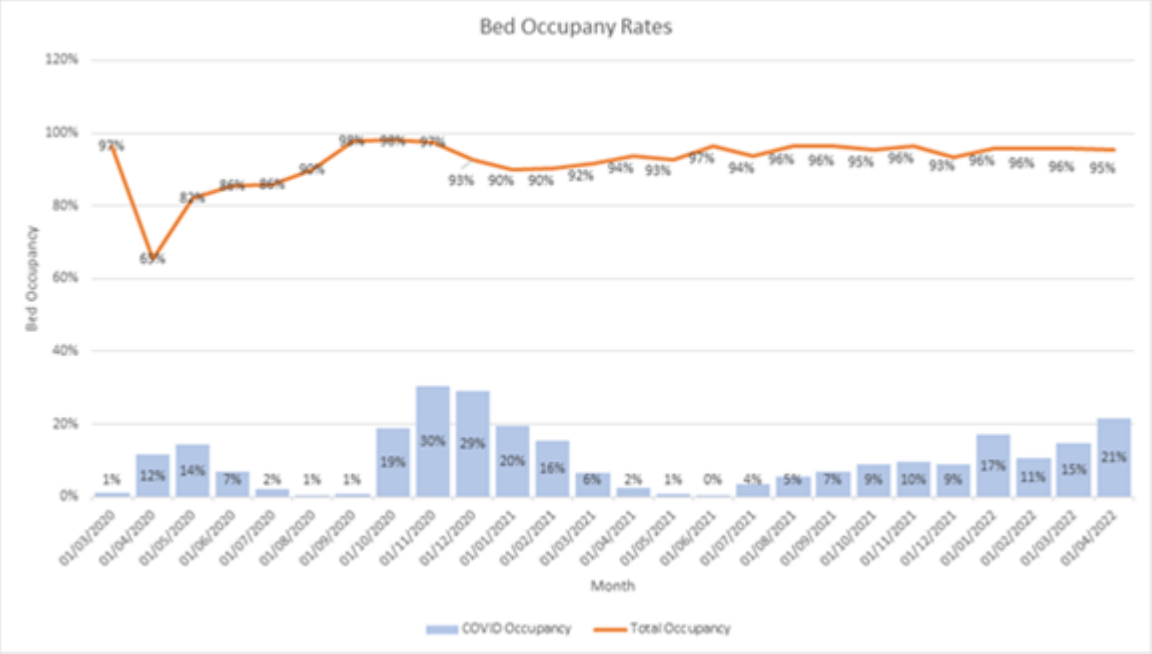
[Last year 147,211]

We delivered approximately **4,484** babies

[Last year 4,287]

Performance analysis 2021/22

In total, the Trust cared for 783,461 patients throughout 2021/22, this is 20,922 more than was the case in the previous financial year. As you can see from the activity infographic, the number of patients we cared for was higher in every single area we have reported, meaning that we have had to deal with additional waves of COVID, in addition to normal hospital activity, making for an incredibly challenging year.



The above graph also tells a similar story, with our COVID-19 activity accounting for between zero and 21% of bed occupancy in the year 2021/22, with the rest being routine referrals or attendances into the Trust.

Emergency care

The organisation achieved 73.26% against the four-hour standard within urgent and emergency care. For comparison, this number was 94.91% for 2020/21.

In total, our Emergency Departments in Doncaster Royal Infirmary and Bassetlaw Hospital, and Minor Injuries Unit at Montagu Hospital cared for 47,783 more patients than the year previous.

At present, a business case is being developed to create a modern centre for urgent and emergency care services at Bassetlaw Hospital, creating an 'Emergency Village'. The new development offers an exciting opportunity to locate the Children's Assessment Unit and Children's Outpatient Department next to the Emergency Department to make best use of specialist nursing and medical staff within the hospital. This creates the option of enhancing children's services within the footprint of the expansion. By co-locating services, this

development also provides the opportunity to secure a permanent overnight inpatient service for children.

18-week referral to treatment (RTT) Patient Pathway

The organisation achieved 68.3% against the 18-Week Referral to Treatment (RTT) Patient Pathway standard. For comparison, this number was 65.7% for 2020/21.

Prior to the pandemic, the Trust had made significant progress, achieving 88% for 2019/20, however, due to the backlog which has been created as a result of COVID-19, this will take some time, and significant effort, to bring performance into line with expectation.

Colleagues innovated in this regard, with the creation of projects such as 'Straight to Test' and our 'One-stop' clinics for specific specialities, as well as better use of software to join up services and reduce any delays in sharing information and corresponding with patients.

Cancer activity and diagnostic tests

The organisation consistently achieved three of the nine cancer targets, with two week wait targets standing at 87.5%.

Similar to the RTT standard, a significant amount of work is being undertaken to improve this area within the Trust.

In 2019, NHS England outlined the intention for local Cancer Alliances to begin to set-up 'Rapid Diagnostic Centres' to provide what is known as a 'single point of access of care' for patients.

This service is now known as the Rapid Diagnostic Service (RDS), with a vision to provide personalised, accurate and speedy investigations, all of which will help us to start treatment quickly if needed, as well as provide a better patient experience.

A tangible example of the work we've undertaken so far is the creation of the Community Diagnostic Centre (CDC) at Montagu Hospital. As part of a five-year development, this has seen the placement of mobile CT and MRI scanners within the Mexborough site, and, in the three months of its operation has seen around 2,500 patients and helped to dramatically reduce our MRI backlog.

There is much more planned for the CDC which is currently being signed-off, but, if successful, will entail millions of pounds worth of investment. As this service was the first within the region to undertake activity, we're particularly proud of it, and can't wait to see it go from strength to strength.

Some of the intention behind the Rapid Diagnostic Service overall, alongside the detection of illness as well as improvement of patient experience, is to reduce health inequalities. With the location of a service such as the CDC in Mexborough, which is within the Dearne Valley, we are placing critical facilities in places which reduce some of the barriers to access for some communities, by placing healthcare closer to home.

The other emphasis on the work we are currently undertaking is about timely referrals, and while there's a lot of work to be done in this regard, we are making progress.

Infection prevention and control

In 2021/22, the Trust registered no Trust-acquired MRSA infections - an improvement over the previous year when this number stood at two. We see some community infection, however we are pleased to minimise any further carriage into our hospitals and underline the strength of our Infection Prevention and Control measures.

In 2021/22, the Trust registered 32 cases of hospital-onset C.Diff infection. This was a reduction from 2020/21 where the number stood at 39.

Looking out for our workforce

At DBTH the health and wellbeing of our colleagues has always been top priority and never more so than in the last twelve months. There is no doubt that, since 2020, we have experienced one of the most challenging periods in our 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. In 2021/22, we had a sickness absence rate for the year of 6.55%, which was around 2% higher than the year previous. This was the result of a combination of factors, including the higher transmissibility of the Omicron variant, as well as the stresses and pressures of the preceding 12 months.

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. This came to an end in mid-2021 as restrictions broadly eased.

In addition to parking, we also offered an enhanced catering offering for all staff to ensure they were able to have access to an appropriate meal whilst on site and working. This included:

- Yellow bus catering
- Smith's Fish and Chips
- Spudbuddies
- Fresh 'n' Local (fruit and vegetable stall)
- Madame Crepe
- Sherwood Fire Pizzas
- El Burrito Box

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 regard 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:

- The Trust's Employee Assistance Programme facilitated by Vivup, offers 24/7 support for all wellbeing needs providing confidential emotional and psychological support for staff.
- Wellbeing Conversations and Wellbeing Appraisals to ensure every member of Team DBTH had a wellbeing conversation during challenging times.

- Provision of Line-managers' wellbeing tools including Team Time, TRiM, Team Huddles, Start well End well and team development.
- The publication of a Wellbeing Support Pack and a similar document to enable leaders to support their teams.
- Introduction of the TLC Service – a service offered to all staff who were absent from work, offering support and even delivering groceries to staff who were asked to isolate or shield, and who lived alone.
- Promotion of self-care through access to change support and proactive lifestyles
- A dedicated counsellor for areas of high pressure (including Department of critical care and respiratory wards – two areas which were most affected by COVID-19).
- A thank you offer was established, supported by the Trust's charitable funds. This included a small voucher at Christmas, providing all colleagues with tea and cake on the NHS' birthday, providing a small bag of sweets on Random Acts of Kindness Day, and a 'Thank You' event at the Yorkshire Wildlife Park.
- Increased Reiki provision for all colleagues and the introduction of a wider range of holistic therapies.
- Introduction of 'Walk and Talk' days in partnership with the Climbing Out Charity.
- Finally we launched three staff network groups: DBTH Disability, Dyslexia and Long-Term Conditions Staff network; DBTH Black, Asian, Minority Ethnic (BAME) Staff Network; DBTH Lesbian, Gay, Bisexual, Trans, Queer/Questioning, Intersex, Asexual and other sexualities (LGBTQIA+) Staff network. The networks play a vital role in identifying issues, gaps or barriers as well as developing pro-active interventions that improve and enhance organisational culture/behaviours, services or opportunities for staff, patients, or communities.

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 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 has been accordingly factored into our plans and strategies as we look ahead to the future.

We have developed and are in the process of 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 began the process of refreshing our Trust strategy, resetting our objectives and factoring in much that we have learnt throughout the past 12 months. This has also been 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 Integrated Care System and Nottingham and Nottinghamshire Integrated Care System.

Additionally, Jon Sergeant was appointed Executive Director of Recovery, Innovation and Transformation and to lead a directorate of the same name focused on the future. The services which have come together to form this new directorate, and are key in supporting and enabling the improvements envisioned, are Strategy and Improvement, Digital Transformation, Information and Informatics, and the Performance Management Office. Together, the team will focus upon enhancing and developing services and systems across the organisation as the Trust emerges from the challenges of COVID-19, ultimately in a bid to improve patient care and treatment.

Throughout the remainder of 2022 and beyond, it is our aim to recover strongly from the impact of the coronavirus, delivering high quality care for our patients and trying to move closer to our goal to be considered to be outstanding.

Significant changes since 1 April 2022:

- **Rebecca Joyce**, Chief Operating Officer, has left the Trust. A recruitment process is currently underway to appoint a successor.
- **George Briggs**, has been appointed Interim Chief Operating Officer and will join the team in the coming weeks.
- **David Purdue**, Chief Nurse, will leave the Trust in the coming weeks to take up a post at NHS England and Improvement. Abigail Trainer, Director of Nursing, will act into the vacant position until a recruitment process is completed in the summer.
- **Jon Sargeant**, Director of Executive Director of Recovery, Innovation and Transformation, has been named Deputy Chief Executive following David's departure.
- **Andrea Bliss**, Divisional Director for Children and Neonates, has stepped down and retired.
- **Laura Chrum** has been appointed as Director of Nursing for Paediatrics and will join the Trust on Monday 16 May.

- **Pat Drake**, Clinical Non-Executive Director, has retired following 52 years within the NHS. A recruitment process is currently underway to appoint to a vacant Non-Executive Director position.
- **Mr Ray Cuschieri**, Deputy Medical Director, has retired following 33 years at the Trust. Ray is succeeded in post by an expanded Medical Director office.
- **Marie Purdue**, Director of Strategy and Transformation, has left the Trust to take up the new role of Managing Director (Interim) for the South Yorkshire Mental Health, Learning Disability and Autism Alliance.
- **Andrew Barker**, has retired following 31 years at DBTH as Chief Pharmacist. Andrew's deputy, Rachel Wilson, has been appointed to the vacant position.
- **Dr Anurag Agrawal**, has been named Divisional Director of Medicine.
- **Dr Naushad Khan**, has been named Clinical Director for Emergency Medicine.
- **Miss Kathryn Rigby** has been appointed as Clinical Director for Breast, Vascular, Urology and Gastrointestinal
- **Mr Tomas Barani** has been appointed as Clinical Director for Obstetrics and Gynaecology
- **Dr Shivani Dewan** has been appointed as Clinical Director for General Medicine

Sustainable Development Plan

As a Trust, we acknowledge the significant challenges posed by the impact of climate change.

As such, we have developed a Green Plan, which can be viewed here: https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy-2017-2022/

We believe it is truly important that we operate as environmentally, economically, and socially sustainable as possible. Implementing the actions presented within our Green Plan will help ensure that the Trust is creating the best environment for our staff and patients, all of which, we believe, will help us in our overall vision of being the 'Safest Trust in England, outstanding in all that we do.'

As one of the largest employers within the two towns we serve, operating across three major sites, we have a significant environmental footprint through our carbon emissions, contribution to air pollution and production of waste materials.

Within the plan, we have detailed a proactive and positive approach that our Trust can take to do our part to reduce and negate the impact that climate change may have on local people.

The comprehensive strategy will enable us to reduce our contribution to these factors and will help to mitigate potential impacts of climate change. Something we believe is our social responsibility.

For the Trust to be a truly sustainable organisation, we need all our staff to play their part in delivering this Green Plan and we strongly encourage all of our colleagues to work together to achieve the aims which are set out in this plan.

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 2021/22 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 third 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 both the Charity and Wholly Owned Subsidiary being published at a later date.

2021/22 in review

As a result of the focus on treating COVID-19 and increasing elective treatment 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 £50.4m in the year, as the Trust received additional income of £3.8m to support the treatment of COVID-19 patients and £46.6m additional patient care income from Clinical Commissioning Groups.

The overall deficit for the Trust was £15.8m, but this includes £18.4m of impairments, as a result of the Trust's annual valuation exercise. Taking this into account, the Trust has a surplus of £2.6m

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 2022 were £46.4m.

Loan Repayments

The Trust made loan repayments of £2.1m in the year.

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 £6m was payable during 2021/22.

Income

We received a total of £502m income in 2020/21, which is growth of £33m from the previous year. The contracting arrangements for 2021/22 remained similar to 2020/21, meaning the vast majority of clinical income came under "Block" arrangements and as such, not linked to activity.

Revenue expenditure

During the year, the Foundation Trust had operating expenses of £494m (excluding impairments). As in previous years, the vast majority of our expenditure is on pay budgets

(staffing) at £322.9m, 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 £35.5m, 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:

- Women's and Children's critical incident - £11.6m
- Targeted Investment Fund for Estates and Technology - £5.3m
- Fire Safety - £4.8m
- Building backlog maintenance - £4.1m

In addition to the expenditure 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 accounted for £25.49m and included 120 projects, some of which are listed below (note all costs are approximates):

- **Electrical incident, reinstatement and recovery (£14.683m):** Works related to the water leak within the Women's and Children's Hospital.
- **Maintenance backlog and critical infrastructure (£7.827m):** Works to improve our electrical infrastructure, fire precautions, water safety, minor repair works, road and footpath upgrades, roofing, window replacement, lifts, ventilation and preparatory works.
- **COVID related works (£620,000):** This includes 72 projects related to safe working, air scrubbing and partitioning wards and corridors.
- **Divisional works (£1,380m):** This includes the enhancement of wards, offices and bathrooms within the hospital.
- **General infrastructure (£535,000):** This includes IT systems, security, site utilisation surveys and rationalisation.

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, once again, 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.

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 2021/22 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. Similar to last year, a number of property improvement areas are to be considered in 2022/23. 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 2021/22 was to recruit, retain and develop sufficient nursing and other clinical staff to ensure safe staffing levels. We are working with partners to increase our international recruitment to help in this regard.

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 2022/23**

I. 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 and will include the provision of an Electronic Patient Record system.
II. We will make best use of our multiple sites to provide access and flexibility within our services
III. 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 and Social Care requires NHS Foundation Trusts to assess 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.

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 throughout the going concern period to 30 June 2023. 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 £46.4m cash in the bank.
- The Trust has delivered a surplus in both 2020/21 and 2021/22.
- There are no licence conditions in place on the Trust from its regulatory body.
- Services will still need to be provided for people in the locations which the Trust serves.

Planning for 2022/23 indicates that the Trust will be in a significant deficit, of c. £25m, and this, coupled with significant capital expenditure plans means that there will be pressures on cash in the short to medium term. However, a proportion of these capital plans will only go ahead if there is available cash, either from Trust cash reserves, or external sources. Also, the Trust has the support of local Commissioners with regards to its financial and clinical plans.

Considering all of the above a cashflow forecast has been prepared which indicates that the Trust will end the next financial year with £13.7m (10 operating days cash). A further reasonably plausible scenario has been considered for the going concern period to 30 June 2023 which models downside risk in relation to inflation, failure to achieve operating targets and further outbreaks of Covid, which equally indicates sufficient liquidity. As a result, the Trust has prepared these financial statements on a going concern basis.

Richard Parker OBE
Chief Executive
22 June 2022

Accountability Report

Directors Report

Composition of the Board

During 2021/22, 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	6 years	1.1 2017	11 of 11
Neil Rhodes	Non-executive Director (Deputy Chair of the Board)	6 years	1.4.2017	10 of 11
Sheena McDonnell	Non-Executive Director	4 Year	1.7.2018	11 of 11
Pat Drake	Non-Executive Director (Senior Independent Director)	4 Year	1.4.2018	11 of 11
Kath Smart	Non-Executive Director	4 Year	1.4.2018	10 of 11
Mark Bailey	Non-Executive Director	3 Year	1.2.2020	11 of 11
Richard Parker OBE	Chief Executive			11 of 11
Karen Barnard	Director of People and Organisational Development (left post March 2022)			9 of 10
David Purdue	Chief Nurse and Deputy Chief Executive			10 of 11
Jon Sargeant	Director of Finance (until November 2021) and Executive Director of Recovery, Innovation and Recovery (from November 2021)			9 of 11
Alex Crickmar	Acting Director of Finance (from November 2021)			5 of 5
Rebecca Joyce	Chief Operating Officer (Left March 2022)			8 of 9
Dr Tim Noble	Medical Director			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 is the Lead Examiner for Chartered Directors for the Institute of Directors. Recently she became a trustee of the NHS Retirement Fellowship.

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 2021/22 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 was focused upon ensuring that patients and the public have a significant voice within the NHS. Pat took 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. Pat left the Trust 31 March 2022.

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 is 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 the 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. Karen left the organisation for retirement in March 2022.

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 Doncaster and Bassetlaw Teaching Hospitals in November 2016 as Director of Finance, leading this service for five years before being named as Executive Director for Recovery, Innovation and Transformation in a secondment capacity. The services which have come together to form this new directorate, and are key in supporting and enabling the improvements envisioned, are Strategy and Improvement, Digital Transformation, Information and Informatics, and the Performance Management Office. Together, the team will focus upon enhancing and developing services and systems across the organisation as the Trust emerges from the challenges of COVID-19, ultimately in an bid to improve patient care and treatment.

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 and left in March 2022 for personal reasons.

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 March 2020.

Alex Crickmar is a Chartered Accountant with significant experience within the NHS, and joined the Trust in March 2018. A graduate of the University of Newcastle, Alex worked as a Senior Manager within PriceWaterhouseCoopers for over ten years, working across both the public and private sectors, specialising within the health service. Following this post, Alex took up the role of Deputy Director of Finance at Yorkshire Ambulance Service for a period of four years, which included a spell of around nine months as Interim Executive Director of Finance and Performance. Since joining DBTH initially as Deputy Director of Finance, Alex has helped to lead and develop the team and these efforts were recognised by the Healthcare Financial Management Association (HFMA) in 2019 when the service was named Yorkshire and Humber Finance Team of the Year. As part of the changes in the Executive Team to support the recovery, innovation and transformation of our services, Alex was subsequently named Acting Director of Finance in November 2021.

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 2021/22 and no charitable donations in 2021/22.

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.

Non NHS	Number	Value '£000
Total bills paid in the year	96,857	£260,222
Total bills paid within target	93,657	£253,580
Percentage of total bills paid within target	**99%**	**97%**

NHS	Number	Value '£000
Total bills paid in the year	3,181	£21,227
Total bills paid within target	2,978	£20,770
Percentage of total bills paid within target	**94%**	**98%**

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 2021/22 the Trust continued to build on the benchmarking work undertaken in previous years, comparing executives' 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.

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 2022, 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 2022/23.

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 sufficient 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 payment	As set out in the Remuneration table. Salaries are determined by the Trust's Remuneration	None disclosed	N/A	N/A	Contributions are made in accordance with the NHS Pension Scheme

	committee				
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 2021/22 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
Karen Barnard	Director of People and Organisational Development	3 of 3

Fair pay comparison

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2021/22 was £195k-£200k (2020/21: £195k-£200k), and the increase between 2020/21 and 2021/22 was 0%, based on the mid-points of the pay bandings. This is 4.9 times higher than the salary and allowances of all employees on an annualised basis, divided by the FTE number of employees. (2020/21: 4.6 times) This was 6.38 times (2019/20: 7.21 times) the median remuneration of the workforce, which is £30,933 (2019/20: £26,553).

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £8k to £393k (2020/21: £8k to £262k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5%. 28 employees received remuneration in excess of the highest-paid director in 2021/22.

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

	2020/21			**2021/22**		
	No. in office	**No. receiving expenses**	**Expenses paid (£)**	No. in office	No. receiving expenses	Expenses Paid (£)
Non-executive directors	6	5	£3,478	6	5	£765
Executive directors	6	0	£0.00	8	2	£0.00
Governors	36	0	£0.00	36	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 2022
Suzy Brain England OBE	Chair of the Board	1.1.2017	Three years and nine months (1)
Sheena McDonnell	Non-executive Director	1.7.2018	Two years and three months (2)
Pat Drake	Non-executive Director (Senior Independent Director)	1.4.2018	Left the organisation 31 March 2022
Kath Smart	Non-executive Director	1.4.2018	Two years (2)
Neil Rhodes	Non-executive Director	1.4.2017	One year
Mark Bailey	Non-executive Director	1.2.2020	Ten months
Richard Parker OBE	Chief Executive	14.10.2013	N/A
Karen Barnard	Director of People and Organisational Development	2.5.2016	Retired from the organisation March 2022
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	Left the organisation March 2022

1. A three-year extension was agreed by the Nominations and Remunerations Committee in March 2022 to reflect the needs of the Trust in the post-Pandemic period.
2. A one-year extension was agreed by the Nominations and Remunerations Committee in November 2021 to reflect the needs of the Trust in the post-Pandemic period.

Name and Title	2020/21							2021/22						
	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	15-20						15-20	15-20						15-20
Mark Bailey Non-executive Director	10-15						10-15	10-15						10-15
Kathryn Smart Non-executive Director	10-15						10-15	15-20						15-20
Sheena McDonnell Non-executive Director	10-15						10-15	10-15						10-15
Patricia Drake Non-executive Director	15-20						15-20	15-20						15-20
Dr Tim Noble Medical Director	165-170				50-52.5		165-170	215–220				70-72.5		290-295
David Purdue Chief Nurse and Deputy Chief Executive	135-140				22.5-25		160-165	140-145				70.72.5		210-215
Richard Parker OBE - Chief Executive	195-200						195-200	195-200				-		195-200
Jon Sargeant – Director of Finance	145-150				40-42.5		185-190	145-150				22.5-25		170-175

Karen Barnard – Director of People and Organisational Development	115-120				25-27.5		140-145	105-110				0-2.5		105-110
Rebecca Joyce – Chief Operating Officer	125-130				42.5-45		165-170	115-120				22.5-25		140-145
Alex Crickmar - Acting Director of Finance								35-40				0-2.5		35-40
Anthony Jones - Acting Director of People and Organisational Development								10-15				0-0		10-15

The 2021/22 Medical Director remuneration includes £28k relating to underpayments in previous years that has been paid within the financial year.

The basis of calculation for pension related benefits is in line with section 7.69 of the Annual Report Manual (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.

	25th percentile pay ratio	Median	75th percentile ratio
2021/22	9.9	7.6	5.4
2020/21	9.3	7.1	5.1

Note: The 2020/21 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 the Chief Executive. Figures were not provided by the NHS Business Services Authority for members that had left the NHS Pension Scheme to allow the disclosure requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21 to be met. As a consequence, the external auditor issued a qualification on the 2020/21 Remuneration Report on this matter. The NHS Foundation Trust Annual Reporting Manual for 2021/22 has been updated to confirm that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported. This updated guidance applies to 2021/22 and 2020/21 comparative guidance. Therefore, there is no qualification in the external auditor's report on the Remuneration Report for 2021/22.

Pension benefits

Salary and pension entitlements of senior managers. * denotes colleague who has left the pension scheme.

	Real increase/ (decrease) in Pension age			Real increase/(decrease) in pension related lump sum at pension age			Total accrued pension at pension age at 31 March 2022			Lump sum at pension age related to accrued pension at 31 March 2022			Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer value at 31 March 2022	Employers contribution to stakeholder pension
	(Bands of £2500)			(Bands of £2500)			(Bands of £5000)			(Bands of £5000)						
	£000k			£000k			£000k			£000k			£000k	£000k	£000k	£000k
Richard Parker *	0	-	0	0	-	0	0	-	0	0	-	0	-	-	-	-
Jon Sargeant	0	-	2.5	-2.5	-	0	50	-	55	105	-	110	996	32	1,050	-
Tim Noble	2.5	-	5	2.5	-	5	65	-	70	140	-	145	1,214	87	1,327	-
David Purdue	2.5	-	5	5	-	7.5	55	-	60	120	-	125	1,010	76	1,108	-
Rebecca Joyce**	0	-	2.5	-2.5	-	0	0	-	0	0	-	0	496	-	-	-
Karen Barnard**	0	-	2.5	0	-	2.5	0	-	0	0	-	0	1,234	-	-	-
Alex Crickmar	0	-	2.5	0	-	0	10	-	15	0	-	0	92	-	108	-
Anthony Jones	0	-	2.5	0	-	2.5	20	-	25	40	-	45	330	-	366	-

* Nil figures as individual is in receipt of pension benefits. Due to updated guidance from NHS England/Improvement, no values are required to be reported

** Individual left Trust during the year

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
22 June 2022

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 2021/22. 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 conducted regular self-assessments of their performance. In 2021/22, 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 2022/23

Audit and Risk Committee

The Audit and Risk 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 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 had a tendered contract for an internal audit function, provided by KPMG until 30 September 2021 and then replaced by 360 Assurance from 1 October 2021. As internal auditors, they 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 applicable 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. EY was reappointed in 2021 following a competitive tender process. Their extended contract runs until 30 September 2024. External auditors review the accuracy of the Annual Accounts and present significant or material matters to the Audit and Risk Committee. For 2020/21, the Trust paid audit fees to the external auditor of £144,000, £25,000 for the Wholly Owned Subsidiary audit and £18,000 for the Charitable Funds Statutory Audit. Value for non-audit work payments stands at zero.

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 6,000 members by March 2022, 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 150,000 page views per month.

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 took place in conjunction with a 'thank you' event at the Yorkshire Wildlife Park. Colleagues nominated their peers, with over 2,000 submissions made.

Health and Wellbeing

A comprehensive description of all Health and Wellbeing services is outlined within the performance report section of this report.

Education and Research

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 and wider learners. 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 another exceptional one requiring us to adapt and respond to the changing COVID-19-pandemic situation.

Our Training and Education Department continues to lead and support all areas of training including Statutory and Essential Training (SET), Role Specific Training (ReST), the wider up-skilling of staff (to complement the introduction of new roles), supporting on-going Professional Development as well as provide high quality clinical placements for a breadth of pre-registration learners and post-graduate doctors in training. Educational Leads collaborate

with the Clinical Division and Corporate Directorate 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, meeting the quality standards outlined in our education contract. We have also worked closely with the Local Workforce Action Board to help shape and support the key regional priorities: South Yorkshire Region Education Collaborative (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 Clinical and Corporate Directorates to maximise the use of apprenticeships. DBTH continues to not only utilise the apprenticeship levy for its own workforce but also supports local health and care partners.

Although we continued to suspend physical work experience placements due to the challenges presented by COVID-19 (in partnership with our Further Education Institutes and local schools), we remained 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 remain a key partner in delivering training for pre-registration students from a number of Higher Education Institutes (HEIs) and Post Graduate Doctors in Training in collaboration with Health Education England (HEE). This is a significant and important part of core business for DBTH. We are pleased to have achieved a reputation for providing high quality clinical education, which is confirmed by our student and wider learner evaluation feedback and confirmed by our annual external assessments. We have and will continue to work flexibly to support our learners with their education recovery requirements (a legacy from the challenges from Covid). Our ambition to continually improve our feedback and providing assurance to the Board 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.

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 2021/2022) 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.

Report

A new Health and Safety Adviser was appointed by the Trust in June 2021 following the retirement of the previous postholder.

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) continues to provide a Trust annual declaration of compliance performance against the Department of Health and Social Care (DOHSC) NHS Premises Assurance Model (NHS PAM), 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 have been 347 accidents/incidents reported on DATIX that may result in personal injury to staff, visitors and contractors. 14 of the reported incidents were reportable to the HSE under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. A full breakdown of incidents into subcategory and site for the reporting period of April 2021 – March 2022 is illustrated in Table 1.

Table 1: Breakdown of incidents into Subcategory and Site April 2021 – March 2022

	Doncaster Royal Infirmary	Bassetlaw Hospital	Montagu Hospital	External to DBH	Community Clinic	Total
Accident caused by some other means	49	7	12	0	1	69
Collisions	17	1	0	1	0	19
Exposure to electricity, hazardous substance,	8	5	0	0	0	13

infection etc						
Injury caused by physical or mental strain	22	6	4	0	1	33
Moving and Handling Incidents	18	6	3	1	0	28
Sharps related incident, including knives	73	22	7	0	0	102
Slips/trips/falls (includes faints)	53	21	3	1	1	79
Transport related incident	3	1	0	0	0	4
Total	243	69	29	3	3	347

The Trust H&S Adviser, Manual Handling Lead and the Education Department have completed a suite of new Trust manual handling and H&S risk assessment E-learning packages, approved by the Education team as part of the H&S and Manual handling learning needs analysis (LNA). The two courses are currently waiting for a go live date and are targeted at supervisory, middle and higher-level management initially.

The courses are to be used in conjunction with a new Trust H&S Management folder held on the Trust internal shared I.T. drive, which all managers will have access to store risk assessments, SOPs and other relevant documentation on following completion of the E-learning training. As part of the improved risk assessment training programme new clinical and non-clinical risk assessment templates have been produced and approved by the Trust H&S committee; these are available for download on a new dedicated H&S page on Trust Hive, including a suite of H&S factsheets and associated H&S management toolbox talks.

Following successful identification of a new external training provider after the previous company ceased trading during the COVID 19 Pandemic, a new Executive Responsible Person training package is currently under review by the Trust H&S Adviser, Head of Compliance and

the new external H&S consultant; with a focus on updated content, learning outcomes and links to the Trust vision, mission and objectives. It is anticipated that commencement for the updated training package will be in the second quarter of the new financial year 2022/2023.

Following an external Health and Safety consultancy report commissioned by management, 15 recommendations were presented to the Board of Directors framed within an action plan and approved by the Board on the 21 September 2021. Included within the action plan was the requirement to review the current Health and Safety Management systems in place within the Trust and the Health and Safety Culture against a recognised framework; (BS ISO 45001:2018; Standard Occupational Health & Safety (OH&S) Management System). To achieve this a QI project was logged and framed around the reports actions, with initial scoping meetings taking place in November/December 2021. Six further stakeholder workshops (3 at DRI and 3 at BDGH) have been arranged with the first two workshops accomplished in March 2022; the remaining four workshops will be delivered in May and June 2022, with outcomes from the workshops anticipated for the second quarter of the new financial year 2022/2023.

A Trust wide Radon Gas review commenced in November 2021 following recommendations included within the current Trust Radon Gas measurement strategy provided by the Trust Radiation Protection Adviser (RPA). The Trust H&S Adviser arranged for the delivery and installations of radon dosimeters for all three Trust sites from Public Health England (PHE). The dosimeters were installed in various ground and basement level offices over a three month measuring period, they were then be returned to PHE for review with a full report to be provided to the Trust of outcomes and actions if required. Although Bassetlaw Hospital and Montagu Hospital are within radon risk areas identified by PHE it is not anticipated that these will present any high reading counts. The Trust are currently waiting for the results from PHE which will be shared with the Trust RPA and reported to the Trust H&S committee following outcome of the review.

Regular review and update of the electronic Control of Substances Hazardous to Health (COSHH) system Alcumus Sypol continues to be undertaken by the H&S Adviser including substance updates and new information additions to ensure continual improvement. The H&S Adviser is also reviewing the current Trust guidance and documentation available to staff on the Hive to ensure continual improvement of information availability.

Fire Precaution works for 2021/22 were significantly affected by an incident in the Women's and Children's Unit which meant that the East wing of the block was decanted due to loss of power. Consequently, as the wards were repatriated for a period, the fire precautions and Central Delivery Suite refurbishment funding was diverted to the east wards and the East Ward Block works moved to commence in the 2022/23 programme of works, with the agreement of South Yorkshire Fire and Rescue.

Capital fire improvement works completed FY 2021/22 are listed in Table 2

Table 2: Capital Fire improvement work completed FY 2021/22

Site	Block	Project
DRI	DRI 09	Level 6 Theatres (Carried over from 20/21)
DRI	DRI 09	Level 4 Children's Observation Unit
DRI	DRI 09	Level 6 Neo-Natal Unit
DRI	DRI 09	Level 3 M2
BDGH	BDGH 43/44	Level 3 Phase 4 main hospital street compartmentation improvement
BDGH	BDGH 44	Level 2 Maternity main hospital street compartmentation improvement
BDGH	BDGH 50	Phase 1 upgrade to L1 Fire Alarm System
MMH	MMH General	Phase 1 Replacement of obsolete TDM fire alarm network

Finally throughout the reporting period the multi-disciplinary Working Safely Group have continued to work 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 have changed.

Workforce statistics as at 31 March 2022 (subject to Audit)

(excl. bank and locum)	Headcount (Perm)	FTE	Headcount (Other)

Total staff employed as at 31 March 2021	6,327	5217.67	552
Clinical Support	1447	1,201.76	36
Other Healthcare Professionals	711	614.12	33
Medical and Dental	317	298.27	338
Nursing and Midwifery	1857	1,572.15	37
Non-Clinical (Admin & Clerical and Estates & Ancillary)	1995	1,541.37	108

Sickness

	2021/22 Actual	**2021/22 Target**	**Benchmarking data**
Staff Sickness Absence Rate	6.55%	3.50%	2020/21 the rate was 4.35% In 2019/20 the regional average was 5.13%

Staff Cost

	Total £000	Permanently employed total £000	Other total £000
Salaries and wages	**249,115**	**222,661**	**26,454**
Social security costs	**23,677**	**21,833**	**-**
Apprenticeship Levy	**1,190**	**1,074**	**-**
Pension cost – defined contribution plans employer's contributions to NHS Pensions	**26,049**	**25,390**	**-**

Pension cost – defined contribution plans employer's contributions to NHS Pensions paid by NHS England on provider's behalf	**11,405**	**11,133**	**-**
Pension cost - other	**125**	**116**	**-**
Temporary staff – external bank	**14,720**	**-**	**14,720**
Temporary staff – agency/contract staff	**14,614**	**-**	**14,614**
Total Staff costs	**327,407**	**271,419**	**55,988**

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 this has not been possible - instead we did some virtual items.

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 regard 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 2022 – Executive and Senior Directors

Gender (Directors Only)	Headcount	Headcount %
Female	3	30.00%
Male	7	70.00%

Senior managers

Gender	Headcount	Headcount %
Female	170	69.39%
Male	75	30.61%

Equality Information as at 31 December 2021

Gender	Headcount	FTE	Headcount %

Female	5,544	4,557.39	82%
Male	1,221	1,128.52	18%

Age	**Headcount**	**FTE**	**Headcount %**
16 - 20	39	35.33	0.58%
21 - 25	441	414.32	6.52%
26 - 30	745	661.68	11.01%
31 - 35	878	751.75	12.98%
36 - 40	772	655.07	11.41%
41 - 45	599	595.59	10.33%
46 - 50	807	704.75	11.93%
51 - 55	852	729.86	12.59%
56 - 60	867	677.97	12.82%
61 - 65	516	363.58	7.63%
66 - 70	123	81.51	1.82%
71 & above	26	14.57	0.38%

Ethnicity	Headcount	FTE	Headcount %
Any Other	77	74.18	1.14%
Asian	398	376.80	5.9%
Black	156	140.38	2.32%
Chinese	29	27.32	0.43%
Mixed	27	63.95	0.40%
White	5,840	4,835.84	86.9%
Not Disclosed	191	167.43	2.84%

Disability	Headcount	FTE	Headcount %
No	5,593	4,701.88	82.7%
Not Declared	132	109.72	2%
Prefer Not To Answer	3	1.93	0%
Unspecified	809	681.41	12%
Yes	228	190.96	3.4%

Sexual Orientation	**Headcount**	**FTE**	**Headcount %**
Bisexual	43	39.03	0.64%
Gay or Lesbian	72	68.85	1.06%
Heterosexual or Straight	4,089	3,490.77	60.44%
Not Disclosed	2561	2,087.27	37.86%

Our Trust values, set out in the strategic direction, embed 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.

Additionally, Doncaster and Bassetlaw Teaching Hospitals (DBTH) became the first NHS organisation to qualify to use the RACE (Reporting Action Composition Education) Equality Code Quality Mark, following assessment. The new code has been developed to help organisations take action to improve race equality within the workplace. The Race Equality Code draws learning and recommendations outlined in reports, charters, and pledges, with the aim of supporting organisations who are actively tackling diversity and inclusion challenges. It was launched in October last year as part of Black History Month 2020 by Dr Karl George MBE and a national steering group of experts in governance and racial inequalities.

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.

Average & Median Hourly Rates

Number of employees | Q1 = Low, Q4 = High

Mar-21

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	23.4124	18.1892
Female	14.9564	12.7690
Difference	8.4560	5.4202
Pay Gap %	36.1177	29.7992

Quartile	Female	Male	Female %	Male %
1	1,398.00	206.00	87.16	12.84
2	1,384.00	220.00	86.28	13.72
3	1,422.00	182.00	88.65	11.35
4	1,059.00	546.00	65.98	34.02

Mar-22

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	23.4280	18.0998

Quartile	Female	Male	Female %	Male %
1	1,381.00	217.00	86.42	13.58

Female	15.3841	13.2064		2	1,449.00	214.00	87.13	12.87
Difference	8.0440	4.8934		3	1,422.00	209.00	87.19	12.81
Pay Gap %	34.3347	27.0358		4	1,090.00	540.00	66.87	33.13

20/21 comparison

Gender	Avg. Hourly Rate	Median Hourly Rate		Quartile	Female	Male	Female %	Male %
Male	0.0156	-0.0894		1	-17.00	11.00	-0.74	0.74
Female	0.4277	0.4374		2	65.00	-6.00	0.85	-0.85
Difference	-0.4121	-0.5268		3	0.00	27.00	-1.47	1.47
Pay Gap %	-1.7830	-2.7634		4	31.00	-6.00	0.89	-0.89

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 University Of Sheffield 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 (ie. 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 2021/22

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 Invitation To Tender (ITT) ocumentation 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;
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

NHS Staff Survey

Our performance on staff satisfaction is benchmarked against other similar trusts once a year in the NHS National Staff Survey. In 2021/22 our response rate was 63% of all staff (total number of replies 4,072). For comparison, this stood at 50% in 2020/21 (total number of replies 3,157).

The Trust's survey is undertaken and overseen by Picker, as an independent third-party in-line with national guidance. As such, the findings, which are disclosed in the proceeding pages, uses categories which are slightly different to what is listed within the NHS Foundation Trust Annual Reporting Manual, however it contains all elements asked for, specifically:

- Equality, diversity, and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying and harassment
- Safe environment – Violence
- Safety culture
- Staff engagement

The 2021/22 this process underwent important changes compared to the 2020/21 iteration. The most significant of these changes has been the realignment of the survey questions to the seven People Promise elements enabling consistent and robust measurement of the working experience of our people across the organisation. The below table reflects the Trust level scores in comparison with other South Yorkshire and Bassetlaw organisations:

Indicators (People Promise elements and themes)	2021/22	
	Trust Score	Benchmarking Group Score
We are compassionate and inclusive	7.2	7.2
We are recognised and rewarded	5.7	5.8
We each have a voice that counts	6.7	6.7
We are safe and healthy	5.9	5.9
We are always learning	5.2	5.2
We work flexibly	5.8	5.9
We are a team	6.4	6.6
Staff Engagement	6.7	6.8
Morale	5.6	5.8

In the summary shared from pages 74 to 90, you can view:

- Response rates compared to the prior year
- Areas of improvement/deterioration from the prior year
- Comparisons to benchmarking group (in our case the average across trusts nationally)
- Key areas for improvement

Future priorities and targets

In 2021/22, we registered our highest ever Staff Survey results, with a significant increase in response as compared to the year before. In all, our overall positive scores, in comparison to other trusts, have only slightly diminished (from 38th place last year to 40th place this year) and that the changes are in-line with the NHS Nationally and locally the results reflect how wider NHS staff are feeling.

Unsurprisingly, we saw more people saying they are considering leaving the organisation, which is something we have witnessed as fewer team members are choosing to retire and return, which impacts on our workforce numbers. This situation, along with high levels of sickness because of the covid peaks, resulted in fewer respondents saying there were enough staff to do the job properly (22%), which has such a big impact on job satisfaction that there is no surprise that fewer people would recommend us as a place to work (56%). It will be our target, in the coming years, to improve these scores and to make our Trust as attractive employer as possible.

One of the key positive messages from the survey is that colleagues recognise all the health and well-being initiatives and support such as the Talk-listen-care (TLC) services, holistic therapies, counselling services and much more put in place. 60% of respondents said they recognised DBTH take positive action on health and wellbeing, which is significantly higher than respondents at other trusts. In fact, eight of the 28 questions on health and well-being were significantly higher than at other trusts. This is something we will seek to build upon in future.

Whilst there has been a slight deterioration across all questions, what does give some optimism is that the deterioration takes most of the scores to a comparable level to our scores in 2019/20 and as we begin to learn to live with COVID-19 we need to look to restart and refresh our improvement journey. We will continue to monitor this with regular Pulse surveys, Friends and Family Tests, and other bespoke and local engagements.

Our new Chief People Officer joined the Trust June, who will aim to build upon the commitment of the Board of Directors and Executive Team, to support the recovery of our people. This is one of our top priorities and we seek to provide the services our patients need and deliver high quality, safe care – and Staff Survey findings figures highly in all our Executive Team's individual objectives. Finally, the overall findings have been shared with each division and directorate to create their own local plans to address areas of concern.

Executive summary (part 1 of 2)

This report summarises the findings from the NHS Staff Survey 2021 carried out by Picker, on behalf of DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST. Picker was commissioned by 60 Acute and Acute Community Trusts organisations to run their survey – this report presents your results in comparison to those organisations.

A total of 117 questions were asked in the 2021 survey, of these 92 can be positively scored, with 60 of these which can be historically compared. Your results include every question where your organisation received at least 11 responses (the minimum required).

6576	6500	**63%**	52%	50%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (4072)	Average response rate for similar organisations	Your previous response rate

56%	q21c. Would recommend organisation as place to work
64%	q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
74%	q21a. Care of patients/service users is organisation's top priority

Comparison to 2020*

Comparison with average*

*Chart shows the number of questions that are better, worse, or show no significant difference

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Executive summary (part 2 of 2)

Top 5 scores vs Picker Average	Trust	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	51%	44%
q15. Organisation acts fairly: career progression	62%	56%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	92%
q16b. Not experienced discrimination from manager/team leader or other colleagues	94%	91%
q11a. Organisation takes positive action on health and well-being	60%	57%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
q7b. Team members often meet to discuss the team's effectiveness	43%	56%
q3e. Involved in deciding changes that affect work	43%	49%
q3i. Enough staff at organisation to do my job properly	22%	27%
q3f. Able to make improvements happen in my area of work	48%	53%
q7g. Team deals with disagreements constructively	50%	55%

Most improved scores	Trust 2021	Trust 2020
q14d. Last experience of harassment/bullying/abuse reported	48%	44%
q13d. Last experience of physical violence reported	66%	64%
q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work	71%	69%
q17a. Would feel secure raising concerns about unsafe clinical practice	73%	72%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	52%	51%

Most declined scores	Trust 2021	Trust 2020
q3i. Enough staff at organisation to do my job properly	22%	33%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	40%	50%
q21c. Would recommend organisation as place to work	56%	65%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	64%	71%
q22a. I don't often think about leaving this organisation	42%	48%

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Tables are based on absolute % differences, not statistical significance

Survey activity

63% Overall response rate (total returned as a % of total eligible)

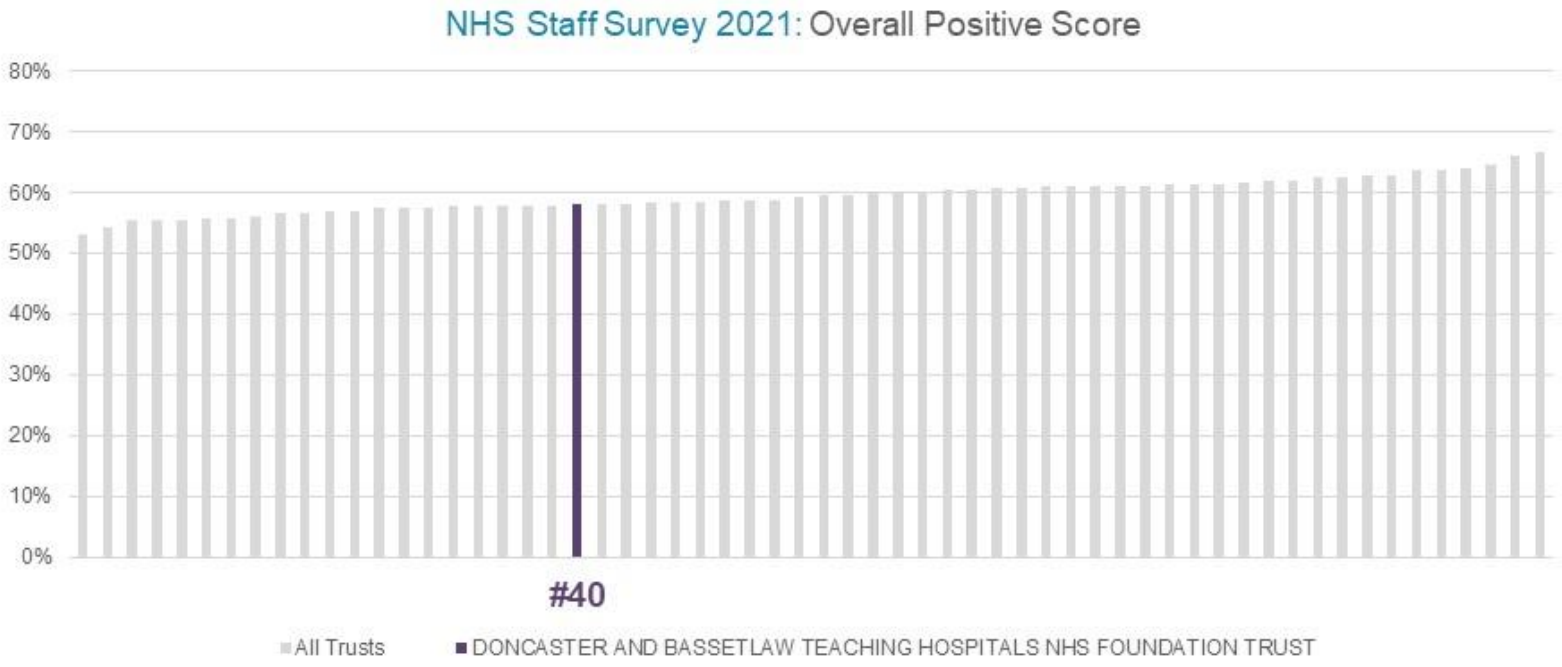
52% Average response rate for similar organisations

Response totals:

Outcome	Paper	Online	Total
Invited	661	5915	6576
Blank	2	0	2
Completed	294	3778	4072
Excluded	0	0	0
Ineligible	0	0	0
Left organisation	17	59	76
Not returned	348	2075	2423
No further mailings	0	0	0
Opted out	0	0	0
Undelivered	0	3	3

League table: overall positive score

The league table shows how your overall positive score is ranked in comparison to the overall positive score of every other Acute and Acute Community Trusts organisation that ran the NHS Staff Survey 2021 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



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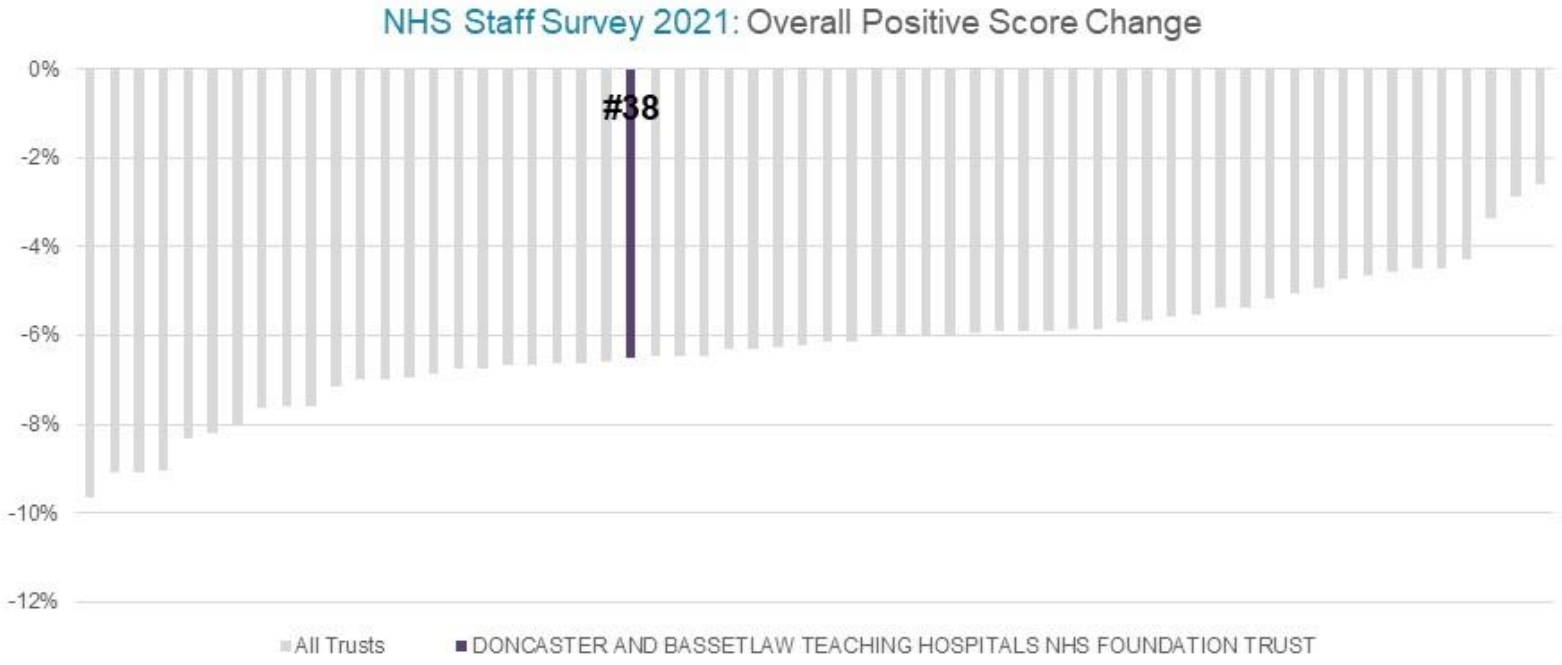
League table: historic positive score

The historical league table shows how your overall positive score changed from the previous survey, and how this change compares to other organisations Acute and Acute Community Trusts who ran the NHS Staff Survey 2021 with Picker.



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YOUR JOB (part 1 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q2a	Often/always look forward to going to work	52%	53%	59%	53%	**49%**	53%	**49%**
q2b	Often/always enthusiastic about my job	70%	71%	75%	71%	**68%**	68%	68%
q2c	Time often/always passes quickly when I am working	73%	73%	77%	74%	73%	74%	73%
q3a	Always know what work responsibilities are	86%	87%	89%	87%	87%	87%	87%
q3b	Feel trusted to do my job	91%	91%	92%	91%	91%	91%	91%
q3c	Opportunities to show initiative frequently in my role	68%	67%	69%	69%	69%	73%	**69%**
q3d	Able to make suggestions to improve the work of my team/dept	71%	69%	72%	70%	**66%**	71%	**66%**
q3e	Involved in deciding changes that affect work	48%	46%	49%	46%	**43%**	49%	**43%**

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

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YOUR JOB (part 2 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q3f	Able to make improvements happen in my area of work	49%	48%	53%	50%	48%	53%	48%
q3g	Able to meet conflicting demands on my time at work	43%	45%	47%	48%	43%	44%	43%
q3h	Have adequate materials, supplies and equipment to do my work	50%	51%	55%	57%	53%	56%	53%
q3i	Enough staff at organisation to do my job properly	28%	28%	30%	33%	22%	27%	22%
q4a	Satisfied with recognition for good work	45%	50%	55%	53%	48%	50%	48%
q4b	Satisfied with extent organisation values my work	39%	43%	49%	46%	41%	42%	41%
q4c	Satisfied with level of pay	28%	35%	38%	35%	29%	32%	29%
q4d	Satisfied with opportunities for flexible working patterns	47%	48%	50%	50%	48%	52%	48%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR JOB (part 3 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q5a	Have realistic time pressures	-	21%	24%	25%	24%	23%	24%
q5b	Have a choice in deciding how to do my work	-	52%	52%	53%	50%	51%	50%
q5c	Relationships at work are unstrained	-	41%	45%	44%	41%	43%	41%
q6a	Feel my role makes a difference to patients/service users	88%	88%	89%	88%	88%	88%	88%
q6b	Organisation is committed to helping balance work and home life	-	-	-	-	41%	43%	41%
q6c	Achieve a good balance between work and home life	-	-	-	-	51%	51%	51%
q6d	Can approach immediate manager to talk openly about flexible working	-	-	-	-	63%	65%	63%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR TEAM & PEOPLE IN YOUR ORGANISATION (part 1 of 2)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q7a	Team members have a set of shared objectives	68%	69%	72%	69%	68%	72%	68%
q7b	Team members often meet to discuss the team's effectiveness	52%	49%	53%	45%	43%	56%	43%
q7c	Receive the respect I deserve from my colleagues at work	*	68%	71%	68%	66%	69%	66%
q7d	Team members understand each other's roles	-	-	-	-	72%	71%	72%
q7e	Enjoy working with colleagues in team	-	-	-	-	80%	81%	80%
q7f	Team has enough freedom in how to do its work	-	-	-	-	53%	56%	53%
q7g	Team deals with disagreements constructively	-	-	-	-	50%	55%	50%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR TEAM & PEOPLE IN YOUR ORGANISATION (part 2 of 2)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q7h	Feel valued by my team	-	-	-	-	65%	68%	65%
q7i	Feel a strong personal attachment to my team	-	-	-	-	63%	63%	63%
q8a	Teams within the organisation work well together to achieve objectives	-	-	-	-	53%	53%	53%
q8b	Colleagues are understanding and kind to one another	-	-	-	-	68%	69%	68%
q8c	Colleagues are polite and treat each other with respect	-	-	-	-	69%	71%	69%
q8d	Colleagues show appreciation to one another	-	-	-	-	65%	66%	65%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR MANAGERS

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q9a	Immediate manager encourages me at work	-	63%	68%	67%	65%	68%	65%
q9b	Immediate manager gives clear feedback on my work	54%	56%	61%	59%	58%	61%	58%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	50%	48%	52%	51%	52%	56%	52%
q9d	Immediate manager takes a positive interest in my health & well-being	61%	61%	65%	68%	63%	66%	63%
q9e	Immediate manager values my work	65%	65%	70%	68%	66%	69%	66%
q9f	Immediate manager works with me to understand problems	-	-	-	-	63%	66%	63%
q9g	Immediate manager listens to challenges I face	-	-	-	-	65%	68%	65%
q9h	Immediate manager cares about my concerns	-	-	-	-	64%	67%	64%
q9i	Immediate manager helps me with problems I face	-	-	-	-	61%	63%	61%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 1 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	67%	65%	62%	64%	59%	61%	59%
q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48%	50%	51%	52%	51%	44%	51%
q11a	Organisation takes positive action on health and well-being	-	-	-	-	60%	57%	60%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70%	68%	71%	72%	69%	69%	69%
q11c	In last 12 months, have not felt unwell due to work related stress	59%	59%	61%	54%	51%	54%	51%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	39%	39%	39%	50%	40%	45%	40%
q11e	Not felt pressure from manager to come to work when not feeling well enough	68%	69%	74%	72%	71%	74%	71%
q12a	Never/rarely find work emotionally exhausting	-	-	-	-	21%	20%	21%
q12b	Never/rarely feel burnt out because of work	-	-	-	-	26%	27%	26%
q12c	Never/rarely frustrated by work	-	-	-	-	18%	20%	18%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 2 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q12d	Never/rarely exhausted by the thought of another day/shift at work	-	-	-	-	32%	34%	32%
q12e	Never/rarely worn out at the end of work	-	-	-	-	15%	17%	15%
q12f	Never/rarely feel every working hour is tiring	-	-	-	-	48%	48%	48%
q12g	Never/rarely lack energy for family and friends	-	-	-	-	33%	33%	33%
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	81%	83%	84%	85%	84%	86%	84%
q13b	Not experienced physical violence from managers	99%	100%	100%	99%	99%	99%	99%
q13c	Not experienced physical violence from other colleagues	98%	99%	99%	99%	99%	98%	99%
q13d	Last experience of physical violence reported	63%	62%	63%	64%	66%	67%	66%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	73%	74%	75%	74%	74%	74%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

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YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 3 of 3)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q14b	Not experienced harassment, bullying or abuse from managers	87%	89%	90%	90%	91%	89%	**91%**
q14c	Not experienced harassment, bullying or abuse from other colleagues	84%	83%	85%	83%	84%	82%	**84%**
q14d	Last experience of harassment/bullying/abuse reported	42%	42%	47%	44%	48%	48%	48%
q15	Organisation acts fairly: career progression	56%	55%	63%	61%	62%	56%	**62%**
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	96%	95%	96%	96%	96%	92%	**96%**
q16b	Not experienced discrimination from manager/team leader or other colleagues	93%	94%	95%	95%	94%	91%	**94%**
q17a	Would feel secure raising concerns about unsafe clinical practice	69%	68%	72%	72%	73%	73%	73%
q17b	Would feel confident that organisation would address concerns about unsafe clinical practice	56%	55%	61%	60%	58%	59%	58%
q18	Feel organisation respects individual differences	-	-	-	-	71%	69%	**71%**

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR PERSONAL DEVELOPMENT & YOUR ORGANISATION (part 1 of 2)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q19a	Received appraisal in the past 12 months	79%	86%	90%	-	81%	82%	**81%**
q19b	Appraisal helped me improve how I do my job	21%	19%	23%	-	18%	21%	**18%**
q19c	Appraisal helped me agree clear objectives for my work	31%	29%	36%	-	31%	31%	31%
q19d	Appraisal left me feeling organisation values my work	26%	26%	33%	-	30%	30%	30%
q20a	Organisation offers me challenging work	-	-	-	-	66%	69%	**66%**
q20b	There are opportunities for me to develop my career in this organisation	-	-	-	-	52%	53%	52%
q20c	Have opportunities to improve my knowledge and skills	-	-	-	-	64%	67%	**64%**
q20d	Feel supported to develop my potential	-	-	-	-	50%	52%	**50%**
q20e	Able to access the right learning and development opportunities when I need to	-	-	-	-	54%	55%	54%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

YOUR PERSONAL DEVELOPMENT & YOUR ORGANISATION (part 2 of 2)

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q21a	Care of patients/service users is organisation's top priority	71%	72%	76%	80%	**74%**	76%	**74%**
q21b	Organisation acts on concerns raised by patients/service users	69%	69%	72%	74%	**70%**	71%	**70%**
q21c	Would recommend organisation as place to work	51%	54%	61%	65%	**56%**	59%	**56%**
q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	62%	63%	68%	71%	**64%**	66%	**64%**
q21e	Feel safe to speak up about anything that concerns me in this organisation	-	-	-	67%	**61%**	62%	61%
q21f	Feel organisation would address any concerns I raised	-	-	-	-	50%	50%	50%
q22a	I don't often think about leaving this organisation	-	43%	48%	48%	**42%**	43%	42%
q22b	I am unlikely to look for a job at a new organisation in the next 12 months	-	54%	58%	58%	**52%**	51%	52%
q22c	I am not planning on leaving this organisation	-	57%	63%	64%	**58%**	57%	58%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

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BACKGROUND INFORMATION

		Historical					External	
		2017	2018	2019	2020	2021	Average	Organisation
q28b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	-	-	-	69%	71%	71%	71%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Picker

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 combatting fraud.

The Acting Director of Finance is nominated to lead counter fraud work and is supported by the Trust's LCFS. We also have an appointed Counter Fraud Champion who assists in raising the profile of counter fraud work and has a detailed understanding of the risks that fraud poses to the Trust. The Acting Director of Finance, Fraud Champion and the LCFS work closely to ensure that our efforts to prevent, deter and detect fraud is fully coordinated and effective. During 2021/22 significant work has been carried out to identify and mitigate fraud risks and our fraud risk assessment is now firmly embedded within our risk management processes.

The NHS Counter Fraud Authority (NHSCFA) provides the national framework through which NHS Trusts seek to minimise losses through fraud. As of April 2021, the Trust is required to comply with the Government Functional Standard GovS 013: Counter Fraud (https://cfa.nhs.uk/government-functional-standard/NHS-requirements) initiated by the Cabinet Office. In our inaugural assessment the Trust has received an overall 'Green' rating and we continue to maintain our contractual obligations in regard to counter fraud compliance with our local Clinical Commissioning Groups.

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%. We also conducted a fraud awareness survey, with approx. 20% of our staff submitting responses. Significant assurance was gained to show that the Trust takes fraud seriously and that our staff can recognise various forms of fraud and cybercrime and would be prepared to report it.

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.

In addition to continuing to raise awareness of fraud against the NHS throughout the year, in November 2021 we also held a Fraud Awareness Month and the Trust was an official supporter of International Fraud Awareness Week in the same month. In the past year it was evident that criminals have used the pandemic to create new fraud risks and as such

during this event we formed a close liaison with the South Yorkshire Police Fraud and Cyber Crime Unit.

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 Acting 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 £2,516k (2020/21: £572k). This increase is a result of the ambitious capital project programme we have embarked upon.

Staff Exit packages for 2021/22

There were no staff exit packages agreed.

High paid and off pay-roll arrangements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2022	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 2021 and 31 March 2022, 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 2021 and 31 March 2022	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 2018 and 31 March 2019

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.	14

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	11 of 11
Rebecca Joyce	Chief Operating Officer*	6 of 11
Jon Sargeant	Director of Finance	10 of 11
Pat Drake	Non-executive Director	9 of 11
Kath Smart	Non-executive Director	9 of 11

* Left organisation in year.

In the year the Committee has, on behalf of the Board:

- Provided assurance on:

- Current financial and operational performance
- 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 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	6 of 6
Sheena McDonnell	Non-executive Director	5 of 6
Mark Bailey	Non-executive Director	6 of 6
David Purdue	Chief Nurse and Deputy Chief Executive	5 of 6
Dr Tim Noble	Medical Director	5 of 6

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.

- 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)	5 of 5
Kath Smart	Non-executive Director	5 of 5
Pat Drake	Non-executive Director	5 of 5
Mark Bailey	Non-executive Director	5 of 5
Karen Barnard	Director of People and Organisational Development	5 of 5
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:

- 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 2021/22 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 (ended 31.03.2022)	2 of 5
Beverley Marshall	Public – Doncaster (ended 21.09.2021)	1 of 2
David Goodhead	Public – Doncaster (ended 31.03.2022)	3 of 5
David Northwood	Public – Doncaster	3 of 5
Dennis Atkin	Public – Doncaster	4 of 5
Geoffrey Johnson	Public – Doncaster (ended 31.03.2022)	4 of 5
Hazel Brand	Public – Bassetlaw (Lead Governor) (ended 31.03.2022)	5 of 5
Jackie Hammerton	Public – Rest of England & Wales	1 of 5
Linda Espey	Public – Doncaster (ended 21.09.2021)	2 of 2
Linda Haglauer	Public – Doncaster (from 21.09.2021)	0 of 3
Lynne Logan	Public – Doncaster	5 of 5
Marc Bratcher	Public – Doncaster (from 21.09.2021)	0 of 3
Lynne Schuller	Public – Bassetlaw	3 of 3
Maria Jackson-James	Public – Rest of England & Wales	1 of 5
Mark Bright	Public – Doncaster	5 of 5
Mary Spencer	Public – Bassetlaw (ended 31.03.2022)	3 of 5
Michael Addenbrooke	Public – Doncaster (ended 31.03.2022)	1 of 5
Mick Muddiman	Public – Doncaster (from 21.09.2021)	2 of 3
Pauline Riley	Public – Doncaster	4 of 5

Peter Abell	Public – Bassetlaw	5 of 5
Philip Beavers	Public – Doncaster (ended 21.09.2021)	2 of 2
Sheila Walsh	Public – Bassetlaw (from 21.09.2021)	2 of 3
Steven Marsh	Public – Bassetlaw (ended 21.09.2021)	1 of 2
Susan McCreadie	Public – Doncaster (ended 31.03.2022)	4 of 5
Dr Vivek Panikkar	Staff – Medical and Dental	3 of 5
Duncan Carratt	Staff – Non-Clinical	5 of 5
Kay Brown	Staff – Non-Clinical	4 of 5
Sally Munro	Staff – Nurses and Midwives	0 of 5
Sophie Gilhooly	Staff – Other Healthcare	0 of 5
Mandy Tyrrell	Staff – Nurses and Midwives (ended 31.03.2022)	2 of 5
Ainsley MacDonnell	Partner – Nottinghamshire County Council	3 of 5
Alexis Johnson	Partner – Doncaster Deaf Trust	1 of 5
Anthony Fitzgerald	Partner – Doncaster CCG	0 of 5
Clive Tattley	Partner – Bassetlaw Community and Voluntary Services (ended 08.01.2022)	4 of 5
Jo Posnett	Partner – Sheffield Hallam University	4 of 5
Phil Holmes	Partner – Doncaster Council	4 of 5
Susan Shaw	Partner – Bassetlaw District Council	4 of 5

Tina Harrison	Partner – Doncaster College and University Centre	0 of 5
Victoria McGregor-Riley	Partner – Bassetlaw CCG	0 of 5
Wendy Baird	Partner – University of Sheffield	2 of 5

During the COVID pandemic these meetings were held virtually and format of meeting changed to presentations from all NEDS, Lead Governor, Chair and Chief Executive and interactive question and answer session in addition to statutory COG business, The executive directors were not required to attend all meetings unless the nature of the business conducted required their attendance in order for them to prioritise the operation service delivery of the business through this challenging time.

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	3 of 5
Mark Bailey	Non-executive Director	5 of 5
Richard Parker OBE	Chief Executive	4 of 5
Karen Barnard **	Director of People and Organisational Development	2 of 5
David Purdue **	Chief Nurse and Deputy Chief Executive	1 of 5

Jon Sargeant **	Director of Finance	2 of 5
Dr Tim Noble **	Medical Director (from 1 April 2021)	3 of 5
Rebecca Joyce **	Chief Operating Officer	2 of 5

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 2022, there were 14,977 members overall. An analysis of our current membership body is provided below:

	Number of members at 31st March 2022
Public Constituency	8,025
Doncaster	4,625
Bassetlaw	2,390

Rest of England and Wales	1,010
Staff Constituency	6,952
Nurses and Midwives	1,885
Non-clinical	2,110
Other healthcare professionals	2,227
Medical and Dental	730
Total	14,977

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 held a virtual member event in June 2021, a DBTH Members' Lecture Series. The Trust debuted its very first lecture series, focused on the Trust's response to COVID-19 pandemic. 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 virtual magazine, Foundations for Health
- Working to ensure contested Governor Elections and improved member participation in the election process

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 sessions.
- 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.
- 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.
- Regular Governor updates by email.

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 on-going 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. 50).
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief 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.	See Accountability Report (p.33); Remuneration Report (p.39); and Audit Committee section (p.51).
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. 95).
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.33).
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.34).
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.39); and Council of Governors section (p.93).
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	See Accountability Report (p.33).

	commitments should be reported to the council of governors as they arise, and included in the next annual report.	
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.99).
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.50).
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.50).
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, 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).	See Governance Report (p.50)
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.107).
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.51).
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.51).
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 report should include a statement of whether or not the director will retain such earnings.	n/a.
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.99).
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. 99).
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.99).

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 2022. 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 Teaching 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)
22 June 2022

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 2022 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 Acting 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, 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 2021/22 a review was reported on the design of the risk management framework, which resulted in a significant assurance with minor improvement opportunities rating. It also included a report on the operating effectiveness of the risk management framework, which resulted in a partial assurance with improvement opportunities rating. Nevertheless, the board is currently reviewing its risk management processes to bring a stronger focus on strategic and operational risks in 2022/23.

Other assurance comes from; NHS Improvement and 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 2021/22 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 - 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 2021/22 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:

- The ongoing challenges presented by COVID-19
- 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
- Failure to deliver and organisational development strategy that allows implementation of trust values
- Risks to patient flow due to external availability of care provision, which adversely affects patient experience
- Risks to patient both in terms of flow and communication as a result of the pathways relating to Infection, Prevention and Control measures

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 Non-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.

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 2021 to 31 March 2022 inclusive, and is based on the audits that were completed in this period, with one deferred to 2022/23 due to the impact of COVID-19.

In providing an opinion for the financial year, it is important to reflect on the environment in which the Trust has been required to function. The impact of the pandemic has continued during 2021/22 presenting significant challenges throughout the year. Organisations were

asked to work collaboratively across systems to meet priorities for the year. The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure.

For the period 1 April 2021 to 31 March 2022 Internal Audit was able to provide an overall opinion of moderate assurance that there is a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
In providing the opinion, Internal Audit considered three main areas outlined below:
Strategic risk management: moderate assurance

The Trust has reported the BAF to the Board throughout the year however acknowledges that further development is needed. The Trust has engaged external support to develop risk management arrangements.

Individual assignment outturn: significant assurance

Considering work completed by the previous Internal Auditors in the first six months of the year as well as work completed by new auditors in the latter six months, an overall significant assurance opinion is provided, though it should be noted that the following pieces of work received partial/limited assurance opinions and raised high risk issues but actions to address these have been received:

- Medicine Management
- Divisional Governance
- Data Quality

Follow up of internal audit actions: moderate assurance

The Trust's overall follow up implementation rate for the year is 84%. The Internal Audit opinion would normally be decided on first follow up rate (34%), and implementation of high risk and historic actions. However, this year the internal Auditors have taken into account circumstances including the change in internal audit provider mid-year, and the delay in obtaining previous actions and the impact of COVID-19.

Third-party assurances received by the Trust are also made available to Internal Audit and are taken into account in the final Internal Audit opinion

Progress in relation to the delivery of the Internal Audit Plan has been reported regularly to the Audit and Risk Committee.

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 SFIs, in March 2021.

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 2021/22, 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 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 the 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.

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
22 June 2022

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Doncaster and Bassetlaw Teaching Hospitals NHS
Foundation Trust for the year ended 31 March 2022 which comprise the Foundation Trust and Group's Statement of Comprehensive Income, the Foundation Trust and Group Statement of Financial Position, the Foundation Trust and Group Statement of Changes in Equity, the Foundation Trust and Group Statement of Cash Flows, and the related notes 1 to 45, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion the financial statements:

- give a true and fair view of the financial position of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and of the Group as at 31 March 2022 and of Foundation Trust's and Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust and the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group or Foundation Trust's ability to continue as a going concern for a period of twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's and the Group's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and

- the parts of the Remuneration and Staff report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;

- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's responsibilities set out on page 103 the chief executive is the Accounting Officer of Doncaster and Bassetlaw Teaching Hospitals NHS
Foundation Trust. The Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group and the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the group or the Foundation Trust, or have no realistic alternative but to do so.

As explained in the statement of the Statement of Accounting Officer's responsibilities, as the Accounting Officer of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, the Accounting Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the group and Foundation Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of

assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

- We understood how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of employee handbooks and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance through improper recognition of revenue and expenditure, inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Foundation Trust's manual year end income and expenditure accruals, challenging assumptions and corroborating the income to appropriate evidence.

- To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Foundation Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

- To address our fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts 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.

Use of our report

This report is made solely to the Council of Governors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Hassan Rohimun
for and on behalf of Ernst & Young LLP
Manchester
22 June 2022

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, 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 **22 June 2022**

Statement of Comprehensive Income

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	451,183	404,601	451,183	404,601
Other operating income	4	51,161	57,902	50,765	64,301
Operating expenses	7	(512,914)	(457,245)	(511,957)	(463,271)
Operating surplus/(deficit) from continuing operations		**(10,570)**	**5,258**	**(10,009)**	**5,631**
Finance income	12	318	278	25	11
Finance expenses	13	(282)	(336)	(282)	(336)
PDC dividends payable		(5,993)	(4,720)	(5,993)	(4,720)
Net finance costs		**(5,957)**	**(4,778)**	**(6,250)**	**(5,045)**
Other gains / (losses)	14	581	1,438	-	111
Corporation tax expense		(15)	(33)	-	-
(Deficit) / surplus for the year		**(15,961)**	**1,885**	**(16,259)**	**697**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Net Impairments	8	4,743	2,409	4,743	2,409
Revaluations		-	88	-	88
Total comprehensive income / (expense) for the period		**(11,218)**	**4,382**	**(11,516)**	**3,194**
Surplus/ (deficit) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(15,961)	1,885	(16,259)	697
TOTAL		**(15,961)**	**1,885**	**(16,259)**	**697**
Total comprehensive income/ (expense) for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(11,218)	4,382	(11,516)	3,194
TOTAL		**(11,218)**	**4,382**	**(11,516)**	**3,194**

Adjusted Financial Performance

(Deficit)/ surplus for the period for Trust	(16,259)	697
Surplus for the period for Wholly Owned Subsidiary	65	140
(Deficit) / surplus for the period for non-charity aspects of the Group	(16,194)	837
Add back all I&E impairments/(reversals)	18,775	4,902
Remove capital donations/grants I&E impact	112	(1,615)
Adjusted financial performance surplus	2,693	4,124

Statement of Financial Position

	Note	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	17	9,990	9,370	9,990	9,370
Property, plant and equipment	18	234,696	225,459	234,696	225,459
Other investments / financial assets	22	9,323	8,741	550	550
Receivables	25	2,371	1,511	2,371	1,511
Total non-current assets		**256,380**	**245,081**	**247,607**	**236,890**
Current assets					
Inventories	24	7,888	7,022	7,411	6,501
Receivables	25	17,712	15,090	17,598	16,549
Cash and cash equivalents	28	47,316	52,085	46,440	50,947
Total current assets		**72,916**	**74,197**	**71,449**	**73,997**
Current liabilities					
Trade and other payables	29	(81,770)	(66,661)	(81,005)	(67,447)
Borrowings	31	(1,872)	(2,112)	(1,872)	(2,112)
Provisions	34	(579)	(637)	(579)	(637)
Other liabilities	30	(1,573)	(1,383)	(1,573)	(1,383)
Total current liabilities		**(85,794)**	**(70,793)**	**(85,029)**	**(71,579)**
Total assets less current liabilities		**243,502**	**248,485**	**234,027**	**239,308**
Non-Current liabilities					
Borrowings	31	(10,793)	(12,618)	(10,793)	(12,618)
Provisions	34	(3,306)	(2,170)	(3,306)	(2,170)
Total non-current liabilities		**(14,099)**	**(14,788)**	**(14,099)**	**(14,788)**
Total assets employed		**229,403**	**233,697**	**219,928**	**224,520**
Financed by					
Public dividend capital		235,793	228,869	235,793	228,869
Revaluation reserve		49,688	44,945	49,688	44,945
Income and expenditure reserve		(65,553)	(49,294)	(65,553)	(49,294)
Charitable fund reserves	44	9,271	9,038	-	-
Doncaster & Bassetlaw Healthcare Services Ltd	45	204	139	-	-
Total taxpayers' equity		**229,403**	**233,697**	**219,928**	**224,520**

The notes on pages 7 to 49 form part of these accounts.

Signed 

Date **22 June 2022**

Statement of Changes in Equity for the year ended 31 March 2022

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 2021	**228,869**	**44,945**	**(49,294)**	**9,038**	**139**	**233,697**
Surplus/(deficit) for the year	-	-	(16,259)	233	65	**(15,961)**
Net Impairments	-	4,743	-	-	-	**4,743**
Public dividend capital received	6,924	-	-	-	-	**6,924**
Taxpayers' and others' equity at 31 March 2022	**235,793**	**49,688**	**(65,553)**	**9,271**	**204**	**229,403**

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 for the year	-	-	697	1,048	140	**1,885**
Net Impairments	-	2,497	-	-	-	**2,497**
Revaluations - property, plant and equipment	-	(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 2022

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021	**228,869**	**44,945**	**(49,294)**	**224,520**
(Deficit) for the year	-	-	(16,259)	**(16,259)**
Net Impairments	-	4,743	-	**4,743**
Public dividend capital received	6,924	-	-	**6,924**
Taxpayers' and others' equity at 31 March 2022	**235,793**	**49,688**	**(65,553)**	**219,928**

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 for the year	-	-	697	**697**
Other reserve movements - charitable fund consolidation adjustment	-	(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**

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

	Note	Group 2021/22 £000	Group 2020/21 £000	Trust 2021/22 £000	Trust 2020/21 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(10,570)	5,258	(10,009)	5,631
Non-cash income and expense:					
Depreciation and amortisation	7.1	11,694	9,828	11,694	9,828
Net impairments	8	18,775	4,902	18,775	4,902
Income recognised in respect of capital donations	4	(347)	(2,038)	(347)	(2,038)
(Increase) / decrease in receivables and other assets		(3,157)	8,651	(1,909)	9,552
(Increase) in inventories		(866)	(385)	(910)	(666)
Increase in payables and other liabilities		13,618	14,038	12,611	11,933
Increase in provisions		1,100	233	1,078	233
Movements in charitable fund working capital		544	6	-	-
Corporation tax (paid)		(15)	-	-	-
Other movements in operating cash flows		292	156	347	-
Net cash flows from / (used in) operating activities		**31,068**	**40,649**	**31,330**	**39,375**
Cash flows from investing activities					
Interest received		25	11	25	11
Purchase of intangible assets		(2,241)	(3,956)	(2,241)	(3,956)
Purchase of non-current assets and investment property		(31,858)	(30,526)	(31,858)	(29,134)
Sales of non-current assets and investment property		-	454	-	454
		(34,074)	**(34,017)**	**(34,074)**	**(32,625)**
Cash flows from financing activities					
Public dividend capital received		6,924	91,681	6,924	91,681
Movement on loans from DHSC		(2,056)	(73,025)	(2,056)	(73,025)
Interest on loans		(313)	(562)	(313)	(562)
PDC dividend (paid)		(6,318)	(4,720)	(6,318)	(4,720)
Net cash flows from / (used in) financing activities		**(1,763)**	**13,374**	**(1,763)**	**13,374**
(Decrease) / increase in cash and cash equivalents		**(4,769)**	**20,006**	**(4,507)**	**20,124**
Cash and cash equivalents at 1 April - brought forward		**52,085**	**32,079**	**50,947**	**30,823**
Cash and cash equivalents at 31 March	28	**47,316**	**52,085**	**46,440**	**50,947**

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 2021/22 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 assessment has been made for the period to the end of June 2023 and 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 £46.4m cash in the bank
- The Trust has delivered a surplus in both 2020/21 and 2021/22
- There are no licence conditions in place on the Trust from its regulatory body.
- Services will still need to be provided for people in the locations which the Trust serves.

Planning for 2022/23 indicates that the Trust will be in a significant deficit, of c. £25m, and this, coupled with significant capital expenditure plans means that there will be pressures on cash in the short to medium term. Directors have considered the impact of the COVID pandemic, Brexit and projected inflationary increases in the reasonable downside scenario. However, the Trust has the support of local Commissioners with regards to its financial and clinical plans and has considered whether in the short to medium term, there would be the need to obtain support from central government bodies or pause any capital spending plans.
It is not likely that the Trust will need to take extreme action or require external funding in order to remain liquid in the Going concern period.

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 main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. 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 also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Note 1.4.1 Revenue from contracts with customers (cont.)

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 are measured subsequently at valuation. 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 and where they do not meet the definitions of investment properties or assets held for sale.

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.

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	8	57
Dwellings	24	28
Plant & machinery	7	17
Transport equipment	9	9
Information technology	7	12
Furniture & fittings	9	10

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	7	12

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 and 2021/22, 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 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. Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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 credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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 are discounted using HM Treasury's pension discount rate of negative 1.30% (2020-21: negative 0.95%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

A nominal short-term rate of 0.47% (2020-21: minus 0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 0.95% (2020-21: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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 the following rates:

Year 1: 4% (prior year: 1.2%)
Year 2: 2.6% (prior year: 1.6%)
Into perpetuity: 2% (Prior year: 2%)

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 where an inflow of economic benefits is probable. There are no such contigent assets.

Contingent liabilities are not recognised, but are disclosed in note 35, 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 operates a Wholly Owned Subsidiary, 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. 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s FReM.

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. The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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 desktop property revaluation exercise as at 31 December 2021, 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 2021/22.

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 2021-22. 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 2022. 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 0.95% 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.

On 1st April 2022, the Trust is expected to recognise assets of £5.52m, with an equal and offsetting amount within lease liabilities.

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 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)	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income	405,861	363,363
High cost drugs income from commissioners (excluding pass-through costs)	24,067	19,461
Other NHS clinical income	102	258
Community services		
Income from other sources (e.g. local authorities)	3,904	3,578
All services		
Private patient income	1,176	740
Elective Recovery Fund	3,704	-
Additional pension contribution central funding	11,405	11,133
Other clinical income	964	6,068
Total income from activities	**451,183**	**404,601**

The increase in patient care activity income is as a result of an increase in clinical activities as a result of Covid-19 affecting the number of treatments being able to be performed during 2020/21.

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	43,029	44,419
Clinical commissioning groups	401,357	354,681
NHS Foundation Trusts	53	6
NHS Trusts	12	-
NHS other	90	-
Local authorities	3,904	3,578
Non-NHS: private patients	765	183
Non-NHS: overseas patients (chargeable to patient)	411	557
Injury cost recovery scheme	1,390	1,046
Non NHS: other	172	131
Total income from activities	**451,183**	**404,601**
Of which:		
Related to continuing operations	451,183	404,601
Related to discontinued operations	-	-

Note 3.2 Income from patient care activities (by source) cont,

Income by Clinical Commissioning Group	2021/22	2020/21
South Yorkshire and Bassetlaw Integrated Care System (ICS)	**£000**	**£000**
Doncaster CCG	275,511	240,599
Bassetlaw CCG	78,493	77,271
Rotherham CCG	10,306	10,108
Barnsley CCG	5,578	5,470
Sheffield CCG	12,191	1,237
Non South Yorkshire and Bassetlaw ICS CCGs	19,278	19,996
	401,357	**354,681**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22	2020/21
	£000	**£000**
Income recognised this year	411	557
Cash payments received in-year	47	72
Amounts added to provision for impairment of receivables	555	448
Amounts written off in-year	47	191

Note 4 Other operating income (Group)

	2021/22	2020/21
	£000	**£000**
Research and development (contract)	567	632
Education and training (including notional apprenticeship levy income)	14,155	13,449
Non-patient care services to other bodies	28,787	23,062
Reimbursement and top-up income	3,808	12,292
Other contract income	1,087	404
Education and training - notional income from apprenticeship fund	989	765
Rental revenue from operating leases	420	232
Donations/grants of physical assets (non-cash) - received from other bodies	203	20
Donated equipment from DHSC for COVID response (non-cash)	-	2,018
Donated equipment from NHSE for COVID response (non-cash)	144	-
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	698	4,448
Charitable fund incoming resources	303	476
Total other operating income	**51,161**	**57,902**
Of which:		
Related to continuing operations	51,161	57,902
Related to discontinued operations	-	-

Non-patient care services to other bodies includes activities such as Lead Unit staff recharges to other NHS organisations. As a result of a change in National Framework in 2021/22, the level of top-up income dropped in year.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

In both 2020/21 and 2021/22, there was no revenue recognised in the reporting period that was included in within contract liabilities at the previous period end and no revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods.

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2022	31 March 2021
	£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 at both 31st March 2021 and 31st March 2022, 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:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	451,183	404,601
Income from services not designated as commissioner requested services	51,161	57,902
Total	**502,344**	**462,503**

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 2021/22 or 2020/21.

Note 7.1 Operating expenses (Group)

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,587	5,459
Purchase of healthcare from non-NHS and non-DHSC bodies	15,106	5,867
Staff and executive directors costs	322,924	306,109
Remuneration of non-executive directors	130	135
Supplies and services - clinical (excluding drugs costs)	35,987	27,986
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	698	4,448
Supplies and services - general	5,319	7,686
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)	41,146	33,724
Consultancy costs	2,530	560
Establishment	3,572	2,555
Premises	17,885	18,901
Transport (including patient travel)	1,662	1,137
Depreciation on property, plant and equipment	10,095	8,848
Amortisation on intangible assets	1,599	980
Net impairments	18,775	4,902
Movement in credit loss allowance: contract receivables / contract assets	32	1,911
Increase in other provisions	446	363
Change in provisions discount rate(s)	(40)	(60)
Audit fees payable to the external auditor		
audit services- statutory audit	144	98
other auditor remuneration (external auditor only)	43	18
Internal audit costs	106	100
Clinical negligence	16,565	15,448
Legal fees	552	212
Insurance	282	282
Research and development	406	391
Education and training	6,540	5,777
Rentals under operating leases	1,301	1,428
Car parking & security	2,564	849
Losses, ex gratia & special payments	14	5
Other NHS charitable fund resources expended	944	1,022
Total	**512,914**	**457,245**
Of which:		
Related to continuing operations	512,914	457,245
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration (Group)

	2021/22	2020/21
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	43	18
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	**43**	**18**

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k (2020/21: £2,000k).

Note 8 Impairment of assets (Group)

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	18,775	4,902
Total net impairments charged to operating surplus / deficit	**18,775**	**4,902**
Impairments (and reversals) of property, plant and equipment charged to the revaluation reserve	(4,743)	(2,409)
Total net impairments	**14,032**	**2,493**

The impairments in 2020/21 and 2021/22 arose due to a revaluation exercise on certain buildings under the modern equivalent asset basis.

Note 9 Employee benefits (Group)

	2021/22	2020/21
	Total	Total
	£000	£000
Salaries and wages	235,427	232,301
Social security costs	23,677	21,833
Apprenticeship levy	1,190	1,074
Employer's contributions to NHS pensions	26,049	25,390
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	11,405	11,133
Pension cost - other	125	116
Temporary staff (including agency and external bank)	29,534	18,641
Total gross staff costs	**327,407**	**310,488**
Recoveries in respect of seconded staff	-	-
Total staff costs	**327,407**	**310,488**
Of which		
Costs capitalised as part of assets	441	546
Disclosed within:		
Staff and executive directors costs	322,924	306,109
Research and development	406	391
Education and training	3,636	3,442
	326,966	**309,942**

Note 9.1 Retirements due to ill-health (Group)

During 2021/22 there were 5 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £297k (£272k in 2020/21). 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	420	232
Contingent rent	-	-
Other	-	-
Total	**420**	**232**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	397	232
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**397**	**232**

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.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	1,301	1,428
Total	**1,301**	**1,428**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	362	601
- later than one year and not later than five years;	68	137
- later than five years.	-	-
Total	**430**	**738**
Future minimum sublease payments to be received	-	-

Note 12 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2021/22	2020/21
	£000	£000
Interest on bank accounts	25	11
NHS charitable fund investment income	293	267
Total finance income	**318**	**278**

Note 13.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	304	347
Total interest expense	**304**	**347**
Unwinding of discount on provisions	(22)	(11)
Total finance costs	**282**	**336**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2021/22	2020/21
	£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 (Group)

	2021/22	2020/21
	£000	£000
Gains on disposal of property, plant and equipment	-	111
Gains / (losses) on charitable fund investment revaluations	581	1,327
Total gains on disposal of assets	**581**	**1,438**
Total other gains	**581**	**1,438**

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 (£15,838k) (2020/21: £697k). The Trust's total comprehensive income/(expense) for the period was (£11,516k) (2020/21: £3,194k).

Note 16 Discontinued operations (Group)

The Trust does not have any operations that are classified as discontinued in the year ended 31st March 2022.

Note 17.1 Intangible assets - 2021/22

Group and Trust	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021	**19,048**	**27**	**19,075**
Additions	2,241	-	**2,241**
Reclassifications	1,150	-	**1,150**
Valuation / gross cost at 31 March 2022	**22,439**	**27**	**22,466**
Amortisation at 1 April 2021	**9,705**	**-**	**9,705**
Provided during the year	1,599	-	**1,599**
Reclassifications	1,172	-	**1,172**
Amortisation at 31 March 2022	**12,476**	**-**	**12,476**
Net book value at 31 March 2022	**9,963**	**27**	**9,990**
Net book value at 1 April 2021	**9,343**	**27**	**9,370**

Note 17.2 Intangible assets - 2020/21

Group and Trust	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020	**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	**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 18.1 Property, plant and equipment - 2021/22

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 2021	**8,510**	**190,565**	**3,179**	**51,792**	**250**	**13,590**	**5,182**	**273,068**
Additions	-	25,547	-	5,657	-	1,599	192	**32,995**
Additions - donations of physical assets (non-cash)	-	-	-	203	-	-	-	**203**
Additions - donations of physical assets (non-cash)	-	-	-	144	-	-	-	**144**
Impact of revaluations/impairments	180	(19,622)	(526)	-	-	-	-	**(19,968)**
Reclassifications	-	-	-	-	-	(1,150)	-	**(1,150)**
Valuation/gross cost at 31 March 2022	**8,690**	**196,490**	**2,653**	**57,796**	**250**	**14,039**	**5,374**	**285,292**
Accumulated depreciation at 1 April 2021	**-**	**1,445**	**28**	**31,851**	**223**	**9,749**	**4,313**	**47,609**
Provided during the year	-	5,568	116	2,836	5	1,156	414	**10,095**
Impact of revaluations/impairments	-	(5,810)	(126)	-	-	(1,172)	-	**(7,108)**
Accumulated depreciation at 31 March 2022	**-**	**1,203**	**18**	**34,687**	**228**	**9,733**	**4,727**	**50,596**
Net book value at 31 March 2022	**8,690**	**195,287**	**2,635**	**23,109**	**22**	**4,306**	**647**	**234,696**
Net book value at 1 April 2021	**8,510**	**189,120**	**3,151**	**19,941**	**27**	**3,841**	**869**	**225,459**

Note 18.2 Property, plant and equipment - 2020/21 - 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
Valuation / gross cost at 1 April 2020	**8,510**	**182,240**	**3,448**	**58,919**	**440**	**26,828**	**6,598**	**286,983**
Prior period adjustment	-	326	-	(17,219)	(190)	(15,259)	(1,549)	**(33,891)**
Valuation / gross cost at 1 April 2020 - restated	**8,510**	**182,566**	**3,448**	**41,700**	**250**	**11,569**	**5,049**	**253,092**
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**	**190,565**	**3,179**	**51,792**	**250**	**13,590**	**5,182**	**273,068**
Accumulated depreciation at 1 April 2020	**-**	**5,873**	**384**	**46,403**	**332**	**23,929**	**5,913**	**82,834**
Prior period adjustment	-	-	-	(17,037)	(109)	(14,934)	(1,811)	**(33,891)**
Accumulated depreciation at 1 April 2020 - restated	**-**	**5,873**	**384**	**29,366**	**223**	**8,995**	**4,102**	**48,943**
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**	**31,851**	**223**	**9,749**	**4,313**	**47,609**
Net book value at 31 March 2021	**8,510**	**189,120**	**3,151**	**19,941**	**27**	**3,841**	**869**	**225,459**
Net book value at 1 April 2020 - restated	**8,510**	**176,693**	**3,064**	**12,334**	**27**	**2,574**	**947**	**204,149**

The prior period adjustment relates to a data cleanse exercise that took place when a new fixed asset register system was implemented. This identified that the gross cost and accumulated depreciation lines had not been adjusted for assets no longer in use and were therefore overstated in the prior year. There is a nil net effect on asset valuations as it related to the recognition of fully depreciated assets. This has no impact on the Statement of Comprehensive Income.

Note 18.3 Property, plant and equipment financing - 2021/22

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 2022								
Owned - purchased	8,690	195,287	2,635	20,141	22	4,295	647	**231,717**
Owned - equipment donated from DHSC and NHS England for Covid response	-	-	-	1,650	-	-	-	**1,650**
Owned - donated/granted	-	-	-	1,318	-	11	-	**1,329**
NBV total at 31 March 2022	**8,690**	**195,287**	**2,635**	**23,109**	**22**	**4,306**	**647**	**234,696**

Note 18.4 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	189,120	3,151	16,605	27	3,826	869	**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**	**189,120**	**3,151**	**19,941**	**27**	**3,841**	**869**	**225,459**

Note 19 Donations of property, plant and equipment

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust has received donated assets totalling £347k in 2021/22. In 2020/21, donated assets totalling £2,038k were received, £2,018k of which 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 last commissioned a full valuation of its land and buildings as at 31st December 2020, which was undertaken by Cushman & Wakefield.

In 2020/21 and 2021/22, 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	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**8,741**	**7,303**	**550**	**550**
Acquisitions in year	1,567	1,427	-	-
Movement in fair value through income and expenditure	581	1,327	-	-
Disposals	(1,566)	(1,316)	-	-
Carrying value at 31 March	**9,323**	**8,741**	**550**	**550**

The Group investments relate to investments made by Doncaster & Bassetlaw Teaching Hospitals Charitable Funds as part of a diverse investment portfolio.

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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Drugs	3,048	2,758	2,571	2,237
Consumables	4,840	4,249	4,840	4,249
Energy	-	15	-	15
Total inventories	**7,888**	**7,022**	**7,411**	**6,501**

Inventories recognised in expenses for the year were £53,885k (2020/21: £46,834k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £0k).

The increase in expenditure recognised is as a result of the increase in activity in 2021/22 due to the impact of Covid-19 on 2020/21 activities.

Note 25.1 Receivables

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Contract receivables	13,225	11,584	12,999	13,528
Allowance for impaired contract receivables / assets	(1,812)	(1,945)	(1,812)	(1,945)
Prepayments (non-PFI)	1,630	2,945	1,630	2,945
PDC dividend receivable	329	4	329	4
VAT receivable	4,301	2,502	4,301	2,017
Clinician pension tax provision reimbursement funding from NHSE	39	-	39	-
Other receivables	-	-	112	-
Total current receivables	**17,712**	**15,090**	**17,598**	**16,549**
Non-current				
Contract receivables	2,880	3,042	2,880	3,042
Clinician pension tax provision reimbursement funding from NHSE	1,047	-	1,047	-
Allowance for impaired contract receivables / assets	(1,556)	(1,531)	(1,556)	(1,531)
Total non-current receivables	**2,371**	**1,511**	**2,371**	**1,511**
Of which receivable from NHS and DHSC group bodies:				
Current	6,345	7,273	6,345	7,273
Non-current	1,047	-	1,047	-

Note 25.2 Allowances for credit losses

	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 2021 - brought forward	**3,476**	**-**	**3,476**	**-**
New allowances arising	181	-	181	**-**
Reversals of allowances (where receivable is collected in-year)	(149)	-	(149)	**-**
Utilisation of allowances	(140)	-	(140)	**-**
Allowances as at 31 Mar 2022	**3,368**	**-**	**3,368**	**-**

	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 (write offs)	(785)	-	(785)	
Allowances as at 31 Mar 2021	**3,476**	**-**	**3,476**	**-**

Note 26 Other assets

The Trust does not have any receivables classified as other assets.

Note 27 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	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
At 1 April	**52,085**	**32,079**	**50,947**	**30,823**
Net change in year	(4,769)	20,006	(4,507)	20,124
At 31 March	**47,316**	**52,085**	**46,440**	**50,947**
Broken down into:				
Cash at commercial banks and in hand	658	444	54	34
Cash with the Government Banking Service	46,658	51,641	46,386	50,913
Total cash and cash equivalents as in SoFP and SOCF	**47,316**	**52,085**	**46,440**	**50,947**

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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Trade payables	15,881	9,255	15,881	10,092
Capital payables	11,510	10,373	11,510	10,373
Accruals	37,979	32,320	37,791	32,320
Annual leave accrual	5,115	5,119	5,115	5,119
Social security costs	6,685	5,809	6,685	5,809
Other taxes payable	15	33	-	-
Other payables	4,023	3,734	4,023	3,734
NHS charitable funds: trade and other payables	562	18	-	-
Total current trade and other payables	**81,770**	**66,661**	**81,005**	**67,447**
Of which payables from NHS and DHSC group bodies:				
Current	6,509	5,280	6,509	5,280
Non-current	-	-	-	-

The level of 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 2022	31 March 2022	31 March 2021	31 March 2021
	£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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	1,573	1,383	1,573	1,383
Total other current liabilities	**1,573**	**1,383**	**1,573**	**1,383**

Note 31 Borrowings

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Loans from DHSC	1,872	2,112	1,872	2,112
Total current borrowings	**1,872**	**2,112**	**1,872**	**2,112**
Non-current				
Loans from DHSC	10,793	12,618	10,793	12,618
Total non-current borrowings	**10,793**	**12,618**	**10,793**	**12,618**

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 2021	**14,730**	**-**	**-**	**14,730**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,056)	-	-	**(2,056)**
Financing cash flows - payments of interest	(313)	-	-	**(313)**
Non-cash movements:				**-**
Application of effective interest rate	304	-	-	**304**
Carrying value at 31 March 2022	**12,665**	**-**	**-**	**12,665**

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 - restated

Group & Trust	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	2019/20 clinicians' pension reimbursement	Lease Dilapidations	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**1,201**	**1,190**	**178**	**-**	**238**	**2,807**
Change in the discount rate	(27)	(13)	-	-	-	**(40)**
Arising during the year	101	53	274	1,086	-	**1,514**
Utilised during the year	(84)	(131)	(82)	-	-	**(297)**
Reversed unused	-	(35)	(42)	-	-	**(77)**
Unwinding of discount	(11)	(11)	-	-	-	**(22)**
At 31 March 2022	**1,180**	**1,053**	**328**	**1,086**	**238**	**3,885**
Expected timing of cash flows:						
- not later than one year;	84	128	328	39	-	**579**
- later than one year and not later than five years;	348	523	-	46	238	**1,155**
- later than five years.	748	402	-	1,001	-	**2,151**
Total	**1,180**	**1,053**	**328**	**1,086**	**238**	**3,885**

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 (2021/22: £1,180k, 2020/21: £1,201k) and Pensions: injury benefits (2021/22: £1,053k, 2020/21: £1,190K) 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.

2019/20 clinicians' pension reimbursement relates to where the Trust makes good any tax incurred relating to clinicians' pensions through their work in the NHS. This is funded via NHS England, which can be seen by an equal and opposite entry within Receivables.

Note 34.2 Clinical negligence liabilities

At 31 March 2022, £319,033k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (31 March 2021: £231,942k).

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	86	92	86	92
Gross value of contingent liabilities	**86**	**92**	**86**	**92**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**86**	**92**	**86**	**92**

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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Property, plant and equipment	1,796	989	1,796	989
Total	**1,796**	**989**	**1,796**	**989**

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.

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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 £70,462k (2020/21: £71,341k), 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 2022 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	13,823	-	-	**13,823**
Cash and cash equivalents	47,316	-	-	**47,316**
Consolidated NHS Charitable fund financial assets	-	9,323	-	**9,323**
Total at 31 March 2022	**61,139**	**9,323**	**-**	**70,462**

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 2022 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	13,709	-	-	**13,709**
Cash and cash equivalents	46,400	-	-	**46,400**
Total at 31 March 2022	**60,109**	**-**	**-**	**60,109**

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 2022 under IFRS 9			
Loans from the Department of Health and Social Care	12,665	-	**12,665**
Trade and other payables excluding non financial liabilities	78,393	-	**78,393**
Consolidated NHS charitable fund financial liabilities	562	-	**562**
Total at 31 March 2022	**91,620**	**-**	**91,620**

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**

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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
In one year or less	77,521	63,568	77,521	63,568
In more than one year but not more than five years	4,589	5,650	4,589	5,650
In more than five years	9,352	9,141	9,352	9,141
Total	**91,462**	**78,359**	**91,462**	**78,359**

Note 40 Losses and special payments - restated

	2021/22		2020/21	
Group and Trust	number of cases	value of cases	number of cases	value of cases
	Number	£000	Number	£000
Total losses - bad debts	**51**	**64**	**182**	**238**
Special payments				
Compensation under court order or legally binding arbitration award	14	63	17	55
Ex-gratia payments	16	14	10	5
Overtime corrective payments	-	-	1	949
Special severance payments	-	-	1	48
Total special payments	**30**	**77**	**29**	**1,057**
Total losses and special payments	**81**	**141**	**211**	**1,295**

There were no individual cases in excess of £300k.

Overtime corrective payments relate to a nationally agreed scheme for members of staff who perform a certain level of overtime, and as such, are subsequently eligible for payments relating to additional annual leave. The scheme is a collective scheme and relates to a number of members of staff.

Note 41 Gifts

In 2021/22, the Trust made a non-contractual "Thank You" payment to all members of staff for their efforts during the Covid-19 pandemic. This is recongised within Staff Costs and totalled £1.4m, including employers National Insurance costs.

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.

Note 42 Related parties

The total value of receivables and payables balances held with related parties as at 31 March is:

	2022 Receivables £000	2021 Receivables £000
Other NHS bodies	5,977	7,269
Other bodies (including WGA bodies)	4,305	2,502
	10,282	**9,771**

	31 March 2022 Payables £000	31 March 2021 Payables £000
Other NHS bodies	6,473	5,281
Other bodies (including WGA bodies)	11,976	9,280
	18,449	**14,561**

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

	2021/22	2020/21
	Total Funds	
	£000	£000
Incoming resources	303	476
Resources expended	(944)	(1,022)
Net outgoing resources	**(641)**	**(546)**
Investment Income	293	267
Gains on revaluation and disposal of investment assets	581	1,327
Net movement in funds	**233**	**1,048**
Fund balances at 1 April	9,038	7,990
Fund balances at 31 March	**9,271**	**9,038**

	2021/22	2020/21
	Total Funds	
	£000	£000
Investment assets	9,323	8,741
Cash	604	410
Current liabilities	(656)	(113)
Total net assets	**9,271**	**9,038**

	2022	2021
	£000	£000
Unrestricted income funds	2,630	2,635
Other restricted income funds	6,641	6,403
	9,271	**9,038**

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

	2021/22	2020/21
	£000	£000
Incoming resources	9,059	7,525
Resources expended	(8,994)	(7,385)
Net outgoing resources	**65**	**140**

	2021/22	2020/21
	£000	£000
Current assets	2,199	1,844
Cash	272	728
Current liabilities	(1,717)	(1,883)
Total net assets	**754**	**689**
Share Capital	550	550
Income & Expenditure reserve	204	139
Total net assets	**754**	**689**

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Quality Accounts 2021/22

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

Chief Executive's statement

As we have reflected within our Annual Report, 2021/22 has been a challenging year for the Trust, with all our quality indicators impacted in some way by COVID-19 and pressures stemming from the pandemic.

As you will see in the pages that follow, we have achieved some of the objectives that we set ourselves in 2021/22, maintaining performance in others and narrowly missing some.

Due to the difficulties we are currently facing and the nature of the coronavirus transmission in South Yorkshire and Bassetlaw, we experienced several waves of increased activity throughout the year, and subsequently had to remodel our priorities. Despite this, we believe that the fact that our quality indicators are broadly like the levels of national performance, should be viewed as an achievement in and of itself.

The impact of the pandemic means that much of the time we would have spent innovating, or driving through changes, has been allocated elsewhere as we mustered an 'all-hands-on-deck' approach particularly during the peaks of activity, which have in many cases been more severe than was seen in the early stages of the pandemic. The impact of COVID-19 has also been reflected in mortality rates which were higher than expected (a picture also seen nationally).

Regardless of COVID-19 however, there are still areas where we can improve, as outlined in the incidences of 'Never Events' and MRSA colonisation, and work is underway to improve this, and we will endeavour throughout the next year to make any necessary improvements particularly as the pandemic continues to recede.

It is important that we understand what has gone well in 2021/22, what could have gone better, and where we need to focus our efforts. All of this must also take place whilst we look to recover our activity levels, reduce our waiting lists, and improve the safety, quality, and responsiveness of our services particularly in the areas where challenges have been exacerbated by the difficulties presented by the pandemic.

As a final note as we look towards the future, in many ways 2022/23 will be a unique year, and while we will push towards further improvements and enhancements, COVID-19 recovery will, and has, impacted upon what we are able to achieve. To the best of my knowledge, the information in this Quality Account is accurate.

Richard Parker OBE
Chief Executive
20 June 2022

Looking forward to our priorities for improvement in 2022/23

Our priorities for the next financial year will align with our updated Trust five-year strategy for 2022 to 2027. At the time of writing this document is not yet available, therefore we are unable to share our full objectives. We will however share the report as soon as we can here: https://www.dbth.nhs.uk/about-us/our-publications/

Furthermore, we will align our improvements in quality standards to our Acting Chief Nurse and Executive Medical Director's annual objectives, specifically:

- Demonstrate Improvements in governance, management information, systems and processes to improve performance against the CQC Acute Insight Standards.
- Demonstrate delivery of the standards required to achieve Outstanding in the CQC domain.
- Demonstrate delivery of the standards required to achieve Good in the CQC domain – are services safe? Specifically:

    1. Develop and implement a Quality Framework which shapes the delivery of improvements in patient safety and experience.
    2. A 20% reduction in falls causing medium – severe harm.
    3. Achieve compliance with the National Perinatal Framework and Ockenden recommendations.
    4. Deliver national access standards for cancer diagnosis and treatment.
    5. Deliver national access standards for elective and diagnostic care.
    6. Deliver urgent and emergency care access standards.
    7. Ensure that the patient and carer voice is listened to by delivering co-produced outcomes.
    8. Celebrate, share and promote good practice.

In identifying and drafting these preliminary priorities for improvement for 2022/23 the Trust has taken into account the views of:

- **Patients and their care outcomes**: Via patient surveys and complaints monitoring.
- **Staff**: Reports on clinical outcomes and incident reporting.
- **Commissioners:** Via quality meetings and contractual arrangements.
- **Service users:** Via the work of the Patient Experience and Engagement Committee and priorities identified in analysis of key themes.

Looking back on our priorities for improvement in 2021/22

Over the last year we have made substantial improvements in delivering harm-free-care. The quality standards are rolled over from last year.

Key ☆ = target achieved → = close to target < = behind plan

Patient safety quality improvement targets	Target 2021/22	Actual 2021/22	Progress
Take a zero-tolerance approach to Never Events	0	1	<
Reduce the number of healthcare associated infections (MRSA bacteraemia)	0	2	<
Reduction in patients suffering moderate and severe harm from an inpatient fall	<40	52	<
Reductions in category three hospital acquired pressure ulcers	<50	46	☆

Clinical effectiveness quality improvement targets	Target 2021/22	Actual 2021/22	Progress
Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	<100	102.71	<
Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	100	111.61	<
Reduce the number of missed hospital appointments	<10%	9.75%	☆

Patient experience quality improvement targets	Target 2021/22	Actual 2021/22	Progress
Reduce the number of complaints relating to staff attitude and behaviour	5% reduction based on 2020/21 outturn	66%	☆
Reduction of noise at night for patients (to minimise disturbed sleep)	70%	No data Survey's not completed	N/A
Ensure patients feel involved with decisions about their care	95%	No data Survey's not completed	N/A

Achievements against quality improvement priorities 2021/22

Quality improvement 1 – Patient safety

Take a zero-tolerance approach to "Never Events"

These are largely preventable patient safety incidents that should not occur if preventative measures have been implemented within the Trust

Outcome = One case, target NOT achieved.

Never Events are defined by the National Patient Safety Agency (NPSA) as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.'

Period	Number of incidents reported*
2015/16	2
2016/17	1
2017/18	0
2018/19	1
2019/20	4
2020/21	4
2021/22	1

During 2021/22 there was one 'Never Event'. This is a significant reduction from the previous years, however work still needs to be done to ensure that there are none.

The Trust has an incident reporting system that specifically enables any member of staff to highlight never events or serious incidents, so that any potential case can be reviewed rapidly. This provides a culture of openness and the duty of candour to our patients. The Never Event in 2021/22 related to:

1. **Retained guidewire**
A guidewire was retained post femoral line insertion. Femoral lines are used for dialysis. This incident resulted in moderate harm to the patient.

Progress, Monitoring & Reporting: The learning from root cause analysis which follows any such events is shared Trust-wide to ensure a Never Event does not happen again in the future. Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Quality improvement 2 – Patient safety

To reduce levels of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia

Why = the Trust wishes to ensure the safest possible care for patients by reducing the number of healthcare acquired infections.

Outcome = Two Cases, target NOT achieved.

Year	Number of reported cases
2012/13	2
2013/14	2
2014/15	2
2015/16	2
2016/17	3
2017/18	2
2018/19	0
2019/20	2
2020/21	2
2021/22	2

With the COVID-19 pandemic gradually resolving, we are focused on the actions which were taken in late 2017 through 2018 and 2019 and which led to the achievement of zero MRSA bacteraemia's for greater than 700 days, and then a period of 340 days:

I. Identifying on admission all previously colonised patients with MRSA, and ensuring if on antibiotic to treat an infection/sepsis they also have anti-MRSA antibiotic, we also advise the use of oral antibiotics if possible to reduce risk of intravenous devises with the increases risk.
II. Visual Infusion Phlebitis (VIP) scores are monitored closely and documented in clinical notes to initiate prompt action on their removal if early sign of phlebitis or infection at the cannula sites.
III. Early initiation and completion of decolonisation treatments and ensuring repeat screening results negative.
IV. Continue to promote the non-touch technique (NTT) when taking blood cultures to reduce risk of picking up skin flora organism during blood culture procedures in septic patients

Progress, Monitoring & Reporting: Dashboards are completed for the monitoring and reporting of HCAIs. Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Quality improvement 3 – Patient safety

Reduction in patients suffering moderate and severe harm from an inpatient fall

Outcome = There were 52 falls which resulted in moderate or severe harm reported during 2021/22 – Target NOT achieved

Year	Moderate/Severe Harm
2019/20	46
2020/21	33
2021/22	52

This year, 1,378 patients have fallen, of which 52 resulted in moderate or severe harm.

In comparison to 2020/21 there were 1,388 falls overall, of which 33 falls resulted in moderate and severe harm.

This means we have seen a 0.7% decrease in identified falls but a 58% increase in falls which have led to moderate and severe harm. Following review, there appears to be a link to restricted visiting and less involvement from family and friends during a patient's hospital stay (meaning individuals are more prone to deconditioning or getting up and moving about unaccompanied. Visiting restrictions have been largely rescinded as of June 2022.

Our 'Learning from Falls' panel extracts learning from these cases, which is sent out to all ward managers, matrons and divisional directors of nursing as live as possible. A year-end collation of themes is also shared across the Trust so the falls accreditation can be based around local learning.

The new Holistic Care Team launched in mid-2021, with the support if the Quality Improvement (Qi) team. The Holistic Care Team includes a falls prevention practitioner, lead dementia nurse along with a multi-disciplinary team. The current focus is working with the 10 wards with the highest number of falls. The team have also worked to introduce visual aids for patients at risk of a fall, such as yellow slippers and blankets to aid in overall efforts.

Progress, Monitoring & Reporting: Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions.

Quality improvement 4 – Patient safety

Reduction in category three hospital acquired pressure ulcers (HAPU).

Outcome = There were 46 hospital acquired category 3 pressure ulcers reported during 2021/22 – Target achieved.

Year	Number of category 3 pressure ulcers
2019/20	57
2020/21	56
2021/22	46

There were 46 Category 3 hospital acquired pressure ulcers reported during 2021/22, a reduction of 25% from last year, and inline with our target.

This progress is the result of an established 'Learning from HAPU' panel which extracts learning from reported cases. The learning is circulated to all ward managers, matrons and divisional directors of nursing.

An annual collation of themes is also shared across the Trust so the Skin Integrity accreditation is based around local learning.

Progress, Monitoring & Reporting: Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions.

Quality improvement 5 and 6 – Clinical effectiveness

Reduce the number of deaths which may have been preventable

Implementing a system for continuous review of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) will support achievement of no avoidable deaths and no avoidable harm to patients.

Outcome = HSMR: 102.71 (Jan 21 – Dec 21) SHMI 111.61 (Jan 21 – Dec 21). Target NOT achieved.

Year	HSMR	SHMI
2013	111.12 (Jan 13 – Dec 13)	108.47 (Oct 12 – Sep 13)
2014	108.68 (Jan 14 – Dec 14)	112.88 (Oct 13 – Sep 14)
2015	95.62 (Jan 15 – Dec 15)	105.7 (Oct 14 – Sep 15)
2016	91.08 (Jan 16 – Dec 16)	102 (Dec 15 – Nov 16)
2017	87.42 (Jan 17 – Dec 17)	101 (Dec 16 – Nov 17)
2018	92.43 (Jan 18 – Dec 18)	101 (Jan 18 – Dec 18)
2019	99.25 (Jan 19 – Dec 19)	111 (Jan 19 – Dec 19)
2020	109.14 (Jan 20 – Dec 20)	112 (Jan 20 – Dec 20)
2021	102.71 (Jan 21 – Dec 21)	111.61 (Jan 21 – Dec 21)

Over the last 12 months the overall HSMR has remained within the expected range however, as with last year, a surge in COVID-19 in the spring and autumn resulted in peaks of mortality which means we are a little off target, but much better than the year previous.

Case mix continues to be challenging with an ageing population and high level of co-morbidity as evidenced in the depth of coding.

The SHMI, which includes deaths outside hospital within 30 days of discharge also remains in the expected range. The SHMI is always higher than the HSMR as it makes no adjustments for palliative care.

Progress, Monitoring & Reporting: Monitoring of the Trust HSMR and SHMI continues through the Mortality Monitoring Group. Reporting to the Board of Directors takes place monthly.

Data Source: HED, this data is governed by: National definitions.

Quality improvement 7 – Clinical Effectiveness

Reduce the number of missed hospital appointments

Outcome = 9.75% did not attend rate within the Trust, target achieved.

In 2017, it was highlighted that the Trust was in the bottom 20% of Hospital Trust for performance in patient did not attend (DNA). With over 500,000 hospital appointments each year, over 50,000 appointments are missed. The impact of missed appointments results in significant waste in precious clinical services, reduced patient experience, impact on patient waiting times and financial risk.

The Trust has therefore undertaken a missed appointments improvement project in partnership with Healthwatch Doncaster to engage with people in Doncaster and Bassetlaw to understand why people miss their hospital appointment and to learn how, together, we can improve our services and overall patient experience. An evaluation report was produced with a number of recommendations. These recommendations were supported by the Trust Board and partnering organisational boards. An action plan was developed and a monthly steering group was formed to drive forward the recommendations.

Much of this work continued throughout the pandemic, however, during spikes of COVID-19 we had to revaluate some of our activity, making use of clinical capacity as appropriate, meaning that some appointments were moved and rescheduled to a later time.

In May 2021, we have launched our digital letters system, as well as brought our reminder service back online and, as the pandemic continues to recede, we anticipate further improvements in our DNA rate.

Year	Actual Performance
2017/18	10.7%
2018/19	10.3%
2019/20	10.3%
2020/21	10.4%
2021/22	9.75

Progress, Monitoring & Reporting: Monthly reporting to Clinical Governance Committee.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions.

Quality improvement 8 – Patient experience

Reduce the number of complaints relating to staff attitude and behaviour

Good attitude and behaviour is paramount to providing a good quality service and patient experience. This also relates to the families and visitors of patients, and reinforces out Trust values.

Outcome= 61, target achieved.

In the Quality account for 2021/22 there was an objective to have a 5% reduction of complaints relating to staff attitude and behaviour, which stood at 181.

In 2021/22, the Trust in fact managed to achieve this target, reducing such complaints by 66% to an overall number of 61. Of these only 13 were partly or fully upheld, representing a very significant reduction.

Some of this reduction reflects the 'Sharing How We Care' work we have undertaken, which underlines patient safety and experience within monthly newsletters and annually events. It will also be a natural result of fewer visitors into services.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Quality improvement 9 – Patient experience

Reduction of noise at night for patients (to minimise disturbed sleep)

Outcome = Not observed due to COVID-19 pandemic.

The Trust continues to work to reduce unnecessary noise at night, with the Sleep Helps Healing (SHH) campaign, raising awareness with all Trust staff of the importance of rest for patients while in hospital. Work will be picked back up following COVID-19 pandemic.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Quality improvement 10 – patient experience

Ensure patients feel involved with decision about their care

Outcome = Not observed due to COVID-19 pandemic

Bedside information has been in place for three years and is available for every inpatient to be able to read and feel informed about decisions in care. We will also be undertaking further work in 2022/23 to ensure that this work continues to progress and monitoring is back in place.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**Agenda Reference:**	**G3**		
Report Title:	**Update to Standing Financial Instructions, Standing Orders and Delegation of Powers**				
Sponsor:	Alex Crickmar, Acting 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: • Removing references to NHS Improvement • Updating names of various job titles, Committees and composition of the Trust Board • Introduction of the Deputy Chief Executive role within delegation limits. This is on an interim basis and the documents will be further reviewed when the structure is finalised. • Introduction of new lease accounting standards within Capital sections • Updating the Procurement tendering limits to harmonise across the ICB. This reduces the number of tenders required on tenders between £25k and the EU limits from 4 to 3, as well as promoting the use of the e-tender portal for all tenders over £25k.				
Recommendation:	The Board is asked approve the documents.				
Action Required:	**Approval**	Information	Discussion	Assurance	Review

Link to True North Objectives:	**TN SA1:**	**TN SA2: X**	**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:		Risk & Audit Committee	
Date:	14/7/2021	**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 2022

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:	Alex Crickmar and Matthew Bancroft
Date written/revised:	July 2022
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2023
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 12	July 2022	• Removed references to NHS Improvement • Updated job titles • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
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 NHS England.

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. 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 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.
"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. Accountability for non-charitable funds held on trust is only to NHS England.

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 they think 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 them 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 their 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.

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

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

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

5.44 The Audit & Risk 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, 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, 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 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, 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.

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 information quotes between £5k and £25k, at least 3 formal quotes via an e-tendering portal between £25k and the EU threshold (currently £181k) and above EU Threshold, the EU tendering process shall be followed.

11.8 **Formal Competitive Tendering and Quotations**

The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); where the value is expected to exceed the financial threshold (11.7)and for disposals.

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

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

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

11.10 Formal tendering procedures are not required where:

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

(b) the requirement is covered by an existing framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.19 Tendering procedures are set out in the Annex.

11.20 Quotations should be in writing 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.

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

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

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

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

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

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

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

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

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

(a) these Standing Orders;

(b) the Trust's SFIs;

(c) EU Directives, 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.

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

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

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

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

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

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

12 DISPOSALS

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

(a) any matter in respect of which a fair price can be obtained only by negotiation or

sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

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

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

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

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

13 IN HOUSE SERVICES

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

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

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

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

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

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

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

14 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**
The Common Seal of the Trust shall be kept by the 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.

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) v12	CE/Finance	Alex Crickmar/Matthew Bancroft	Existing Policy	July 2022

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 2023

Checked by: Alex Crickmar/Matthew Bancroft Date: July 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Standing Financial Instructions

July 2022

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:	Alex Crickmar – Acting Director of Finance
Date written/revised:	July 2022
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2023
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 10	July 2022	• Removed references to NHS Improvement • Updated job titles • Introduction of IFRS 16 within capital section • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
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. 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;
"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, 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. (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.

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 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 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, 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.

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'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.

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.

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 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 their 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 Chief People Officer is responsible for:

(a) ensuring that arrangements in place so that the Trust receives 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 Chief People Officer 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 Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

(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 Chief People Officer must be informed immediately.

9.4.4 Where the Chief People Officer has contracted with another body to administer the Trust's payroll service responsibility for compliance with the above requirements remain with the Chief People Officer.

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 Chief People Officer's instructions and in the form prescribed by the Chief People Officer.

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 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.

12.1.6 Due to the introduction of IFRS 16, for the avoidance of doubt, leases of over 12 months in length should follow the process for capital projects.

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 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.

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 2018;

(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 Chief People Officer 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 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 on an annual basis).

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 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. Any contract over £1,000,000 requires Board approval before Chief Executive authorization.

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 £25,000)

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 £25,000; 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 (£25,000 and under)

3.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £25,000 but is above £5,000. For quotations over £25,000, these must be undertaken by the Procurement Department.

3.2 Non-competitive quotations in writing may be obtained for the following purposes:

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

or where in the opinion of the Finance Director:

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

(c) competition would be impractical, impossible or not beneficial;

(d) the requirement is to be ordered under existing contracts;

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment;

(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the 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 EU Threshold	Director of Finance

Anything over EU Threshold needs initial advice from the Head of Procurement before commencement

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 2022 - CORP/FIN 1 (B) v.10	CE/Finance	Alex Crickarm/Matthew Bancroft	Existing Policy	July 2022

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 2023

Checked by: Alex Crickmar/Matthew Bancroft Date: July 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Reservation of Powers to the Board and Delegation of Powers

July 2022

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:	Alex Crickmar, Acting Director of Finance
Date written/revised:	July 2022
Approved by (Committee/Group):	Board of Directors
Date of approval:	
Date issued:	
Next review date:	July 2023
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 11	July 2022	• Introduction of the Deputy Chief Executive role within the delegation limits • Updated job titles • Removed reference to NHS Improvement • Updated Procurement tendering limits in line with guidance from regional ICB	Matthew Bancroft
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	Robert Paskell

		consistency to revised Standing Orders section 11 and tendering annex; • Clarification added to the posts included in role of 'Senior Officer'.	

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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, 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, 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 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'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 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 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 Recovery, Innovation and Transformation – 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'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	CHIEF PEOPLE OFFICER	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 requirements.
12.4.1	CE	Overall responsibility for fixed assets.

SECTION 4 – SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.4.4	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,
CPO – Chief People Officer, 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 - and not part of agreed plan		
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 and not part of agreed plan		
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 between £5,000 and £25,000 – three informal quotes b) 3 written quotations via e-tendering portal for goods/services from £25,000 to EU threshold (currently £118k) c) Competitive tenders via e-tendering portal for works goods/services for tenders above EU threshold d) Single quotation approval between £5,000 to EU threshold (single quotation above EU threshold is not permitted)	 Buyers & Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) Senior Officers (Procurement and Estates) or Executive Director 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)	 Authorised Signatory for Budget Head of Dept. General Manager or Divisional Director Executive Director CE, Deputy CE or DOF CE DoF CE CE CE or Deputy CE, after approval by the Board	 SFIs Section 10 & SOs Section 11& Annex
5. Capital Schemes Business Cases - not part of agreed plan		SFIs Section 12

Delegated Matter	Authority Delegated To	Reference Document
a) Production of case of need for every capital expenditure proposal	DoF and Deputy CE	& SOs Section 11
b) Certification of costs and revenue consequences	DoF and Deputy CE	
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 and Deputy CE	
b) Confirmation of capital funds available	DoF and Deputy CE	
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 and Deputy CE	
b) Responsibility of keeping expenditure within scheme budget	Scheme Manager	
c) Responsibility of keeping expenditure within total capital budget	DoF and Deputy CE	
d) Approval of variations to scheme budgets from plan:		
i) To 10% of original scheme budget, a maximum of £50,000	DoF and Deputy CE	
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 and Deputy CE	
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 annual rent >£100k	CE	
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 NHS England price caps)		SFIs Section 9
a) Management Consultancy	Executive Director (over £50k requires NHSE sign-off and Executive Committee sign-off)	

Delegated Matter	Authority Delegated To	Reference Document
b) Engagement of Trust's Solicitors c) Booking of Bank or Agency Staff i) Medical Locums ii) Nursing iii) Clerical Outside NHSI price caps	CPO, MD and DoF General Manager or Divisional Director General Manager General / Department Manager or Divisional /Executive Director Executive Director	
8. Expenditure on Charitable and Endowment Funds Up to £25,000 per request Over £25,000 per request	 DoF CEO or DoF after authorisation from the Charitable Funds Committee.	SFIs Section 17
9. Agreements/Licences a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff b) Extensions to existing leases c) Letting of premises to outside organisations d) Approval of rent based on professional assessment	 DoF and CPO DoF DoF DoF	
10. Condemning & Disposal a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively b) disposal of x-ray films c) disposal of controlled drugs	 Divisional Director of Operations (GM)/Department Manager and Condemning Officer Superintendent Radiographer Chief Pharmacist	SFIs Section 14
11. Losses, Write-off & Compensation a) Losses and Cash due to theft, fraud, overpayment & others Up to £50,000 b) Fruitless Payments (including abandoned Capital Schemes) Up to £100,000 c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000 e) Compensation payments made under legal obligation	 Two Executive Directors Two Executive Directors Cash Committee Two Executive Directors Two Executive Directors	SFIs Section 14

Delegated Matter	Authority Delegated To	Reference Document
f) Extra Contractual payments to contractors Up to £50,000	Two Executive Directors	
<u>Ex-Gratia Payments</u> g) Patients and staff for loss of personal effects Up to £50,000	Two Executive Directors	
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)	 CPO 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 CPO DoF	SFIs Sections 2 & 14
<u>13. Petty Cash Disbursements (not applicable to central Cashiers Office)</u> a) Expenditure up to £25 per item	Petty Cash Holder	SFIs Section 10
<u>14. Receiving Hospitality</u> Applies to both individual and collective items of hospitality received **or offered and declined**, in excess of £50.	Declaration required in Trust's Hospitality Register	
<u>15. Implementation of Internal and External Audit Recommendations</u>	DoF	SFIs Section 2
<u>16. Maintenance & Update on Trust Financial Procedures</u>	DoF	SFIs Section 1

Delegated Matter	Authority Delegated To	Reference Document
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	CPO	
d) Upgrading & Regrading		
All requests for upgrading/regrading shall be dealt with in accordance with Trust procedure	CPO	
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.	Executive Director	
iv) Compassionate leave up to 3 days	Senior Officer or Executive Director	
v) Compassionate leave over 3 days	Executive Director	
vi) Special leave arrangements	Executive Director	
paternity leave	Senior Officer or Executive Director	
vii) Leave without pay	Executive Director	
viii) Medical Staff Leave of Absence	MD and CE	
paid and unpaid	General Manager or Divisional Director	
ix) Time off in lieu	Automatic approval with guidance	
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 CPO	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with CPO	

Delegated Matter	Authority Delegated To	Reference Document
iii) Extension of sick leave on full pay	CPO or CE	
i) Study Leave		
i) Study leave outside the UK	CPO 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)	CPO	
k) Grievance Procedure	CPO	
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	CPO	
Requests for new posts to be authorised as mobile telephone users	CPO	
m) Renewal of Fixed Term Contract	Senior Officer or Executive Director	
n) Redundancy	CPO	
o) Ill Health Retirement		
Decision to pursue retirement on the grounds of ill-health	CPO	
p) Dismissal	Appointing Officers	
q) Development of personnel, industrial relations & training strategies and procedures	Executive Directors	
r) Authorisation of expenditure on recruitment advertising	CPO	
s) Day to day management of Consultants' contracts	MD Divisional Directors	
t) Excellence Awards to Medical staff.	CE	
19. Authorisation of New Drugs		SFIs Section 10
Estimated total yearly cost up to £25,000	Medicines Management Group	
Estimated total yearly cost above £25,000	CE (Subject to consultation with the above)	
20. Authorisation of Sponsorship deals	CE	
21. Authorisation of Research Projects	CE or MD or Chief Nurse	
22. Authorisation of Clinical Trials	CE and MD	
23. Insurance Policies and Risk Management	DoF	SFIs Section 19
24. Patients & Relatives Complaints		

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

Delegated Matter	Authority Delegated To	Reference Document
Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience students	CPO	
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	
42. Retention of Records	COO	
43. Clinical Audit	MD	
44. Nominated Fire Director		

Delegated Matter	Authority Delegated To	Reference Document
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	Alex Crickmar /Matthew Bancroft	Existing Policy	June 2022

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 2023

Checked by: Alex Crickmar/ Matthew Bancroft Date: June 2022

AUDIT AND RISK COMMITTEE ANNUAL REPORT 2021/2022

DATE:	**18th July 2022**
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 ARC and due to go to Board for approval.

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; 21st May 2021, 9th June 2021, 15th July 2021, 12th October 2021, and 24th March 2022 (all via videoconferencing). The normal January meeting was postponed due to Omicron operational pressures, and all items moved to the next meeting in March 2022, with an additional meeting being held in April 2022 on top of normal workplan requirements.

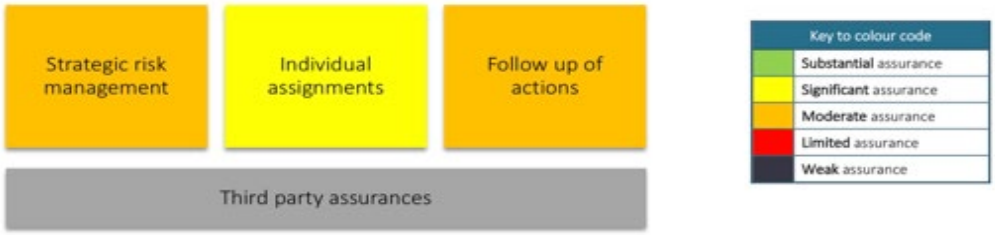
1.2 This report summarises the key information required against last year's recommendations and the following: -

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 2021/22 the Committee has delivered its key responsibilities and duties as outlined in its Terms of Reference and although the Covid-19 pandemic was ongoing with peaks during this time, with the exception of the January 2022 meeting (where most corporate meetings were stood down due to the Omicron pandemic wave), meetings were held appropriately and in line with the workplan.
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. ARC has escalated a number of items to Board to ensure Board members are fully aware and appraised of the risks and actions to manage the risk.
	<u>Governance, Risk Management and Internal Control</u>
4.3	<u>Internal Audit</u> The Committee welcomed a new provider mid-way through the year as 360 Assurance were appointed following a robust tending process. The Committee hence had to review delivery of the outgoing auditors (KPMG) and the incoming auditors (360 Assurance) the risk-based audit plan, the KPIs and the audit reports, to ensure both Internal Auditor providers 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.

	The outcome of all internal audit work carried out is shown in the 360 Assurance Annual Report which was shared with ARC on 27th May 2022. ARC has considered in detail all Audit Reports, and especially provides a focus on those which have not met the standard of "Significant/Substantial Assurance". Any below this standard are reviewed in detail, and actions escalated where necessary to ensure improvement is made in these areas. There reports are also referred onto relevant Board Committees to ensure appropriate awareness of the risks pertaining to that Committee. The Committee has not undertaken a review of the effectiveness of Internal Auditors a full tender process was completed during 2021, with new auditors appointed from 1 October 2021. This review of effectiveness will be scheduled for October 2022. <u>Head of Internal Audit Opinion</u> The Draft HOIA were presented to ARC in advance of year end, enabling timely escalation to Board. The final HOIA confirms a "Moderate Assurance" outcome for 21/22 due to 2 main factors; Strategic Risk Management and Follow up of Audit Actions. This has been highlighted at both ARC and Trust Board aa areas requiring improvement in 22/23. The Committee acknowledges that improvements are required in both Risk Management and Audit Recommendations closure rates in order to receive an improved opinion for future years. This was escalated and discussed at the March 2022 Board with assurances given on action being taken. It was noted that an ongoing review of Risk Management by KPMG will be reported to Board (carried out in April 2022) alongside closer understanding of the Trusts Risk Appetite (carried out in April 2022). The Committee will continue to monitor delivery of this work. 
4.4	<u>Internal Audit Recommendations</u> The Committee follows up medium and high audit recommendations at each of its meetings. The current closure rates (as reported in the HoIA opinion of 34% first follow up rate; 84% overall completion) have caused concern for the Committee during this challenging year for the Trust. This was escalated to Board of Directors and the rates reported to the March 2022 Board. Assurances have been given of tightening up of follow-up processes, appropriate sign off dates being agreed, utilisation of the new IT system to improve the rate for 2022/23. However, the Committee will continue to apply pressure for recommendations to be completed in a timely manner.

4.5	<u>Financial Reporting</u> The internal audit plan contained work to review General Ledger and Financial Reporting arrangements which was given a significant assurance rating. This is positive for the Trust.
4.6	<u>Counter Fraud</u> The Committee has continued to monitor the activities in place to deter & prevent fraud 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 which pleasingly remains at a high compliance rate for 21/22. 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, and the 21/22 self-assessment tool was signed off as an overall 'GREEN' rating, with 2 Amber areas which the Committee will receive progress updates on during 22/23.
4.7	<u>Information Governance</u> 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 2020/21 was "Significant Assurance". The 2021/22 work was undertaken later due to changes in the national submission timetable and was reported to the July 2022 ARC with a "significant assurance" which is a positive outcome for the Trust. 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 2021.
4.8	<u>Health, Safety, Security and Fire</u> 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 2021.
4.9	<u>External Audit</u> The Committee has not undertaken a review of the effectiveness of External Auditors as the focus of 21/22 was to support the CoG appointment of the External Audit service via a tendering process. The outcome of the tendering was EY were re-appointed to the External Audit contract. The 2021/22 External Audit Report (ISA 260) conclusion was a positive "clean" opinion and will be presented at the June meeting. It concluded that: *"In our opinion the financial statements:-* *-give a true and fair view of the financial position of DBTH and of the Group as at 31 March 2022 and of the FT's & Group's income and expenditure for the year then ended;*

	-have been properly prepared in accordance with the DoHSC Group Accounting Manual 2021 to 2022; and *-have been properly prepared in accordance with the NHS Act 2006 (as amended by the H&SC Act 2012"* There were a number of recommendations contained within the ISA 260 and progress will be reviewed in October 2022. There were also some delays in this yearend process and hence work will be undertaken between the DBTH Finance Team and EY to ensure a smoother running of year end, aimed at minimizing any delays, but with an achievable reporting date. These matters will also be reported directly through to the CoG from EY at the appropriate meeting.
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 in the front sheet format under the assurance section in the business-as-usual reports and clearly includes within the new Trust BAF which shows outcomes of Audit Reports. A number of items have been referred onto Board Sub-Committees and the Board itself.
5.3	The Chair of Audit and Risk Committee attends Council of Governors to provide assurance to governors via a short presentation covering ARC meetings and answers any questions required.
6	**MEETINGS AND MEMBERSHIP**
6.1	The Committee met on 5 occasions during 2021/22 and the Committee's membership and attendance has been satisfactory as follows:-

Kath Smart – Chair	Non-executive Director	5 of 5
Sheena McDonnell	Non-executive Director	4 of 5
Neil Rhodes	Non-executive Director	4 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 Board has an approved Committee effectiveness process, but due to operational commitments during the pandemic it has not yet been rolled out to Committees. This is planned for 22/23. As an interim position the Committee self-assessed itself against the HFMA Handbook Standards early 2021 and there were no areas of concern or action identified in this self-assessment.
9.2	The Committee held a private meeting with both sets of auditors in May 2022 to ensure direct lines of communication between the Committee and auditors, without management present. There was discussion on several areas, which were then taken into the formal ARC meeting, hence there are no areas of escalation from the private meeting.
9.3	ARC also received and reviewed the Annual Reports of the Board Governance sub-Committees, namely Finance & Performance; Quality & Effectiveness and People Committee and concluded they satisfactorily met their workplans and Terms of Reference. All Committees are required to go through an effectiveness review during 22/23 and ARC will work with the Company Secretary to deliver the approved process.
10	**CONCLUSION AND RECOMMENDATIONS**
10.1	In conclusion, the Committee believes it delivered against its key objectives during 2021/22.
11	**WORK FOR 2021/22**
11.1	Work to progress in 2022/23 includes: a) Delivery of 2022/23 Internal Audit Plan; b) Declarations of Interest – Ensuring continued compliance with DOI and the process to achieve compliance, c) Supporting Council of Governors with any requirements of their appointment of the External Auditors. d) Continuing to drive down the number of outstanding audit recommendations; e) Improving the rating of the 22/23 Year End HOIA Opinion. f) Gaining assurance on progress with improvement to the “No assurance” Audit Report on Job Planning. g) Completion of the ARC Committee effectiveness process h) Ensuring any year end delays with the ISA 260 are minimised and setting a realistic, challenging yet achievable timescale.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page					
Meeting Title:	**Board of Directors**				
Meeting Date:	26 July 2022	**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 2022'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

It has been another busy month since our June Board meeting.

We said "farewell" to Sheena McDonnell who has gone to be the Chair of the Board at Barnsley Hospital Foundation Trust. We are already working well with her at the Acute Federation which has held further monthly meetings and development sessions to flesh out how together we can be safer, more sustainable, more efficient and effective.

The June Board saw Anthony Fitzgerald, our former Partner Governor, present his aspirations as the new Lead for Doncaster Place. While there are governance structures in place for officer representation for the Trust there is still more to be explored regarding non-executive engagement.

July 1st saw the creation of the new statutory Integrated Care Boards. We continue to be involved at Chair and Deputy, CEO and Deputy levels in South Yorkshire and in Nottinghamshire. The date saw the end of independent Clinical Commissioning Groups and therefore saw our CCG Partner Governor roles falling vacant. Options are being explored to bring a constitutional change to the Council of Governors around September to bring on new partners which will increase the diversity of our Governing Council.

The South Yorkshire Integrated Care Board has decided not to bring Governors together in any way across the region, as each governor is appointed to single Trusts. The Chair and Chief Executive have offered to speak to individual Councils of Governors. The Acute Federation is looking at how it would like Lead Governors to network and communicate with governors in other hospitals.

The addendum to the Monitor Guidance on the role of Governors was discussed by the Governor Advisory Committee which I and Peter Abell, Bassetlaw Public Governor, attend. They sent in a response to the national consultation. Our own Governor with Peter's help were to debate the addendum this month.

I have completed training in order to assist in the marking of what used to be called National Clinical Excellence Awards. They have been renamed the National Impact Awards. They are for doctors who can evidence that they have gone 'over and above' their job plans to have a national impact.

I was pleased to attend the We Care into the Future careers event at Doncaster Dome. I was proud to see and hear many of our teams sharing with the city's young people why they should seek a career in the NHS. I am hoping the Teaching Hospital Committee will, overtime, evaluate the impact of our big careers efforts.

I spent 24 hours at a conference covering a wide agenda covering the current and future potential of enhanced IT in NHS settings. It is vital all board members seek to remain UpToDate with fast moving areas of our business in order to be able to make the right decisions about developments which will best contribute to our agenda and journey to be the safest Trust in England.

I have been pleased to see the robust approach being taken by our new internal auditors, 360 Assurance. I engaged with them to look at what we had hoped to get from being accredited under the Race Equality Code. While they have found gaps in the delivery of our action plan, with the support of our new Chief People Officer, Zoe Lintin, I am hopeful we can get back on track in the coming year to improve diversity in all areas of activity.

As the NHS Providers' Board representative on the Governor Advisory Committee, I participated in three days of the national Governor conference, facilitating break out groups on two days and chairing the whole event on the middle day. Many areas of concern and interest to governors were covered including their role in the new ICBs. We ensured that we filled every place offered to us and I am certain our governors felt the benefit of engaging with other governors and hearing some excellent speakers and showcase winners.

I represent the Trust on the Doncaster Chamber of Commerce Board. We were invited to give a presentation and talk about the trust at the Patrons event in Bawtry. The audience was fully engaged hearing about Covid numbers, our hopes for a new hospital, planned capital schemes at Montagu and Bassetlaw. I delivered the messages that the Covid vaccine had had a beneficial impact, significantly reducing the numbers of patients who become seriously ill with Covid. I was also able to show them a graph about the spike in flu cases in Australia and asked them to encourage everyone: "If you are eligible for a flu vaccine, please seriously consider having it."

I have started appraisals and objective setting with non-executive directors. I am proud of the hard work, dedication and constructive demonstrating of our values from our non-executives and look forward to working with our new clinical NED Jo Gander and Hazel Brand in due course. I have already agreed that Kath Smart will continue as Chair of the Audit & Risk Committee and Mark Day will chair our People Committee and be Senior Independent Director. I will spell out other "designated NED roles" once agreed.

I have had a few unique opportunities through NHS Providers. Peter Abell and I were filmed discussing how to develop the Chair-Governor relationship to be used on training courses for aspiring Chairs. I also chaired an uplifting induction event for new executive directors.

I have continued my approach to speak to new senior leadership appointments and recently met Laura Churm, new Director of Paediatric nursing.

I meet the Lead and Deputy Lead Governor monthly with Trust Board Office Colleagues.

NED Reports

Mark Bailey

Since the last Board report, Mark has participated in the Board Committees for Finance & Performance, Quality & Effectiveness, People and Audit & Risk and chaired the meeting of Charitable Funds Trustees and Teaching Hospital Board.

A briefing and discussion on the future strategy for the Trust Charity has been held with Executors of the Fred and Ann Green Legacy and summarised in the July presentation to the Council of Governors. Similarly, Mark was pleased to meet members of the Doncaster Chamber at the Bishop's Breakfast event held at Doncaster College campus and discuss informally our Charity and its activities.

In June, Mark attended the "Excellence in Healthcare" Conference in Lincolnshire which brought together a wide range of NHS Trusts to share innovations and lived experiences with digital solutions for patients and staff. On-site visits to DRI have incorporated assurance discussions with the Director of Midwifery as part of the interim NED Safety Champion for Maternity and familiarisation of the Trust's Research and Education activities.

Regular catch-up calls with our Chair, Executive and Non-Executive colleagues continue including specific assurance discussions on Charitable Funds, Health & Wellbeing, digital programme development and research opportunities on healthcare innovation.

Kath Smart

Kath has attended her regular committee meetings including Board, Finance & Performance Committee, People Committee and Charitable Funds. She also presented at the July Council of Governors and hosted the June Governor briefing on the "Stay & Thrive" approach being used to assist the international nurse colleagues who have joined Team DBTH.

It has been a busy time as Audit Committee Chair, and 2 meetings in May and June have been held to sign off the year end accounts, annual report and required declarations. There have been numerous meetings with EY, 360 Assurance and the Acting Director of Finance, plus all Audit & Risk Committee NEDs attended an informal session to "walk through" the Trust accounts in advance of them being signed off. She has signed off the Counter Fraud annual return in conjunction with the Acting Director of Finance and the Local Counter Fraud Specialist and has also met with the acting Estates Management team to discuss Health, Safety and Security reporting to the Audit & Risk Committee ARC. July's Audit & Risk Committee will also have been held by the time this paper comes to Board.

As temporary Chair of the Quality & Effectiveness Committee, she has chaired the June meeting and held a planning meeting to agree the agenda for September's meeting. She has also met with senior staff to talk about Clinical Audit progress.

Kath has supported recruitment within the Trust including being on the panel for the new Chief Operating Officer, on the advisory panel for the two NED appointments, and chaired panels for the appointments of Consultant Radiologist (MSK) and a Consultant in Respiratory Medicine.

Finally, it was great to attend the "We Care into The Future" event held at the Dome where over 1000 year 8 pupils were invited to come and see for themselves what careers exist in DBTH. It was a hugely popular event and very well organised, credit to those who took part and the organisers.

Neil Rhodes

Since the last full board meeting Neil has represented the Chair at the Nottingham and Nottinghamshire ICB Chair and Chief Executive meeting, subsequently meeting Suzy Brain England, with the Deputy Chief Executive, to brief her on progress and direction of travel.

Prior to each Finance and Performance Committee Neil holds an agenda setting meeting with executives and then immediately prior to the meeting has a number of 1:1s with key presenters to prioritise business. Prior to Finance & Performance Committee on 26 May he held those meetings with Gill Marsden, Debbie Pook, Jon Sargeant and Alex Crickmar. He held a similar series of meetings prior to the Finance & Performance Committee on 30 June.

On 6 June Neil chaired an exceptional meeting to consider the business case for an electronic patient record system, which was subsequently commended to the Board.

In addition, he had a 1:1 meeting with Acting Chief Nurse, Abby Trainer, to discuss a profile of key reports to schedule over future months. He also met with new governor observer Andrew Middleton, briefing him on the work of the committee, before subsequently welcoming him to June's committee meeting.

As part of his executive buddying role, he met recently with Divisional Director, Antonia Durham-Hall.

Preparations have now begun for the next Finance and Performance Committee with agenda setting meetings, where the new interim Chief Operating Officer, George Briggs was welcomed for the first time to agenda setting.

Neil also has also had a period of leave during this period.

Mark Day

Mark joined the Board on 1 May and wants to thank everyone for making him so welcome through a combination of formal and informal induction. The former has included the Trust's own Corporate Induction and a two-day programme for new NEDs run by NHS Providers. The latter has included one to one meetings with executives and non-executives both prearranged and impromptu. A special thank you to the team in the Trust Board office for making everything run so smoothly.

*A*s well as attending his first two Board meetings Mark has been attending as many committee meetings as possible, three Finance and Performance, including the additional meeting to consider the excellent EPR business case, two Audit and Risk, and one Quality and Effectiveness. On 5 July Mark enjoyed chairing his first People Committee and was very impressed with the knowledge and experience in the People and Organisational Development teams and the potential that comes with having a new Chief People Officer in place.

Other meetings/events have included the Minister of State's visit to DRI in May with the Estates team making the most of the opportunity to explain, in a calm and professional manner, the infrastructure challenges we face. It also provided the opportunity to meet some senior staff, local MPs and the Mayor of Doncaster. June included planning the agenda for the People Committee (with a very helpful handover from Sheena), a Governor Briefing highlighting the work of the 'Stay and Thrive' programme, a helpful briefing on the revised financial plan, objective setting for the year ahead, and his first Council of Governors meeting. A planned tour of the DRI site was understandably postponed until the latest coronavirus surge subsides.

Finally, Mark has, from 1 July, been appointed as Senior Independent Director and has also taken up the role of Designated Member.

Chief Executive's Report
July 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

An update on the Trust's response to COVID-19 and activity

As a result of the rising rates of COVID 19 infection in our communities the Trust has cared for an increasing number of patients who have tested positive for COVID-19. We have also had a similar rise in infection rates amongst colleagues which has created staffing issues in several areas, and more recently the weather has contributed further challenges to the start of the summer months.

All of this taken together has resulted in specific pressures particularly in emergency where the activity for our Emergency Departments has been particularly high. Clearly these pressures are being felt across health and social care services which is increasing the number of patients who remain in hospital when medically fit for discharge.

For their part, Team DBTH have responded magnificently as usual, working in what are very uncomfortable conditions in the recent heat wave, particularly as we have had to bring back masking in every area of the Trust in response to rising COVID-19 transmission.

As a Trust we continue to ask colleagues to follow our guidance and policies in relation to coronavirus to minimise any potential carriage into our hospitals, and we ask the same of our patients and visitors when coming on to site.

At present, we haven't changed our visiting restrictions and we are optimistic that infection rates will begin to decline as we head towards August as we anticipate that this current wave of Covid activity will begin to reduce.

Minister of State for Health visits Doncaster Royal Infirmary

The former Minister of State for Health, Edward Argar MP, visited Doncaster Royal Infirmary (DRI) on Tuesday 31 May to meet with local health professionals and discuss future plans for the NHS.

Met by Jon Sargeant, Deputy Chief Executive of Doncaster and Bassetlaw Teaching Hospitals (DBTH), Dame Rosie Winterton, MP for Doncaster Central, Nick Fletcher, MP for Don Valley, and Ros Jones, Mayor of Doncaster, the Minister of State discussed challenges faced by colleagues throughout the past few years, as well as plans for development within the Women and Children's Hospital at Doncaster Royal Infirmary and the wider Trust.

The Minister was shown around the current Central Delivery Suite (CDS) before refurbishment work commences, as well as being given an insight into the challenges posed by the overall infrastructure of the Women's and Children's Hospital, and the wider DRI.

Speaking about the visit, Minister for Health, Edward Argar said: "It was fantastic to join my colleagues Nick Fletcher MP and Dame Rosie Winterton MP, along with the Mayor of Doncaster, to visit Doncaster Royal Infirmary.

"It was a great opportunity to meet some of the dedicated NHS team at the hospital to hear about their work over the past two years, and their plans to recover from the pandemic and bring down waiting lists.

"It was also a chance to see first-hand the estate challenges faced by the hospital, and to hear about proposals to improve their buildings."

Urgent and emergency care at Bassetlaw Hospital

In early 2020, following a visit to Bassetlaw Hospital from Prime Minister Boris Johnson, £17.6m was announced in support of a proposal by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) to create an Emergency Village at Bassetlaw Hospital.

The development of modern urgent and emergency care service will meet the needs of the communities of Bassetlaw, now and for years to come. The development will increase the size of the Emergency Department (ED) and provide more accessible same day services, so we can get patients to where they need to be to receive the best care more quickly.

Development work for the Emergency Village project commenced in 2021 with the formation of a project team, including Programme Directors (a shared role) Anna Fawcett and Chris Turner from Archus (healthcare infrastructure experts) and Programme Manager Lesley McKay from DBTH.

Meetings were established and all relevant clinical teams were invited to discuss space and clinical requirements for the planned new build. This also includes meeting with clinical colleagues at partner organisations.

A comprehensive consultation surrounding the future paediatric model took place with staff, patients, partners, and the Bassetlaw community. 1,893 people responded to the consultation.

85% of respondents indicated that their preference was building a new Children's Assessment Unit next to the emergency department, allowing children to stay at Bassetlaw Hospital for a short stay, including overnight (patients requiring a longer length of stay will continue to be transferred to Doncaster Royal Infirmary).

Respondents were asked to consider which factors would be most important in the development of the new Emergency Village. Within the survey findings, the top three priorities were: timely access to clinical treatment (82%), the availability of staff to help with queries (71%), and comfortable surroundings which are inclusive of neurodiversity (55%).

I am pleased that all of this hard work is nearing completion and that Board of Directors will receive the Outline Business Case at today's meeting.

£2.5 million refurbishment of maternity services

The Central Delivery Suite at Doncaster Royal Infirmary (DRI) is currently undergoing a £2.5 million refurbishment as the area is updated and modernised.

The work includes a full refurbishment of the site's birthing rooms, as well as the creation of a new reception, waiting area and Birth Centre. The delivery suite will include a fully equipped Obstetric Observation Area to support patients who need additional observation and a triage area.

With this investment, we will be able to create a 'Birth Centre' at DRI, which will allow us to offer the option of Midwifery-led care to our patients, alongside the current Obstetric-led unit. Essentially this will give parents more choice, accessing a service which is like a home-from-home, with a birthing pool, whilst we will still also have the Obstetric service for those mums who need a little more support and monitoring, should they run into any difficulties.

To facilitate the refurbishment, we will be temporarily relocating the current Central Delivery Suite to the ground floor of the Women's and Children's Hospital.

The works are expected to take 26 weeks.

Digitalised X-ray room opens at Doncaster Royal Infirmary

The installation of a new general X-ray room marks a now fully digitalised service at Doncaster Royal Infirmary.

Up until recently, most X-Rays have been undertaken using cassettes to capture images, which are then used to aid in the diagnosis of a patient. With the installation of new equipment, individuals can be x-rayed, with the image coming straight through onto a computer screen significantly increasing the speed at which radiographer can work within the hospital.

The equipment used to achieve this way of working is a Siemens Ysio Max with the project cost being just over £250,000, and all types of patients can be imaged in the newly refurbished general X-Ray room. The x-ray table is height adjustable to allow patients to get on easily which means it's perfect for children and those with complex needs.

Bespoke and colourful graphics touch the ceiling and floor of the wall behind the x-ray table; a purposeful choice to help distract nervous patients, with the graphics commissioned by the Trust from Keane Creative (local company in Doncaster) and are unique to this room. They have been printed and installed by SPJ Marketing Limited.

Throughout the Trust, a total of over 440,000 radiology examinations are carried out each year.

Reciprocal mentoring at the Trust

The Trust has recently undertaken a reciprocal mentoring programme, with 18 candidates taking part and successfully completing the course.

Reciprocal mentoring focuses on the career development of Black, Asian, and Minority Ethnic (BAME) aspiring leaders and the development of inclusive leadership skills, particularly in relation to racial equality among senior leaders.

As part of the programme, nine senior leaders were paired with nine colleagues from a range of backgrounds to provide crucial insights and better understanding of the barriers some colleagues can experience in their day-to-day roles. Importantly, participants are equal partners, each taking on the role of both mentor and mentee throughout the programme.

Over the course of a few months, I had the opportunity to work with my partner, and I found the whole process really valuable, as well as hugely helpful in terms of my own personal development and where we can develop as an organisation to create a more inclusive environment for all colleagues.

On 18 July, the first cohort of colleagues to undertake the programme graduated with a special ceremony held within the Rainbow Garden at Doncaster Royal Infirmary.

I want to thank all of the colleagues who took part, and we will be running further programmes in the future.

Health and social care careers fayre returns to Doncaster Dome

Organised in partnership between Doncaster and Bassetlaw Teaching Hospitals (DBTH), Hall Cross Academy and other health, social care, and educational organisations in the area, 'We Care – Into the Future' allowed our young people to understand what the NHS and care sector has to offer local students upon completing school. Attending on the day were clinical teams specialised in training

and delivering care, who provided attendees with an insight into the real world of health and social care work.

The event was designed as a highly interactive experience. Firstly, the students were guided through a simulation corridor that demonstrated a patient's journey from the community through to the emergency department, operating theatres, a hospital ward and back to the community. From there, our young people were able to speak to specialists from approximately 350 different careers who held stands that displayed their career pathways, examples of their practice and a hands-on approach through games, quizzes and interactive models and displays.

The stands were facilitated by health and social care staff from across Doncaster, who helped to challenge the perceptions of available roles within health care and raise the aspirations of our young people. The students interacted with a range of education providers who were able to advise and guide the students on the range of vocational and academic pathways available to them after leaving comprehensive school.

The event organisers approached all secondary schools within the Doncaster area to invite their year eight students to the day. This year, the event saw many more schools sign up to take part, with attendance up from 700 attendees in 2019 to 1,000 students this year.

Safe Effective Quality Occupational Health Service (SEQOHS) reaccreditation

I am pleased to share that, for the fourth year running, the Trust has received reaccreditation for Safe Effective Quality Occupational Health Service (SEQOHS)

SEQOHS accreditation provides independent and impartial recognition that the occupational health service provider has objectively demonstrated their competence, as defined by the SEQOHS standards, to a team of trained assessors.

I want to share my thanks with the team for their work in achieving this accreditation.

Green light given to further develop its Community Diagnostic Centre in Mexborough

Just over £9 million will be invested at Montagu Hospital in the coming months, as plans to further expand and enhance the site's Community Diagnostic Centre (CDC) are approved by The National CDC Programme, with support from NHS South Yorkshire.

In 2021, Montagu Hospital was selected to host one of a pair of 'Community Diagnostic Centres' (CDCs) within South Yorkshire, following a £3 million investment from NHS South Yorkshire, of which Doncaster and Bassetlaw Teaching Hospitals (DBTH) received around £230,000 of initial capital funding.

Phase one of the project began in January 2022 when a mobile MRI was placed at Montagu Hospital, and this was joined in early February by a CT scanner. Between January and the end of March, around 2,600 patients were seen – work that has helped to reduce the backlog of activity which has accumulated as a result of COVID-19-related restrictions throughout the past two years.

Since that time, the Trust's Strategy and Improvement team and service leads have been hard at work to develop a new business case to enhance services offered by the CDC as it enters its second phase, with further funding secured as a result.

The CDC will be housed in vacated space within the main area of Montagu Hospital, referred to as the 'rotunda', which will be familiar to many who are local to the site. The additional monies will

expand diagnostic services, as well as increase staffing for the service, and developments will include:

- The provision of a new endoscopy suite
- The creation of ultrasound facilities and related rooms
- The development of multifunctional clinic rooms which can be used for screening and mobile services
- Further training facilities to develop workforce for the future.

These facilities will create much-needed capacity for imaging and other diagnostic services and enable patients to get their diagnosis quicker and, it is envisaged, in one place within a community setting.

Colleagues at the Trust also plan to prepare a further business case to procure static CT/MRI facilities on site, which will replace the mobile units which are currently being used. This work will form part of the next phase of the CDC's development, and the three-to-five-year plan for the project, with an emphasis upon developing 'hub and spoke' models in other areas of Doncaster and Bassetlaw, working closely with primary care (services such as GP practices) to develop pathways like cardio-respiratory and lung health within the community.

Jeannette Fish MBE CT Imaging Suite opens at Doncaster Royal Infirmary

After a delay due to the difficulties posed by the pandemic, the Jeannette Fish CT Suite has officially been opened at Doncaster Royal Infirmary (DRI).

Building works initially began in February 2019, following an investment of more than £4.9 million from the Department of Health and Social Care. This money was awarded thanks to a bid put forward by the South Yorkshire and Bassetlaw Integrated Care Board (of which DBTH is a key member), to build the brand-new facility at DRI, and the project was completed in March 2020.

Integral to the scheme was the support of the Doncaster Cancer Detection Trust, a local charity which has supported DBTH since the early 1970s, raising more than £10 million to aid in the care and treatment of local people. In all, and with support from communities in Doncaster, the team managed to raise around £500,000 to purchase a new CT scanner, which enabled the development of the new suite with the aid of additional funding from the Government.

To honour these efforts, and particularly the memory of the one of the charity's co-founders, the facility has been named the Jeannette Fish MBE CT Imaging Suite, with a suitable plaque to be placed at the entry of the service, and all signage soon to be updated to reflect this change.

A former nurse, Jeannette was a co-founder of the DCDT, and sadly passed away in May 2018. Amongst her many achievements, including the procurement of an MRI scanner at DRI, Jeannette helped to raise millions of pounds for cancer diagnosis, care, and treatment, aiding in the purchasing of equipment which helped to bring cancer services to Doncaster, hugely benefitting local patients. For these efforts, she was awarded a Most Excellent Order of the British Empire (MBE) in 2012.

Although the Jeannette Fish CT Suite officially opened on Friday 24 June, it became operational in March 2020, and since that time has increased the Trust's scanning capacity by around 50% – a particularly timely improvement as the organisation seeks to catch up on the backlog created because of the COVID-19 pandemic.

Appointments and departures at the Trust

Introducing our new Chief Operating Officer:

After an extensive and robust recruitment process, Denise Smith will join Doncaster and Bassetlaw Teaching Hospitals (DBTH) later this year as the organisation's new Chief Operating Officer (COO).

Denise is currently the Chief Operating Officer at The Queen Elizabeth Hospital, King's Lynn, a position she has held since May 2019.

Originally from York, Denise joined the NHS over 25 years ago, starting in operational management in Women & Children services. She has worked across primary and secondary care, in both commissioner and provider organisations and, since 2009, Denise has worked in operational leadership positions in a number of Acute Trusts across the country.

Speaking about her appointment as Chief Operating Officer Denise said: "I am absolutely delighted to be joining Doncaster and Bassetlaw Teaching Hospitals. While we have faced an incredibly challenging couple of years because of the pandemic, I believe this Trust has the vision and ambition to do the very best for its patients. I believe that, together, we will provide faster access to the highest quality of care, putting patients at the heart of everything we do.

The Chief Operating Officer is an integral role at the Trust and is responsible for the leadership and delivery of the Trust's operational services, ensuring high quality care and the delivery of performance standards in a safe and sustainable way.

We know the pandemic has had a significant impact on our teams and the services we provide, I am confident Denise will help to support our recovery and renewal post pandemic, and I look forward to working closely with her as part of the Executive Team.

Denise will begin to undertake induction with the Trust for one-day-a-week from mid-August, before assuming the role full-time on 3 January 2023. Until that time, the Trust will continue to be supported by George Briggs, Interim Chief Operating Officer.

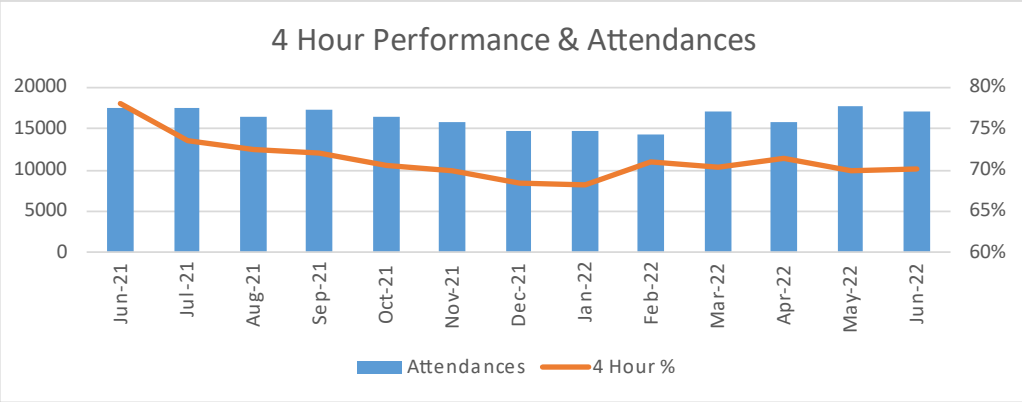
Other appointments:

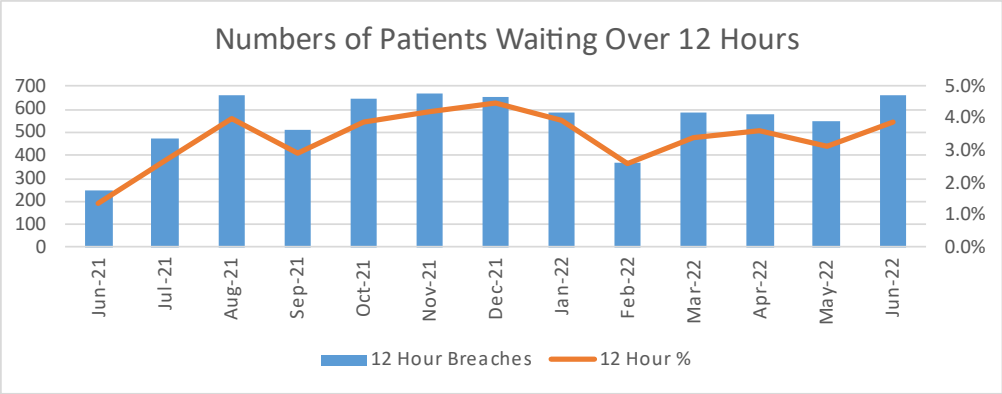
- **George Briggs** has joined the Trust as Interim Chief Operating Officer.
- **Mark Day, Joanne Gander and Hazel Brand** have been appointed as Non-executive Directors.
- **David Purdue**, Chief Nurse, has left the Trust to take up the post of Chief Nurse, NHS Northeast, and North Cumbria. Abigail Trainer, Director of Nursing, is acting into the vacant position until a recruitment process is completed in the summer. Abi will be supported by **Kirsty Clarke** and **Simon Brown** who have been appointed Acting Deputy Chief Nurse(s)
- **Laura Chrum** has joined the Trust as Director of Nursing for Paediatrics.
- **Zoe Lintin** has joined the Trust as Chief People Officer.
- **Natalie Griffiths** has been appointed Head of Nursing for Emergency Department and Acute.

Trust Integrated Exception Performance Report – June 2022

1. Urgent and Emergency Care – 4 hour standard and new standards
2. Urgent and Emergency Care – Ambulance Standards
3. Urgent and Emergency Care – Length of Stay
4. Urgent and Emergency Care – Length of Stay (Discharge)
5. Elective – Activity
6. Elective – Waiting List and Long Waiters
7. Elective – Outpatients
8. Diagnostic Waits
9. Cancer – Referral to Diagnosis
10. Cancer – Treatment
11. Health Inequalities
12. Performance – The Forward View

1. Urgent and Emergency Care: 4 hour performance and 12-hour standards





Key issues:

- 4 hour performance ↑ 70.08% for Trust. Main breach reasons continue to be doctor and bed waits
- Re-surge in COVID patients impacting discharges, flow and Infection Control limitations in June
- Attendance levels remain higher than any of previous four years, with main increase across Minors pathway
- Increase in ambulances at peak periods continues
- Significant sickness and staff absence due to Covid isolation
- Significant exit block impacting on flow due to delays in discharging patients into community and increasing LoS in June
- Closure of community beds due to infection outbreaks impacting on flow

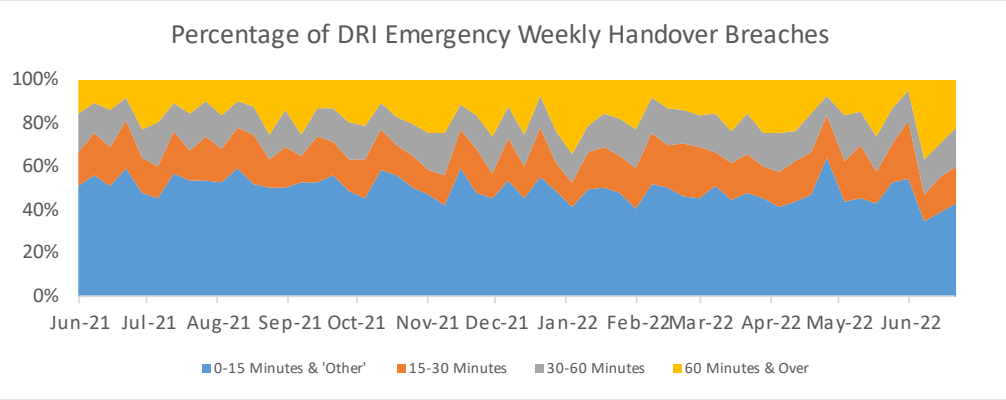
Key actions:

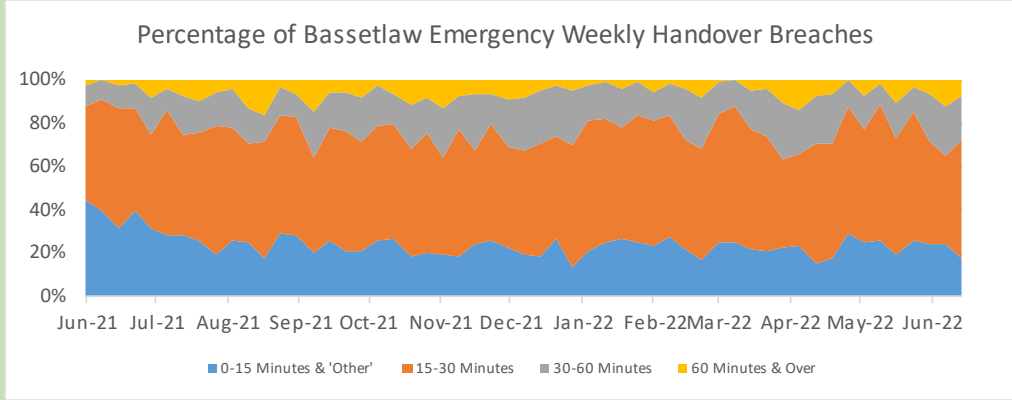
- Acute Medical Unit re-located to ED, focused on admission avoidance and short turnaround at front door
- Reviewing Early Assessment Unit model options
- Re-establishment of Early Senior Assessment model at Front Door
- Additional ED capacity now in place in Out Patient Department 2 to support escalation as required
- Focus on Length of Stay, Flow and Discharge (Ongoing)
- Daily assurance template training and PDSA through now moved to monitoring.
- Refresh of training and implementation of operational huddles and escalation process work continues to embed

June 2022 Performance

Hospital	4 Hour % Achieved	Attendances	Breaches	%Streamed From FDASS
Bassetlaw	76.47%	5326	1253	7.72%
Doncaster	62.04%	10047	3814	19.70%
Montagu	96.85%	1746	55	0.00%
Trust	70.08%	17119	5122	13.96%

2. Urgent and Emergency Care: Ambulance waits





Key issues:

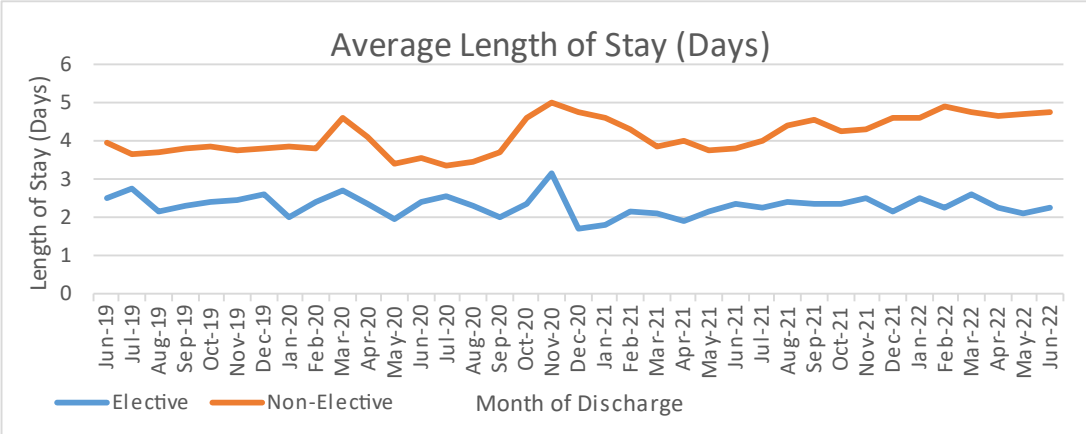
- Ambulance handover performance position challenging in June 2022.
- High levels of ambulances continue in the Doncaster & Bassetlaw area.
- Further increase in COVID patients in June caused an ongoing exit block from ED increasing challenges to flow of ambulances coming into and the receiving of handovers.
- Issues relate to flow out of ED & wider trust continue to cause delays
- Medical Director supporting engagement work with specialties to support flow out of the department – workshop completed with little engagement from specialties – execs to support

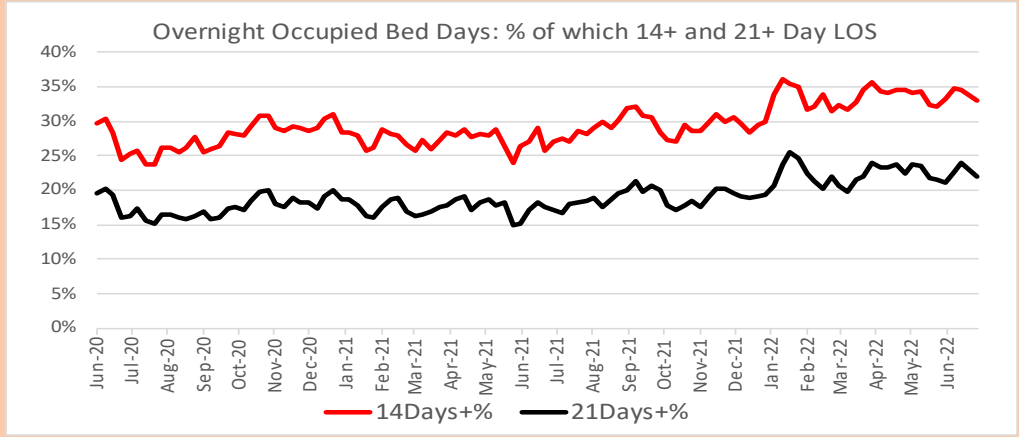
Key actions:

- Direct pathways for YAS to Medical Same Day Emergency Care (SDEC) and Surgical SDEC implemented Nov 21. Direct pathways for Community Response Team being scoped (June 2022)
- Direct pathways for EMAS to Medical Same Day Emergency Care (SDEC) at BDGH now in place
- Same Day Emergency Care full review – to include review of Directory of Services now complete
- Reviewing referral criteria for surgical and medical SDEC pathways
- Length of Stay work stream key enabler
- Improvements to handover process to improve accuracy of data now complete

Month	Hospital	Total Arrivals	%<15 Minutes	% 15-30 Minutes	% >30 Minutes	Longest Wait
Jun-22	Bassetlaw Hospital	812	22.17%	49.88%	27.96%	04:03
Jun-22	Doncaster Royal Infirmary	1959	43.03%	17.71%	39.25%	04:17
Jun-22	Trust	2771	36.92%	27.14%	35.94%	04:17

3. Urgent and Emergency Care: Length of Stay (LoS)





Key issues:

- Ongoing work to improve use of data on Length of Stay and Discharge Practice for internal teams.
- SAFER, Red 2 Green & Good Board Round Practice not consistently implemented on all wards R2G team due to finish in late August.
- EDD on assessment units not consistent.
- Discharge update information on nerve centre completion to inform ops meeting
- Ongoing review of site management processes
- Challenges with patients who no longer have 'right to reside
- Implementation of Hospital and Community Discharge Policy across all area's in line with Transfer of Care Hub formation on both sites.

Key actions:

- Review 'Walkaround Wednesday's with focus on patients with 7 day + length of stay, ensuring all patients have a plan , potential to trial walkaround earlier in the week
- Red 2 Green team to continue with focus on supporting areas with lower compliance & engaging with wider multi-disciplinary team
- Red2 Green delay data shared with Ward Managers and Matrons
- Red2Green data reviewed for themes and trends across all area's to identify potential area's for improvement.
- Partnership working to continues twice daily to review patients who no longer have a right to reside.
- Partnership working to develop Transfer of Care Hubs and a discharge to assess model of care.

4. Urgent and Emergency Care: Length of Stay (Same Day Emergency Care - SDEC)

Discharges by Time of Day (Excluding Day case)

Discharge Time	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Before Noon	15.5%	13.8%	14.9%	14.2%	13.1%	14.9%	15.4%	14.1%	13.5%	12.0%	14.1%	13.2%	12.9%
Before 4PM	47.8%	45.6%	46.7%	46.1%	45.8%	48.2%	47.7%	47.0%	46.5%	42.9%	46.8%	46.9%	46.4%
After 4PM	51.8%	53.9%	53.0%	53.5%	53.8%	51.3%	51.7%	52.7%	53.1%	56.8%	53.1%	52.8%	53.2%

Key issues:

- Not currently co-located with other SDEC areas (surgery/gynae) or ED – deters direct referrals
- Current staffing shortfalls - both ACP and medical for medical SDEC (ACU)
- Increase in overall attendances and reduced space in ED – opportunity identified for streaming to SDEC
- Issues for DBTH relate to flow into ED and into wider Trust
- Referral criteria pathways focused which reduces opportunities

Key actions:

- Work ongoing developing plans for SDEC co-location with support from Real World
- SDEC Pathways with surgical and acute medicine being reviewed to access additional opportunity
- Exploring potential combined MDT SDEC to incorporate medical, surgical, gynae and ortho
- Direct referral pathways in place for YAS and EMAS to SDEC – now in monitoring stage
- Working with ICS SDEC Transformation group to make further improvements
- Re-implementing Early Senior Assessment model to improve streaming to SDEC from arriving ambulances
- Single point of access now in place via Consultant Connect

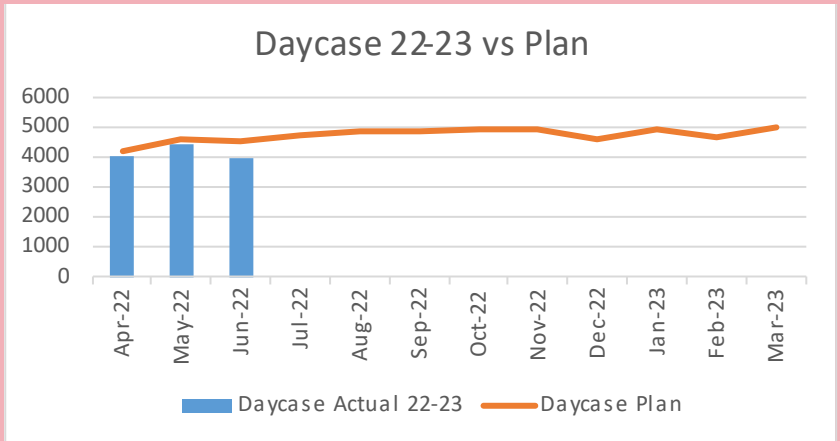
% of all Non-Elective Admissions to an SDEC Ward

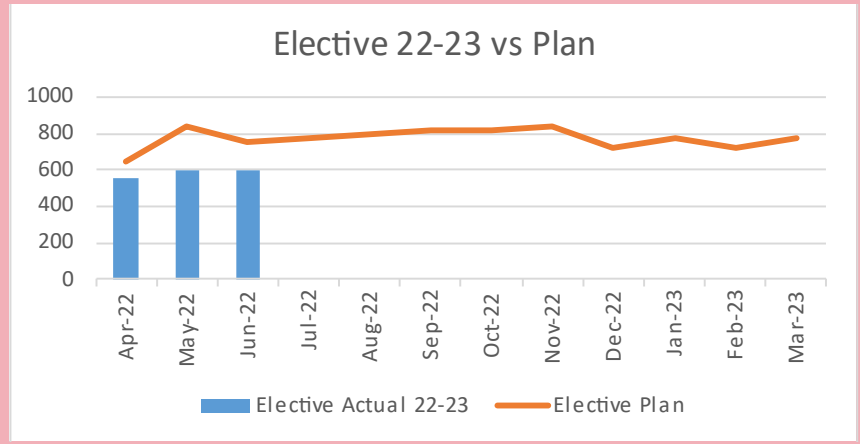
Ward	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
ACUTE MEDICINE DECISIONS UNIT							3.2%	5.2%	4.5%	4.0%	3.2%	4.2%	3.5%
AMBULATORY CARE UNIT - DONCASTER	8.8%	8.0%	7.7%	8.0%	8.1%	8.4%	7.5%	8.9%	8.8%	10.1%	9.2%	10.1%	11.1%
EMERGENCY SURGICAL AMBULATORY CARE	3.4%	4.4%	4.8%	4.3%	4.3%	4.7%	5.2%	6.3%	5.0%	5.0%	5.2%	5.2%	6.0%
GYNAE SAME DAY EMERGENCY CARE			0.2%	0.3%	0.4%	0.4%	0.4%	0.3%	0.2%	0.1%	0.0%	0.5%	0.8%
Grand Total	12.2%	12.4%	12.7%	12.6%	12.9%	13.5%	16.3%	20.8%	18.6%	19.2%	17.6%	19.9%	21.4%

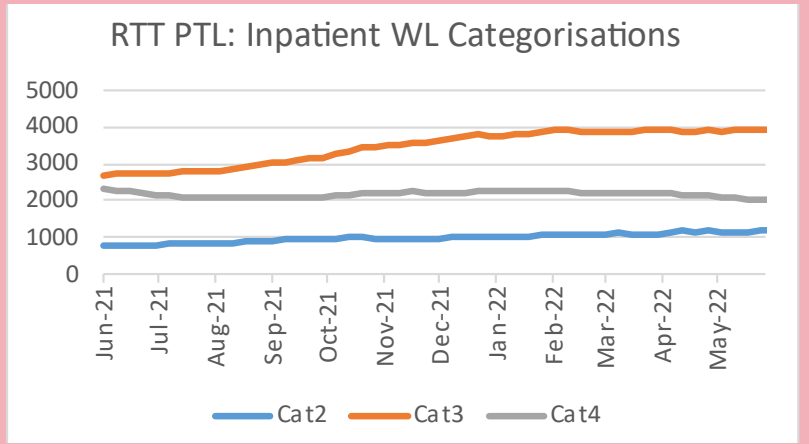
Number of Non-Elective Admissions to an SDEC Ward

Ward	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
ACUTE MEDICINE DECISIONS UNIT							142	219	178	174	133	190	158
AMBULATORY CARE UNIT - DONCASTER	428	377	345	356	377	372	330	375	347	442	389	459	497
EMERGENCY SURGICAL AMBULATORY CARE	167	207	214	191	202	206	231	264	198	219	219	239	270
GYNAE SAME DAY EMERGENCY CARE			8	13	19	18	18	13	7	4	1	23	34
Grand Total	595	584	567	560	598	596	721	871	730	839	742	911	959

5. Elective: Daycase and Inpatient Elective







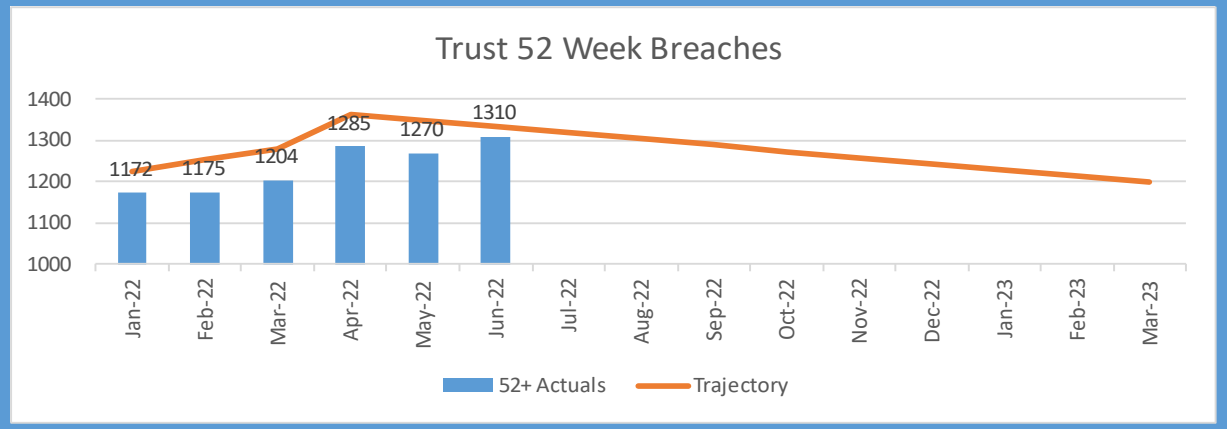
Key issues:

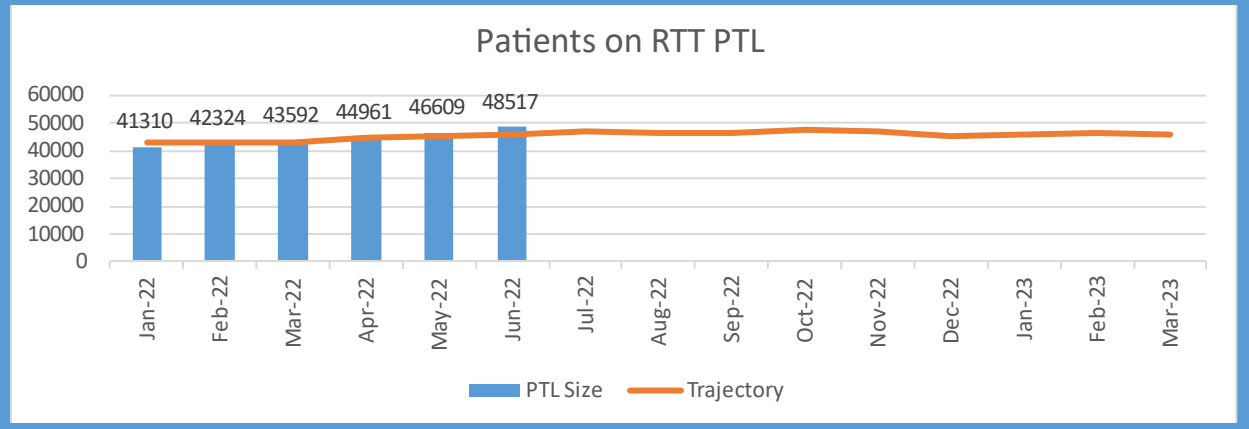
- Day case - Trust delivered 87.2% of plan and 91.6% of 19/20 activity
- Inpatients - Trust delivered 79.9% of plan and 84.8% of 19/20 activity
- All patients are listed on the basis of clinical prioritisation and longest waiting times
- Daily clinical review continues to prioritise patients according to available capacity
- Loss of available capacity throughout June due to lack of emergency surgical beds, prolonged spike in increased trauma demand, resurgence of C19, lack of non-elective flow and staffing gaps (leave and sickness, particularly in anaesthetics – 12 wte for 1 week)
- Bed pressures continued to be an issue although Ward 19 opened in June with 10 beds initially, 5 for emergency surgery (due to lack of junior doctor cover as the intention was for all emergency surgery) and the other 5 beds to support medicine

Key actions:

- Continue to list all patients, prioritising Cat 2's and the longest waiting Cat 3's & 4's
- Critical Care capacity available to support elective programme
- Beds at Parkhill used tactically to support DRI bed base (ongoing)
- Outsourcing continues and is front loaded into the first 6 months of the year to maximise flexibility going forwards
- Maximising surgical activity at Doncaster, Bassetlaw and Mexborough to maintain elective programme
- Ongoing clinical review & challenge of categorisation at DBTH in line with the ICS led group (ongoing) – also known as Harm Minimisation approach
- Conversion of inpatients to day case wherever possible
- Maximising use of theatre lists/sharing lists to ensure best use of theatre, surgeon, anaesthetic resources (ongoing)
- Ensure the Outstanding Theatres programme supports approach
- Increasing the number of patients of patients booked onto all lists

6. Elective: Patient Tracking List and Long-Waiters





Key issues:

- 52 week wait position has deteriorated slightly at 1310 at end June, but is still below the target of 1334
- The total number of Incomplete pathways has increased in June to 48517 from 46609 in May. Target <45607 for June, so a breach of target by 2910.
- **There was one 104 ww at the end of June.**
- The Trust Level month end 18 week performance for June 2022 is 69.1%, lower than May 2022 which was 70.7% though higher than April's performance of 68.1%, and still lower than 'normal' due to the continued impact of Covid-19.
- Monitoring all pathways waiting 78 weeks and above 20 of whom have no decision to treat, (reduced from 29 in May)

Key actions:

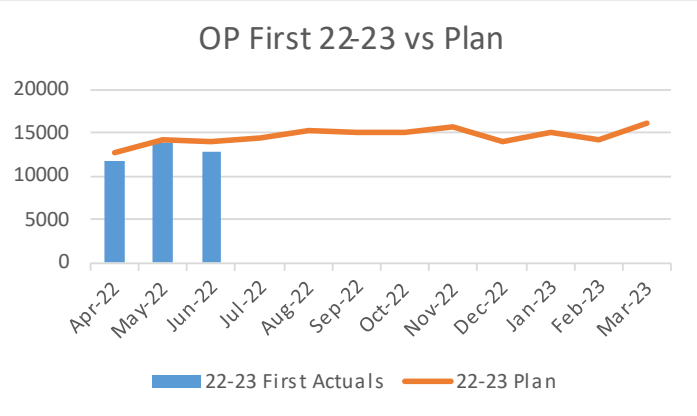
- Weekly PTL meetings maintained to ensure consistent approach across Trust to managing long waiters, both for outpatient and inpatient activity
- RTT Audits being rolled out across all clinical service areas to identify opportunities for improvement/training
- RTT training for clinicians reinstated (recent audit in gynae showed 57% incorrect clock stops)
- Maintained focus on 104 week waiters with weekly external reporting to NHSEI
- All 78 ww patient pathways man-marked and tracked
- Ongoing focus on validation at specialty level with focussed training/support to ensure highest levels of data quality

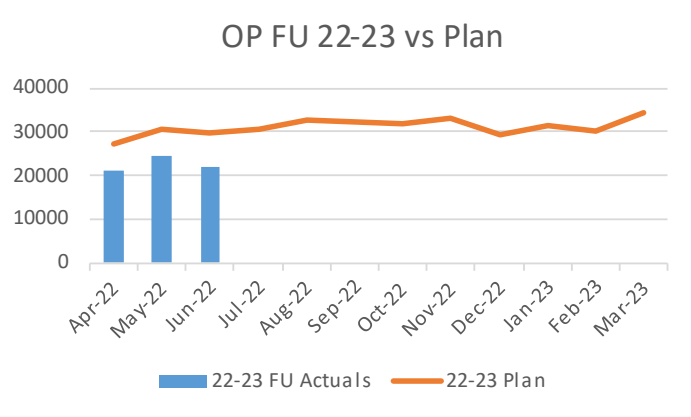
CCG	Values	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS Bassetlaw CCG	Total Waiters	9475	9440	9269	8936	8848	9014	9334	9601	9922	10234
	% Under 18 Weeks	69.6%	69.2%	70.1%	66.6%	66.2%	66.3%	67.0%	67.3%	69.8%	68.1%
NHS Doncaster CCG	Total Waiters	26793	26942	26526	26083	25967	26589	27380	28196	29327	30620
	% Under 18 Weeks	70.4%	71.4%	70.9%	67.9%	67.0%	67.1%	68.3%	67.7%	70.7%	69.4%
Trust	Total Waiters	43125	43156	42372	41503	41310	42324	43592	44961	46609	48517
	% Under 18 Weeks	69.7%	70.3%	70.5%	67.4%	66.8%	67.3%	68.3%	68.1%	70.7%	69.1%

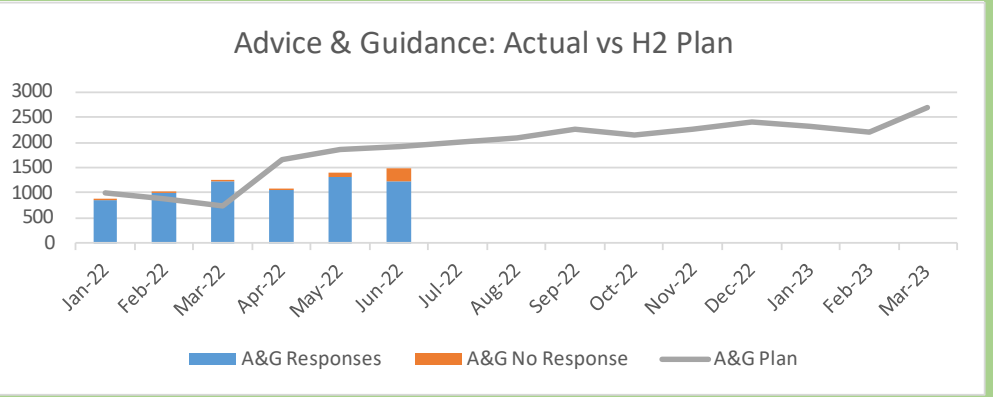
Reported 52+ Weeks: Top 6 Specialties

Specialty	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
TRAUMA & ORTHOPAEDICS	615	599	582	618	622	561	564	555	540	532	616	670	740
OPHTHALMOLOGY	139	153	193	230	252	239	275	279	287	321	317	224	150
ENT	160	131	114	106	111	107	108	119	112	96	91	103	112
GYNAECOLOGY	6	5	7	12	18	20	29	38	45	77	103	127	139
UROLOGY	81	72	89	192	81	67	92	91	92	103	88	76	88
GENERAL SURGERY	94	63	56	53	39	28	34	39	34	21	12	16	10

7. Elective: Outpatients





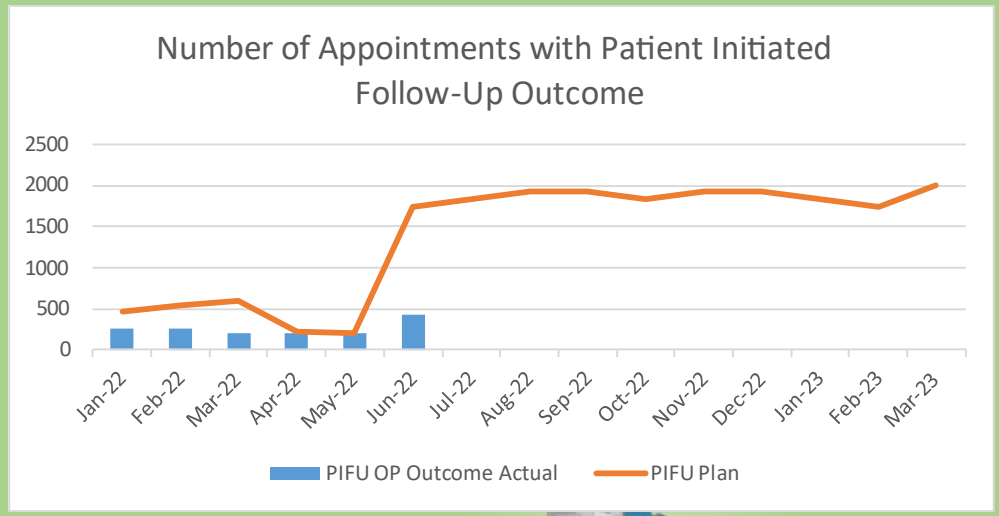


Key issues:

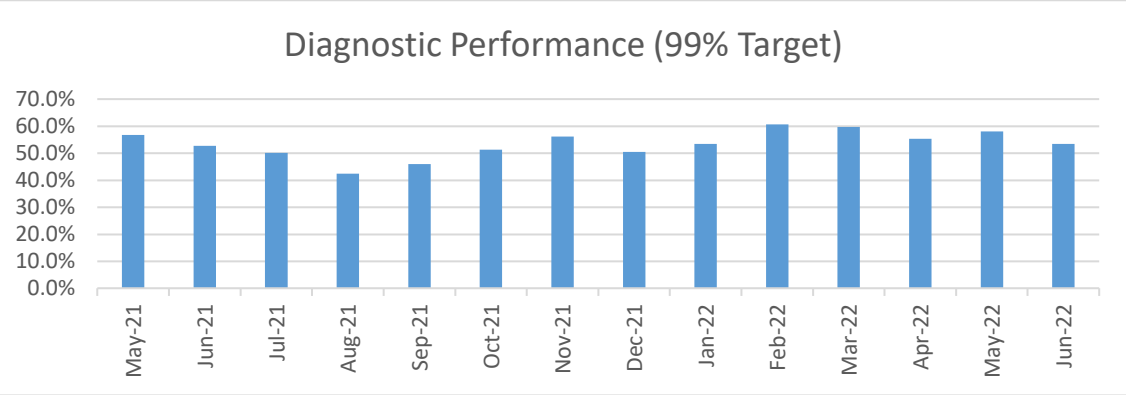
- First outpatient appointments the Trust delivered 93.0% of plan and 89.4% of 19/20 activity. A decrease on May -3.8% decrease on plan and -3.0% decrease on 19/20 activity
- Follow-up outpatient appointments the Trust delivered 74.2% of plan and 84.6% of 19/20 activity. A decrease from May -5.3% decrease on plan and -3.4% decrease on 19/20 activity
- Some activity stood down due to sickness, but also due to planned annual leave
- Patient Initiated Follow Up (PIFU) activity being rolled out in 5 more specialties with potential for digital PIFU being explored
- Advice & Guidance demand increasing, particularly from out of area – being escalated at ICS level
- PIFU plans progressing and considering open appointments as part of plan

Key actions:

- Look for opportunities to increase capacity, deal with the backlog and reduce waiting times for patients
- Review of booking rules for OP's
- Working across ICB to improve patient information, targeted support and self-management eg My Planned Care
- Increase A&G (16 per 100 OPFA by March 23)
- Embed PIFU (5% of all OP attends by March 23) across specialties
- Promote use of revised DERICK dashboards to support monitoring / improvement work
- Outstanding Outpatient focussing on 22/23 targets but also continues to develop support systems/processes
- Continued focus on validating patient pathways
- Consultant RTT training to ensure sound understanding of RTT rules and guidelines



8. Diagnostic waits



	Waiters <6W	Waiters >=6W	Total	Performance
Trust	10131	8839	18970	53.41%
NHS Doncaster	6792	5949	12741	53.31%
NHS Bassetlaw	2553	2166	4719	54.10%

Exam Type	<6W	>=6W	Total	Performance	Longest Waits
MRI	1441	242	1683	85.62%	55
CT	2789	1633	4422	63.07%	68
Non-Obstetric Ultrasound	3331	4559	7890	42.22%	57
Barium Enema	0	0	0	0	0
DEXA	434	833	1267	34.25%	39
Audiology	314	1120	1434	21.90%	49
Echo	511	334	845	60.47%	18
Nerve Conduction	146	72	218	66.97%	44
Sleep Study	16	4	20	80.00%	9
Urodynamic	41	38	79	51.90%	117
Colonoscopy	329	0	329	100.00%	5
Flexible Sigmoidoscopy	96	0	96	100.00%	5
Cystoscopy	324	4	328	98.78%	15
Gastroscopy	359	0	359	100.00%	5
Total	**10131**	**8839**	**18970**	**53.41%**	**117**

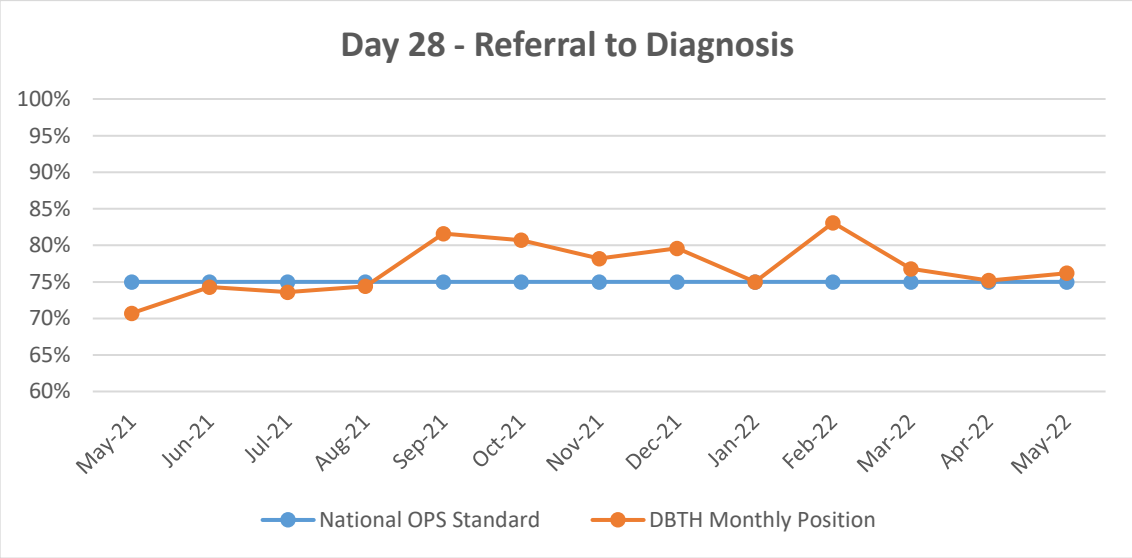
Key issues:

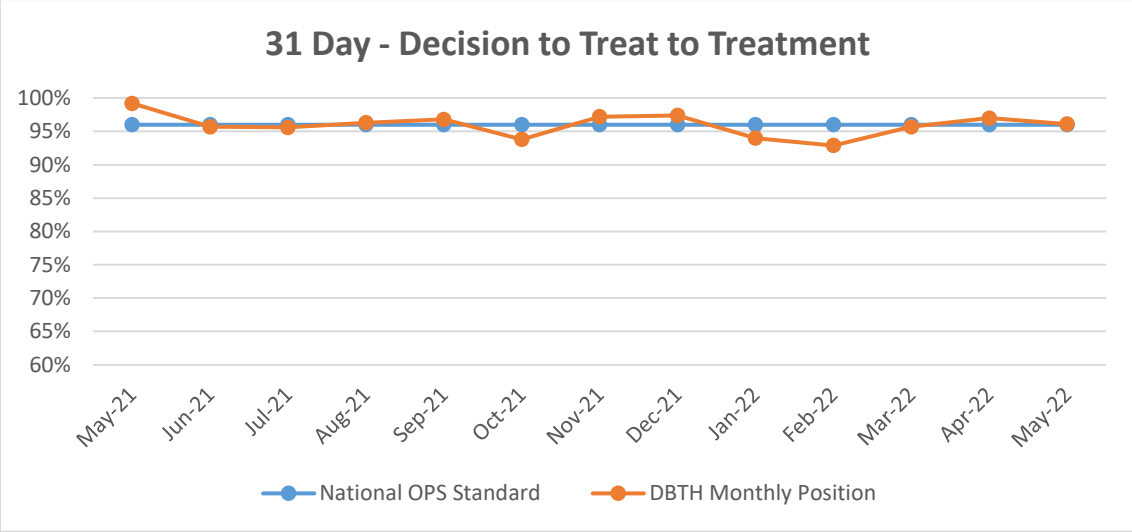
- Performance against the 6-week target decreased to 53.41% compared with 58.03% in May.
- Significant improvement was achieved in Urodynamics and Nerve Conduction Studies with increased performance of 6% and 4% respectively.
- Performance of 100% was maintained for colonoscopy and gastroscopy.
- NOUS, and DEXA remain well below target with performance between 34% and 42%.
- Audiology waits being finalised
- The number of CT waits in excess of 6 weeks increased from 1232 in May to 1623 in June, an increase of 33%.

Key actions:

- Audiology is implementing a plan delivering increased clinic capacity and less non-attendance.
- New guidelines for referral for emergency CT imaging are being applied.
- An additional 1000 NOUS scans are being performed between June and September by an insourcing provider.
- Additional CT activity is being undertaken by an insourcing provider in July and August which will deliver around 1600 scans.
- Additional CT activity will be undertaken in August and September at Montagu Hospital using a mobile scanner as part of the CDC development.

9. Cancer: Referral to Diagnosis (Faster Diagnosis Standard & Diagnosis)





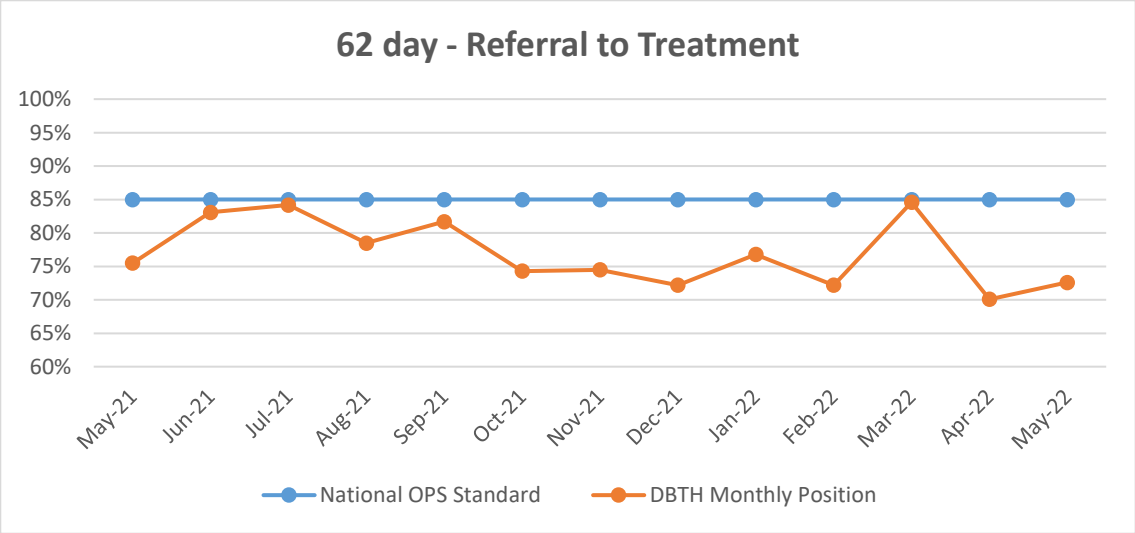
Key issues:

- Trust FDS standard compliant May 76.2% – but variability in percentage linked to core staffing resource month on month
- Management of individual diagnostic waits within the Day 28 time line impacting on individual tumour groups achieving Best Practice Time Pathway milestone events
- Reporting and review of diagnostic results attribute to significant percentage of administrative breaches within individual tumour groups
- Key staffing pressure in Histopathology from June likely to impact on turnaround times for reporting and significantly impact on all Cancer Services

Key actions:

- Continue to review position on a 3 monthly rolling model till year end to establish key themes and pinch points regarding medical and clinical resources
- Establishing a quarterly improvement trajectory for each individual tumour groups for the FDS standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard and overlay BPTP guidance.
- Histopathology pathways and transfer models linked across the wider ICS are now being reviewed

10. Cancer - Treatment



May-22	31 Day Classic	31 Day 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)***
Trust	96.1%	94.1%	100.0%	72.6%	75.9%	76.2%

Key issues:

- Complexity of pathways either based on clinical findings or Genomic testing resulting in delayed pathways
- Challenges in pathway flow linked to internal transfer between tumour sites – on going work between Skin and ENT.
- Compliance linked to Day 38 IPT impacting on Tertiary Care compliance, some of these issues can be linked to Day 28 compliance for certain tumour groups

Key actions:

- Establishing a quarterly improvement trajectory for each individual tumour groups for the 62 day standard, based on 2021/22 compliance utilising activity, breach reasons, performance against to standard. Potential to improve on Day 38 IPT transfers delays
- Reduce the number of 104 day referral to treatment breaches on classic 62 day pathway
- Patient Navigator posts established in in 6 services although funded from external funding - Business case required to ensure substantive funding n place.

11. Health Inequalities

Ethnic Category	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List Ethnicity Breakdown: July-22
Asian/Asian British	2.5%	1.1%	**2.1%**	1.5%
Black/African/Caribbean/Black	0.8%	0.5%	**0.7%**	0.6%
Mixed/multiple ethnic groups	1.1%	1.1%	**1.1%**	0.8%
Other ethnic group	0.4%	0.6%	**0.4%**	0.9%
White *	95.3%	96.7%	**95.7%**	83.9%
Not stated /Not known / NULL	0.0%	0.0%	**0.0%**	12.3%

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10%)	Doncaster Population %	Bassetlaw Population %	Doncaster and Bassetlaw Combined %	Waiting List IMD Breakdown: July-22
1	25.3%	8.3%	**20.5%**	19.9%
2	16.0%	13.2%	**15.2%**	15.3%
3	11.9%	12.6%	**12.1%**	12.7%
4	9.2%	8.5%	**9.0%**	9.2%
5	6.8%	9.2%	**7.5%**	7.6%
6	10.0%	13.4%	**11.0%**	10.8%
7	7.4%	12.3%	**8.8%**	9.0%
8	6.8%	14.0%	**8.8%**	8.5%
9	5.1%	8.4%	**6.0%**	6.0%
10	1.5%	0.0%	**1.1%**	1.0%
Unknown	0.0%	0.0%	**0.0%**	0.0%

*Based on 13/07/2022 Data

Key issues:

- Awaiting confirmation of SRO
- Delay in recruitment of Consultant in Public Health (joint funded with partners)
- 5 applications, interview date is 20th of July.

Key actions:

- Project manager now in post and initiating discovery work.
- Initially identified work streams
  - **Data set (Supply/need/demand)**
  - **Audit current position (ASIS)**
  - **Stakeholder/ initial engagement**
  - **Communication development**
  - **Education**
- Collaborative working with the community is underway (Place HI lead Mandy Espey)
- Initial Links with Midland NHS trust around work and data collections they have undertaken.

12. Performance – The Forward Look – June 2022

Priority - The Trust continues to experience significant operational challenges and to continue to focus on safety/sustainability/supporting its staff and our patients

Urgent and Emergency Care

- Establish Urgent and Emergency Care Board with focus on recovery, extending the frailty pilot
- Develop “the winter plan”
- Reduce Ambulance handover delays
- Significant focus on patients with no right to reside (approx. 2 wards worth of beds)

Elective

- Agree and embed enhanced rates payment approach across clinical teams to further reduce waiting times
- Establish Elective Recovery Board –target of 104% of 19/20
- Finalise plans for use of modular theatre and ward at DRI site from October for surgery (once central delivery suite have returned after refurb)
- Ward 19 now fully staffed with nursing team but aim to improve junior doctor cover to enable all 16 beds to be used for emergency surgery
- Maintain grip and focus on all long-waiting patients; IP challenges in ENT and ophthalmology due to sub-specialisation/orthopaedics due to demand and backlog

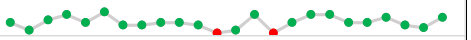
Cancer

- The Trust remains focussed on recovering its 62 day position and returning to pre-COVID performance

Category	Indicator	Benchmarking Month Reported	Peer Benchmark	National Benchmark	Latest Month Reported	CURRENT MONTH			YEAR-TO-DATE			Trend Graph (Jul-20 - 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-22	66.3%	60.2%	Jun-22	95%	70.1%	-24.9%	95%	70.5%	-24.5%	
	ED Attendances (For Monitoring Only)	-	-	-	Jun-22	-	17119	-	-	50618	-	
4 Hour Access - Trust Boarding Times	Average Wait Time (from clinically ready to proceed to admission) - Medicine	-	-	-	Jun-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Surgery	-	-	-	Jun-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Gynaecology	-	-	-	Jun-22	<1 Hour	-	-	<1 Hour	-	-	
	Average Wait Time (from clinically ready to proceed to admission) - Paediatrics	-	-	-	Jun-22	<1 Hour	-	-	<1 Hour	-	-	
Performance (NHSI Compliance Framework - Elective Care)	Max time of 18 weeks from point of referral to treatment- incomplete pathway	Apr-22	71.4%	61.7%	Jun-22	TBC	69.1%	-	TBC	69.3%	-	
	RTT 52 Week Breaches to date	-	-	-	Jun-22	1334	1310	24	1334	1310	24	
	Waiting list size - 18 Weeks referral to treatment -Incomplete Pathways	-	-	-	Jun-22	45607	48517	-2910	45607	48517	-2910	
	% waiting less than 6 weeks from referral for a diagnostics test	Apr-22	68.6%	71.6%	Jun-22	99%	53.4%	-46%	99%	55.6%	-43%	
Performance (Cancer)	Maximum 2 week wait to see a specialist for all patients referred with suspected cancer symptoms	-	-	-	May-22	93%	-	-	93%	-	-	
	Maximum 2 week wait to see a specialist for breast symptoms, even if cancer not suspected	-	-	-	May-22	93%	-	-	93%	-	-	
	Day 28 Standard (patients received diagnosis or exclusion of cancer within 28 days)	-	-	-	May-22	75%	-	-	75%	-	-	
	Maximum 31 day wait from decision to treat to first definitive treatment for all cancers	-	-	-	May-22	96%	96.1%	0%	96%	96.5%	0%	
	Maximum 31 day wait for subsequent treatment - Surgery	-	-	-	May-22	94%	94.1%	0%	94%	96.3%	2%	
	Maximum 31 day wait for subsequent treatment - Drugs	-	-	-	May-22	98%	100.0%	2%	98%	100.0%	2%	
	Maximum 62 day wait for patients on 2ww pathway to first definitive treatment	-	-	-	May-22	85%	61.5%	-23%	85%	66.9%	-18%	
	Maximum 62 wait from referral from NHS cancer screening service to first definitive treatment	-	-	-	May-22	90%	87.5%	-3%	90%	82.0%	-8%	
	Cancer Waiting Times Open Suspected Cancer Pathways 63 - 104 Days - reduction of 10% month on month (trajectory at trust level - tracking only at specialty)	-	-	-	May-22	79	-	-	79	-	-	
	Cancer Waiting Times Open Suspected Cancer Pathways 104 Days +	-	-	-	May-22	0	10	10	0	13	13	
	Non Elective Activity - Discharges	-	-	-	Jun-22	-	4460	-	-	13139	-	
	TOTAL Activity (against plan - numbers)	-	-	-	Jun-22	48788	39140	-9648	143696	118806	-24890	
	Day Case Theatre Activity (against plan - numbers)	-	-	-	Jun-22	867	765	-102	2499	2244	-255	
	In Patient Elective Theatre Activity (against plan - numbers)	-	-	-	Jun-22	394	300	-94	1144	913	-231	

Activity Against Plan	Endoscopy Activity (against plan - numbers)	-	-	-	Jun-22	1397	1301	-96	4191.351	4118	-73	
	Non-Theatre Elective Activity -excluding Endoscopy (against plan - numbers)	-	-	-	Jun-22	259.863	280	20.13701	804.2653	784	-20.2653	
	Elective Patient Activity - Independent Sector	-	-	-	Jun-22	-	25	-	-	70	-	
	Outpatient New Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Jun-22	11587	10161	-1426	34128	29845	-4283	
	Outpatient New Activity - telephone (against plan - numbers)	-	-	-	Jun-22	2204	2256	52	6549	6982	433	
	Outpatient New Activity - video (against plan - numbers)	-	-	-	Jun-22	72	69	-3	233	156	-77	
	Outpatient Follow Up Activity - face to face (Including Procedures against plan - numbers)	-	-	-	Jun-22	24773	17867	-6906	72974	53989	-18985	
	Outpatient Follow Up Activity - telephone (against plan - numbers)	-	-	-	Jun-22	5005	4267	-738	14592	13723	-869	
	Outpatient Follow Up Activity - video (against plan - numbers)	-	-	-	Jun-22	57	41	-16	180	127	-53	
	Outpatient Procedures (For Monitoring Only)	-	-	-	Jun-22	-	5805	-	-	17631	-	
	Outpatient Activity - Independent Sector	-	-	-	Jun-22	0	232	232	0	650	650	
Activity Against Value (19/20) - Elective Recovery Fund National Submission	TOTAL Activity Value (%19/20)	-	-	-	Jun-22	104%	88.31%	-15.7%	104%	88.92%	-15%	
	Day Case Theatre Activity Value (% 19/20)	-	-	-	Jun-22	104%	103.71%	-0.3%	104%	104.62%	0.6%	
	In Patient Elective Theatre Activity Value (%19/20)	-	-	-	Jun-22	104%	71.20%	-32.8%	104%	73.34%	-30.7%	
	Outpatient New Activity Value (%19/20)	-	-	-	Jun-22	104%	92.69%	-11.3%	104%	90.42%	-13.6%	
	Outpatient Follow Up Activity Value (%19/20)	-	-	-	Jun-22	75%	84.36%	9.4%	75%	85.48%	10.5%	
Addressing Health Inequalities	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
	TBC	-	-	-	-	-	-	-	-	-	-	
Performance Ambulance Handover Times	Ambulance Handovers Breaches -Number waited <= 15 Minutes	-	-	-	Jun-22	79%	36.9%	-42%	79%	40%	-39%	
	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	-	-	-	Jun-22	21%	27.1%	-6%	21%	27%	-6%	
	Ambulance Handovers Breaches-Number waited >30 Minutes	-	-	-	Jun-22	0%	35.9%	-36%	0%	32%	-32%	
Performance	Overall SSNAP Rating	-	-	-	Mar-22	B	C	-	B	C	-	
	Proportion of patients scanned within 1 hour of clock start (Trust)	-	-	-	Apr-22	48%	53.7%	6%	48%	54%	6%	
	Proportion directly admitted to a stroke unit within 4 hours of clock start	-	-	-	Apr-22	75%	39.0%	-36%	75%	39%	-36%	

Stroke	Percentage of all patients given thrombolysis	-	-	-	Apr-22	90%	100.0%	10%	90%	100%	10%	
	Percentage treated by a stroke skilled Early Supported Discharge team	-	-	-	Apr-22	24%	48.8%	25%	24%	49%	25%	
	Percentage discharged given a named person to contact after discharge	-	-	-	Apr-22	80%	53.7%	-26%	80%	54%	-26%	
Performance - Outpatients	New to Follow Up Ratio (DCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (BCCG) (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	New to Follow Up Ratio (TRUST) (For Monitoring Only)	-	-	-	Jun-22	-	1:1.78	-	-	1:1.83	-	
	Out Patients: DNA Rate (first appointment)	-	-	-	Jun-22	-	10.97%	-	-	11.33%	-	
	Out Patients: DNA Rate (Follow up appointment)	-	-	-	Jun-22	-	11.00%	-	-	10.57%	-	
	Out Patients: DNA Rate (Combined) (For Monitoring Only Target Set At Specialty Level)	-	-	-	Jun-22	-	10.99%	-	-	10.83%	-	
	Out Patients: Hospital Cancellation Rate (under 6 weeks)	-	-	-	Jun-22	-	10.93%	-	-	10.69%	-	
	Out Patients: Patient on the Day Cancellation Rate (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Backlogs - To reflect Simple PTL Excluding Active Waiters (For Monitoring Only)	-	-	-	-	-	-	-	-	-	-	
	Typing Turnaround (Trust Contract)	-	-	-	Jun-22	7WD	91WD	84WD	7WD	68WD	61WD	
	Out Patient Clinic Utilisation - Booked 2 weeks Prior	-	-	-	Jun-22	95%	61.40%	-33.60%	95%	60.44%	-34.56%	
	Out Patient Clinic Utilisation (attended)	-	-	-	Jun-22	90%	90.44%	0.44%	90%	90.03%	0.03%	
	Registered Referrals not Appointed	-	-	-	Jun-22	0	28444	28444	0	81696	81696	
	Unreconcilled Appointments 14 days + E-Reconcillation	-	-	-	-	-	-	-	-	-	-	
	Unreconcilled Appointments 14 days + CAMIS	-	-	-	-	-	-	-	-	-	-	
	ERS Advice & Guidance Response Time	-	-	-	Jun-22	2WD	3WD	1WD	2WD	3WD	1WD	
	ERS Advice & Guidance Activity (Trust)	-	-	-	Jun-22	TBC	263	-	TBC	251	-	
	Number of Specialities offering PIFU (ENT / Cardiology / Dermatology) TRUST TAB ONLY	-	-	-	-	-	-	-	-	-	-	
	% of OP appointments delivered virtually (video or telephone)	-	-	-	Jun-22	25%	19.14%	-5.86%	25%	20.02%	-4.98%	
Performance - Theatres	Theatre Booking - 4 weeks prior -Lists Populated	-	-	-	Jun-22	50%	56.34%	6.34%	50%	45.14%	-4.86%	
	Theatre Booking - 2 weeks prior -Lists Populated	-	-	-	Jun-22	75%	80.88%	5.88%	75%	77.16%	2.16%	
	Theatre Booking - 1 week prior -Lists Populated	-	-	-	Jun-22	95%	91.73%	-3.27%	95%	90.20%	-4.80%	
	Theatre Utilisation	-	-	-	Jun-22	87%	79.21%	-7.79%	87%	80.30%	-6.70%	
	Number of Prioirity 2 Patients waiting 28 days + for surgery from date of listing/P2 Categorisation	-	-	-	Jun-22	0	572	572	0	1483	1483	

Theatres	% Cancelled Operations on the day (non-clinical reasons)	-	-	-	Jun-22	1%	1.57%	-0.57%	1%	1.35%	-0.35%	
	% Cancelled Operations on the day (clinical reasons) (For Monitoring Only)	-	-	-	Jun-22	-	-	-	-		-	
	Cancelled Operations Not Rebooked within 28 Days	-	-	-	Jun-22	0	15	15	0	26	26	
	EBI (TBC)	-	-	-	Jun-22	-	-	-	-	-	-	
	Validation (TBC)	-	-	-	Jun-22	-	-	-	-	-	-	
Patients (National Requirements)	Infection Control Hosptial Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-22	2.3	2	0.3	6.9	7	-0.1	
	Infection Control Community Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-22	1	1	0	3	2	1	
	Infection Control Combined Onset C.Diff (Medicine & Surgery Only)	-	-	-	Jun-22	3.3	3	0.3	10	9	0.9	
	MRSA Cases Reported	-	-	-	Jun-22	0	0	0	0	0	0	
	HSMR (rolling 12 Months - Combined)	-	-	-	Mar-22	100	103.33	-3.33	100	103.33	-3.33	
	HSMR : Non-Elective (rolling 12 Months)	-	-	-	Mar-22	100	103.78	-3.78	100	103.78	-3.78	
	HSMR : Elective (rolling 12 Months)	-	-	-	Mar-22	100	66.39	33.61	100	66.39	33.61	
	Never Events	-	-	-	Jun-22	0	0	0	0	1	1	
	Serious Incidents Reported in Month (For Monitoring Only)	-	-	-	Jun-22	-	4	-	-	11	-	
	SI Action Plans closed within 3 months of CCG closure of incident	-	-	-	Jun-22	100%	-	-	100%	-	-	
	All open incidents on Datix to be closed within 3 months of reporting (excluding patient experience)	-	-	-	Jun-22	100%	-	-	100%	-	-	
	Pressure Ulcers - Category 4	-	-	-	Jun-22	0	0	0	0	1	-1	
	Pressure Ulcers - Category 3	-	-	-	Jun-22	4	6	-2	13	11	2	
	Pressure Ulcers - Category 2 / UNS / DTI	-	-	-	Jun-22	61	41	20	184	168	16	
	Falls with Severe Harm / Lapse in Care / SI	-	-	-	Jun-22	-	0	-	-	0	-	
	Falls with Moderate or Severe Harm	-	-	-	Jun-22	1	0	1	4	0	4	
	Complaints Resolution Performance (% achieved closure in agreed timescales with complainant)	-	-	-	Jun-22	95.0%	45.5%	-49.5%	95.0%	45.5%	-49.5%	
	Complaints Upheld / Partially Upheld by Parliamentary Health Service Ombudsman	-	-	-	Jun-22	0	0	0	0	0	0	
	Claims CNST (patients)	-	-	-	Jun-22	-	0	-	-	0	-	
	Claims LTPS - staff	-	-	-	Jun-22	-	0	-	-	0	-	
	Friends & Family Response Rates (ED)	-	-	-	Jun-22	15%	0.00%	-15%	15%	0.01%	-15%	
	Friends & Family Response Rates (Inpatients)	-	-	-	Jun-22	30%	4.69%	-25%	30%	7.21%	-23%	

	Emergency Readmissions within 30 days (PbR Methodology)	-	-	-	Sep-20	7%	6%	1.4%	7%	8%	-0.7%	
	% Reduction on LoS for patients remaining in hospital between 7-14 days compared to 2019-20	-	-	-	-	-	-	-	-	-	-	
	Mixed Sex Accommodation	-	-	-	Jun-22	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	-	-	-	Jun-22	95%	86%	-9.24%	95%	93%	-1.65%	
	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	-	-	-	Jun-22	-	-	-	-	-	-	
	% Patients Asked for Smoking Status	-	-	-	-	50%	-	-	50%	-	-	
People	Staff Flu Vaccinations (1.9.21 - 28.2.22)	-	-	-	-	-	-	-	-	-	-	
	Agenda for Change Appraisals (rolling 12 months)	-	-	-	Mar-22	90%	-	-	90%	-	-	
	Non-Medical Appraisals - in season (April - July)	-	-	-	Mar-22	90%	-	-	90%		-	
	Sickness (rolling 12 months)	-	-	-	Mar-22	4%	9%	-6%	4%	-	-	
	Job Planning (TBC)	-	-	-	Mar-22	TBC	-	-	TBC	-	-	
	SET Training	-	-	-	Mar-22	90%	84%	-6%	90%	-	-	
	Vacancies	-	-	-	-	5%	-	-	5%	-	-	
	Turnover (rolling 12 months)	-	-	-	Mar-22	10%	13%	-3%	10%	-	-	
	Casework - number of grievances opened in month	-	-	-	Mar-22	-	7	-	-	0	-	
	Casework - number of conduct cases opened in month	-	-	-	Mar-22	-	232	-	-	0	-	
	Number of Incorrect Payments (Trust Originated) (rolling 12 months)	-	-	-	Oct-21	-	25	-	-	0	-	
	Compliance with EWTD (on hold until 2021)	-	-	-	-	YES	-	-	YES	-	-	
	Time to Fill Vacancies (from TRAC authorisation - unconditional offer)	-	-	-	-	47WD	-	-	47WD	-	-	

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 25th April 2022 at 09:00 via Microsoft Teams

Present:	Neil Rhodes, Non-executive Director (Chair) Mark Bailey, Non- executive Director Kath Smart, Non-executive Director Alex Crickmar, Acting Director of Finance Jon Sargeant, Interim Director of Recovery, Innovation and Transformation	
In attendance:	Ken Anderson, Chief Information Officer Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Andrea Squires, Divisional Director of Operations for Urgent and Emergency Care James Grabham, Real World (Item C2) Alistair Nelson, Real World (Item C2) James Shillito, Real World (Item C2)	
To Observe:	Lynne Schuller, Public Governor Suzy Brain-England, Chair of the Board	
Apologies	Gillian Marsden, Deputy Chief Operating Officer – Elective Debbie Pook, Deputy Chief Operating Officer – Non-Elective	
		ACTION
FP22/04/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance. No declarations of interest were declared.	
FP22/04/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/04/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: **Action 1 – FP21/10/C1** Closed **Action 2 – FP21/11/C2** Plan was in place and would be brought back in May 2022 **Action 3 – FP21/11/D4**	

	In progress NR to escalate to RP and to be discussed further at Board **<u>Action 4 - FP21/11/G1</u>** In progress NR to escalate to RP and to be discussed further at Board **<u>Action 5 – FP22/02/G2</u>** Further update to be provided at the May 2022 meeting **<u>Action 6 – FP22/02/C2</u>** In progress – remain open until further update **<u>Action 7 – FP22/03/B1</u>** Closed	
	The Committee: • ***Noted the updates and agreed, as above, which actions would be closed.***	
	<u>Action</u>: Claudia Gammon would update the Action Log.	
FP22/04/ B1	**<u>Business Plan & Budget 2022/2023</u>** The Interim Director of Recovery, Innovation and Transformation gave an update on the small changes to the Business Plan and Budget. Timeline's: 9th March submitted to ICS with the final plan being submitted on the 17th of March, with all deadlines internally and externally being met. The Process for submitting the plan this year was more robust with all senior teams signing off their areas. The Trust was behind on some planning areas due to Covid-19 which had little impact on activity. There were some areas in diagnostics that required looking at to ensure they were compliant. Move 5% of outpatient attendances to Patient Initiated Follow Up work with ICS on cancer department. The Trust covers twice as much work in CT scans, looking to change clinical pathways for the 120% target. Discussed with ICS and understood the point. Shortage of sonographers won't hit 120% would help with back log. Movement of staff from non-obstetric to obstetric ultrasounds. The Trust had vacancies in scanning areas, this was a national shortage, the machines were available but no staff. Further to a question from the Chair about the significant number of open appointments and changing them to patient initiated follow ups. Was it correct that a large number of appointments were sitting open and required tidying up. The Interim Director of Recovery, Innovation and Transformation answered that by reducing the Patient Tracking List in some areas would be beneficial. Encourage people to use the choose and book service again after Covid-19. Following a question from Kath Smart about if the report had any financial impact on the Elective Recovery Fund. The Interim Director of Recovery Innovation and Transformation confirmed there was no financial impact to the Elective Recovery Funds. Making improvements on the backlog, with meetings happening for this over the past month had been difficult with staff absences. There were plans for modular theatre to enhance day cases. This would be discussed further at May's meeting. Kath also asked about the virtual outpatient consultants and was the 25% a national benchmark. The Interim Director of Recovery, Innovation and Transformation added that consultants don't favour virtual appointments and therefore were mostly conducting follow up calls. The Interim Acting Director of Finance gave an update of the financial plan 2022/2023. This would include an update on the context of the plan within the wider ICS, a draft plan, a deficit plan, and	

	the financial risks of the plan. Chair, Chief Executive and place level meetings and taken place to look at the plans and reduce the deficits financial gap. Reduction in trust gap by £9.1m from £34.1m deficit draft plan to £25m deficit final plan. Meetings with the ICB would support this. The drivers of the 2022/2023 financial gaps v's 2021/2022 - £25m deficit were: - 2021/2022 – surplus (H2 £2.6m surplus, H1 breakeven) - Underlying deficit - £31.6m - Sub-total - £58.9m - Draft deficit - £29.7m - Final 2022/2023 deficit - £25m Following a question from the Chair regarding achieving a solution that was acceptable to the ICB and delivering a performance. Was this a palatable level and what were the risks? The Acting Director of Finance replied that if the Trust doesn't move towards the £20.3m then there would be risk of intervention from the ICB. Meaning the Trust would lose control of its finances. The ICB have been informed of the £25m and may contact about the deficit. The Interim Director of Recovery, Innovation and Transformation commented that the next planning steps would explain the deficit, looking at organisation position on a balance sheet, looking at levels of risk, other trusts spending money, cost pressures and working to minimum standards. Further to a question from Mark Bailey regarding the Cost Improvement Programme (CIP) submission and whether the £19/20m internally changed the way the Trust operates to deliver this and what was it that was driving the non-medical costs. The Interim Director of Recovery, Innovation and Transformation answered that when everything runs well it was never more than 13m. It was recognised that improvements to grip and control and business case preparation was required. More money was required to look after the estate and IT areas. Address issue with clinical teams, changes to the CT pathways, which had doubled the workload. Some internally, should be having agreed pathways, sharing resource across alliance pathways. Shortages of staff, using agency staff and thinking of the Trust as a system. ICB approach understand the emergency pathways across hospitals and take pressure off. Further to a question from Kath Smart regarding the ICB position, their proposed position was £20m. Kath Smart also added that once the plan had been submitted this would include, imposed controlled plan, deliverability and achievability looking at multiyear CIPS before being presented at Board. Risk within agency staff as if covid goes up as well as staffing levels increasing this puts costs up. Glad that there was some push back to the ICB as this made the gap wider before singing off. Require more assurance on the pay budget and they were aligned to the workforce budget plans and how this filters to the rotas. The Acting Director of Finance confirmed that the workforce plans were carried out by each division to deliver activities within the plan, ongoing improvements in plans was being seen. Following a question from Kath Smart regarding last year's 3% CIPs and that they were a challenge and now moved to £4m what plans were to bridge the gap and investigate. The Acting Director of Finance confirmed a need to scrutinise all pay and non-pay increases and to close the gap. There were risky elements to this with funding. Looking at the resources across the system as it appears there were issues with funding. It was acknowledged there was a high risk of non-delivery around the CIP. The Interim Director of Recovery, Innovation and Transformation added that there was work to be done on how we move forward and look at the CIP gaps linking everything to delivery plans. The Acting Director of Finance concluded his item and discussed the risks and the impact of Covid-19, on delivery of the Elective Recovery Fund (ERF) including staff issues. The 4% CIP was challenging. Elective Recovery Fund (ERF) not agreed, intersystem agreements were still ongoing	

	and were different by region. Non pay inflation based on energy and utilities. 1.8m gained due to backlog maintenance in estates and medical equipment. Large capital spends Bassetlaw Emergency Village, Mexborough, and the Community Diagnostic Centre bid. Need prioritised plan and based on what we have at present. Following a question from the Chair about the medical equipment and was there a cap set. The Acting Director of Finance confirmed that each area, IT, Estates and Medical Equipment have an allocation based on the national average.	
	The Committee: - **Noted the Business Plan & Budget 2022/2023**	
FP22/04/ B2	**Recovery Update** The Interim Director of Recovery, Innovation and Transformation advised of the ongoing work on the Mexborough scheme and the modular build, a paper would be included at the next meeting. Continued work with KPMG and Real-World Health was in progress, an outline plan for structure would come back to May's meeting. The Chair raised the issue of the lack of pace in the infrastructure meetings to support the delivery of change and to seek assurance and progress through Executive team.	
	Action: - ***Raise the lack of pace in the infrastructure meetings to support the delivery of change and to seek assurance and progress through Executive Team.***	**NR**
	The Committee: - ***Noted and took assurance from the Recovery Update***	
FP22/04/ C1	**Integrated Performance Report** This item was delayed until the May meeting	
FP22/04/ C2	**Urgent and Emergency Care** Alistair Nelson from Real World Health discussed the focus on Urgent and Emergency care and the Emergency Departments performance targets. The presentation was to show the Emergency Department's performance targets for the past 3 months as a comparison to other trusts within the ICB. Improve the targets with some areas at a level 4. Looking at the ICS plan submitted last year focussing on several targets, using online web based, safety and assurance tools to capture key elements. Asses the dept every 2 hrs via escalation tools to see what the environment was like. The Trust can then escalate if required to Opel levels 1-4. Both East Midlands Ambulance Service (EMAS) and Yorkshire Ambulance Service (YAS) look at direct referrals and Same Day Emergency Care (SDEC). Working with the immediate business team and in readiness of a potential CQC visit. Plan was being worked upon for a proposed urgent care centre and the relocation of patients. This would include a minor injuries unit and larger wating areas, a paper would be submitted by estates to the Executive Team meeting. One of the key elements for emergency performance was having the correct amount of medical staff The Divisional Director of Operations for Urgent and Emergency Care described that the Emergency Department was currently using rotas of which 47% of staff were locum/bank. The have	

	developed a recruitment plan to close gaps, currently recruited 4 new consultants and budgeted for 28 middle grades. There were 8 in post, a further 5 recruited and 10 more positions have been advertised. International roles and educational roles were also being promoted; this should then reduce the number of agency staff. Alistair Nelson explained that another area of concern that had an impact on the Emergency Department was Acute Medical Decision Unit (AMDU) due to pressures at the front door. It wasn't as efficient therefore over the next few weeks a pilot would be trialled and developed to have the Clinical Decisions Unit running. Another focus was the 4 hr improvement trajectories and continuing to look at triage and Acute Medical Decision Unit (AMDU) including the staff involved within this. Compared to other trusts in the ICB Doncaster was in the upper section along with Sheffield. The Trusts handover breaches were reducing especially at Doncaster however, Bassetlaw attendances had gone up. Following a question from Kath Smart about the Emergency Department staffing position and to understand if the posts were existing and not filled or if they were new? Alistair Nelson confirmed that they were existing posts. Kath Smart asked another question about the change in improvement plans in the Emergency Department and had there been any staff feedback on the changes. The Divisional Director of Operations for Urgent and Emergency Care confirmed that the work via the Emergency Department Organisation Development programme continually develops, and they'd hope to close the programme at the end of April as all actions were complete. This would then be presented at the People Committee. Real World Health were working with staff, to understand what was needed. Following a final question from Kath Smart about ambulance handover and whether previous actions were being investigated and assurance was required. The Divisional Director of Operations for Urgent and Emergency Care explained that the paper was for a month-by-month period. The actions appeared closed but were still in progress. Make improvements sustainable and take them further, this was a large piece of work and would take time to embed. Following a question from Mark Bailey regarding the layout of the areas and what was the overall performance, what was the operating model and was it written down as to how the department would work. The Divisional Director of Operations for Urgent and Emergency Care explained that an overview of the work had been provided and that an operational model could be shared. The Interim Director of Recovery, Innovation and Transformation added that the urgent and emergency reporting board filter into the Finance & Performance Committee to provide assurance. There was a design model drawn up and further meetings with each division would take place to review this. James Grabham discussed the ward flow project covering a range of topics that impact length of stay in wards. The data had been difficult to gain looking at front door admissions and ward level information. Have a range of performance tools to see where areas of concern were and what requires focus. Looking at forward planning, data gathering around length of stay and the turnover. The internal delay main themes were associated with on the day discharge activities and assessments by outside care teams. The external delay main themes were associated with assessment and delivery of packages of care. Super stranded patients were those who have been in hospital for more than 21 days. Alistair Nelson confirmed the site management team were working with them to develop an operational plan. The Divisional Director of Operations for Urgent and Emergency Care added that they were piloting the plan to improve flow. Feedback would be presented at Trust Executive Group once received.	

	Following a question from the Chair regarding the next steps, Alistair Nelson confirmed that they were trying to move this on at pace and the focus was on the emergency department. Issues were that there were so many areas to pull together and keep the momentum. The next steps were confirmed as hitting trajectories and ensuring patients were in the correct places. James Grabham added that a forward plan had been created to look at discharge planning. This would maximise discharge lounge usage and the process for discharge to improve the turnover of beds. This was the final focus. The Divisional Director of Operations for Urgent and Emergency Care added that to improve the process all aspects, bringing it all together, implementing it and what we need to change. Continuously monitoring the work streams was also part of this.	
	The Committee: - ***Noted and gave assurance from the Urgent and Emergency Care Update***	
FP22/04/ C3	**Outpatient Recovery Plan** The Chair asked the Interim Director of Recovery, Innovation and Transformation to bring a revised form of this paper back to the next meeting. This was agreed and would include the outpatient follow ups.	
	Action: - ***Paper to be presented at May's F&P including the Outpatient follow up plan***	**JS/GM**
FP22/04/ D2	**Year-end Monthly Update** The Acting Director of Finance discussed the key highlights: • A £2.6m surplus year end with a forecast surplus of £2.8m • A group surplus of £2.7m and have a Trust and group position on the accounts. • Agency spend in March was £1.9m, driven by the nursing spend of £0.7m • Capital position – delivered the plan and overspent by £12,000 • Cash position – £46.4m at year-end pay increased by £5m from month 11 - dividends and capital funds pay out in month 11 to affect this. • Yearend accounts working on at present and would be presented at Audit and Risk committee before going to Board. The Chair added that the position was where the Trust wanted to be after a challenging year. Accurate picture presented throughout the year. Kath Smart commented that it was a good outcome and getting so close to predictions, when we have the walk through of the accounts ensure everything was in depth for the governors.	
	The Committee: - ***Noted and took assurance from the Year-end Monthly Update***	
FP22/04/ E1	**Board Assurance Framework SA1 and SA4** The Acting Director of Finance has updated as per year end, including the risks. One risk was given assurance on the Ledger and presented at Audit and Risk with corrective actions included.	

	Following a question from Kath Smart about agency/ temp staff and that the risk had been marked as a corrective action. The Acting Director of Finance confirmed that this was looked at and there needed to be a clearer plan.	
	The Committee: - ***Noted the Board Assurance Framework***	
FP22/04/ E2	**Corporate Risk Register** The Company Secretary explained that this was the same as the one received at Audit and Risk Committee and the only new risk was the counter fraud functional standard. Reviews have been updated and no further updates since Audit and Risk.	
	The Committee: - ***Noted and took assurance from the Corporate Risk Register***	
FP22/04 /E3	**Assurance Summary (Verbal)** The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting,*** ***- Progress against committee associated Executive's objectives,*** ***- Divisional compliance with the Trust's risk management process.***	
FP22/04/ F1	**Governor Observations** Lynne Schuller observed that shared pathways across the alliance were a good idea and the need for systems to work together. Looking at the expectations of patients, managing and changing them.	
FP22/04/ G1	**Any Other Business** There were no items for any other business	
FP22/04/ G2	**Performance Report Appendixes**	
	The Committee - ***Noted the Performance Report Appendixes***	
FP22/04/ G3	**Minutes of the Sub – Committee Meetings (Enclosure)** ***The Committee noted:*** - ***Capital Committee –21st December 2021***	

FP22/04/ G4	**Minutes of the meetings held on 19th January & 24th February 2022** - ***The Committee approved the minutes of the meetings held on the 19th January & 24th February 2022 once changes were made***	
FP22/04/ G5	**Date and time of next meeting (Verbal)**	
	Date: Thursday 26th May 2022 **Time:** 09:00 **Venue:** Microsoft Teams	
	Meeting Close: Meeting closed at 12:11	

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 26th May 2022 at 09:00 via Microsoft Teams

Present:	Neil Rhodes, Non-executive Director (Chair) Mark Bailey, Non- executive Director Kath Smart, Non-executive Director Alex Crickmar, Acting Director of Finance Jon Sargeant, Interim Director of Recovery, Innovation and Transformation	
In attendance:	Ken Anderson, Chief Information Officer Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Gillian Marsden, Deputy Chief Operating Officer – Elective Debbie Pook, Deputy Chief Operating Officer – Non-Elective	
To Observe:		
Apologies	Lynne Schuller, Public Governor	
		ACTION
FP22/05/A1	**Welcome, Apologies for Absence and declarations of interest (Verbal)**	
	The Chair welcomed members and those in attendance and welcomed Mark Day to his first F&P. No declarations of interest were declared.	
FP22/05/A2	**Requests for any other business (Verbal)**	
	None.	
FP22/05/A3	**Action Notes from Previous Meeting (Enclosure A3)** Updates were provided on the below actions: **Action 1 – FP21/11/C2** Closed as within the agenda – however a brief report would be presented at each Finance and Performance meeting. **Action 2 – FP21/11/D4** Closed as within the agenda **Action 3 – FP21/11/G1** Closed as within the agenda, a new action was opened to update on the detailed report **Action 4 – FP21/02/C2**	

	Closed as within the agenda **<u>Action 5 – FP21/02/C2</u>** The report was from KPMG had been presented at Audit and Risk committee. This would also come under the risk committee chaired by the executive medical director. Any operational issues would be presented at F&P	
	The Committee: • ***Noted the updates and agreed, as above, which actions would be closed.***	
	<u>Action</u>: Claudia Gammon would update the Action Log.	
FP22/05/ B1	**<u>Recovery Update</u>** o Sodexo Plans – within the pack however no discussion at the meeting The Interim Director of Recovery, Innovation and Transformation provided the key highlights: • The teams were finalised at the end of April/May, with the new Director of Innovation and Infrastructure starting in their new role and working with the strategy and improvement team. • The intention was that from the end of June the re structure would be in place to enable the support for the outpatients and emergency care teams. The Interim Director of Recovery, Innovation and Transformation discussed the key projects: **Bassetlaw Emergency Village** • An outline business case was to be put together before the end of June, however, there had been issues with the plan. The total cost for the scheme was £23million however the funding available was £17million but had increased to £19million. • Within the Trust the assumption was that they were working on a modern scheme with an element of modular build however, it had been planned as a traditional build with a 2-year programme. • The full business case would be presented in September 2022, with a final approvement of September 2023 and the completion of work by September 2025. • The Trust would look at the modular build for the extension and to reduce costs. The recovery directorate had been looking at the build and the programming and should hopefully be able to bring the full business case forward to March 2023 with approval. • The project team were being supported by Archus, meetings had been booked to look at the new build projects. • Discussions with the ICS maybe required to determine if the money could be drawn down from the RAC money. The Trust were given an allowance of £10million to spend this financial year on the RAC work. If the building cost ran over the year, the Trust would be required to fund the remaining.	

	Electronic patient records system • The business case would be presented on 6th June 2022. Positive feedback had been received by the centre who should receive £14m capital to create a business case. The centre had also indicated that the trust could receive some revenue support for the first years of the project. The Interim Director of Recovery, Innovation and Transformation explained there was a huge amount of work on the other three cases along with the new build. Other work included Monday.com and the governance around this. The DRIT report would be sited at the trust executive group meetings in the future along with the integrated quality performance report. The integrated quality performance report would become digital with all indicators present by June 2022. It had been agreed that the accountability meetings would be retitled to Performance Overview and Support meeting. The Chair had requested an overview/update of the projects to be received at each meeting. This would then be the basis for questions from the committee. The new meeting structure appeared to achieve grip and control around the performance, driving an elective recovery update, and managing agency budgets. The Interim Director of Recovery, Innovation and Transformation advised that meetings had been set up via Monday.com since February 2022. Any future issues surrounding grip and control would then be scrutinised at the future Performance, Overview and Support meeting. The Chair also asked about an overview of the electronic patient records and a brief update of the Bassetlaw emergency village: • The Chief Information Officer confirmed that the minister for health had provided all trusts with a target for the end of 2023 for an electronic patient record to be in place. • This would include outpatients, bookings, inpatients and pre operation assessments. At present the information was received by multiple systems, the aim was to have fewer systems. • The Interim Director for Recovery, Innovation and Transformation discussed about the Bassetlaw emergency village and that there had been an update to the emergency department with an extension area that flows through the unit to ensure the trust had the right co locations. Investigations were in place as to how a Same day emergency care unit would be placed on the site.	
	Action: - ***Produce a report to include each project from the Recovery Directorate including updates.***	**JS**
	The Committee: - **Noted and took assurance from the Recovery Update**	
FP22/05/ B2	**<u>Mexborough Trauma Work</u>** • The Interim Director for Recovery, Innovation and Transformation confirmed that a proposal had been made for an orthopaedic centre at Mexborough for 24 beds and 2 theatres.	

	• The ICS requirement initially was for knees and hip replacements. The proposal was to look at 2 and a half sessions a day which would allow 2 procedures a session. • The Trust was currently investigating into working alongside Barnsley and Rotherham with an ICS resource situated on the Mexborough site. • There were some critical success factors into this proposal: Strategic and meets business needs, potential value for money, supplier capacity and capability, potential affordability, and potential achievability. • There were several options for the build with the preferred option being a single build with beds and theatres within the same building. The other preferred options were modifying parts of the existing estate. • Modular solutions were being investigated against the preferred option with the get it right first-time requirements agreed on everything in separate areas. • The Trust were trying to keep the cost under the £15million threshold, this meant that a shortfall business case could be carried out and submitted for approval within the region. • Whilst carrying out surveys on the site more work had been established on the power supplies, inflation along with the impact of Covid-19 had increased the prices. • Additional power supply costs of £750,000 would be used from the Trusts capital funds to keep the cost below £15million • The Trust were also looking investigating into the costs of a hydrotherapy pool. • The project timetable for approval was the end of June/July, with the final full business case being assessed for approval in September. • The ICS were providing increased pressure on the 9month build, legal advice had been taken for this. • Discussions were in progress with Rotherham and Barnsley regarding the process for the business case to be seen/approved at their board further update would be received, with a six-week approval process. • A draft memorandum of understanding had been supplied with responses from Rotherham but awaiting Barnsley. • The ICS would cover any fixed costs if this couldn't be covered by the elective recovery funds. • A meeting was to take place the on 27th May with the planners from the council to discuss new rules in which the systems had to be turned around in 10days. Kath Smart asked if there were any financial risks in terms of the partners with Rotherham and Barnsley. The Interim Director of Recovery, Innovation and Transformation explained how the plan would run itself, no Trust would be disadvantaged as this work wouldn't be impacted by emergency work due to Mexborough being a non-acute site. This would allow more procedures to take place at Rotherham and Barnsley in other specialties. Both doctors and nurses from Rotherham and Barnsley would work in the unit. Mark Bailey commented about where the trust was positioned could there be any future collaboration. Also, when the Trust goes through the business case was it possible that there would be other ways to ensure it was accepted. The Interim Director of Recovery, Innovation and Transformation confirmed that the contingency plan was that it was for £15million however any additional cost for equipment maybe purchased via the Charitable Funds Committee. A hydrotherapy pool could also be built on the Mexborough site with funding from the Fred and Ann Green charity.	
	The Committee: - ***Noted and took assurance from the Mexborough Trauma Work***	

FP22/05/ C1	**<u>Integrated Performance Report</u>** The Deputy Chief Operating Officer for elective provided an update: • April had been a challenging month due to Covid-19. As a result, there were flow issues and staff sickness this impacted on elective recovery. • An elective recovery programme was being investigated to provide and care and deliver the 89 procedures that couldn't take place. • There was a slight deficit for May with the figures to date being at -29, the target was a lot higher. • The plan was to enable open ward 19 as a surgical ward on the 20th of June. The Trust were looking at the modular ward and the theatres from October 2022, currently they were used as a central delivery suite due to the continued work within women and children's. • The Trust were anticipating that the 104 weeks wait should be at zero by the end of June 2022. • Meetings with the clinical teams had been organised to help with the leadership of the recovery team. • The radiology plan had two key things that were progressing, firstly that the British medical ultrasound society guidance had been implemented. A pressure on the service was the CT scans and the increased demand from 2019/2020 and the current backlog however, a mobile scanner would be arriving on the Doncaster site in August to assist. • Recruitment and staffing were still an issue, junior staff, clinical health care workers were part of a training programme to become radiographers. The Chair referenced the ability to get some traction, helping with the ways that the Trust used to work prior to Covid-19. One of the large items for this committee was the new meeting structure which would allow the executives to have grip and manage resistance to change. The Chair Level asked what the was the level of confidence that the Trust have reached so far. The Deputy Chief Operating Officer for Elective confirmed there had been focus group meetings over a 12-week period, there was nervousness within the departments initially. However, once they had been participating in them, they provided good feedback. The Interim Director of Recovery, Innovation and Transformation confirmed that the new performance overview and support meetings would replace the old focus and delivery meetings. Further to a question from Kath Smart regarding elective surgery, day case inpatients and tracking waiting lists, do some areas require extra support with performance. The Deputy Chief Operating Officer confirmed that ophthalmology, trauma, and orthopaedics still required extra support. Due to an increased spike in trauma activities within the previous two weeks 22 procedures had been cancelled. Ophthalmology, Ear, Nose and Throat and trauma and orthopaedics were continued pressures within the ICS. A piece of work had taken place to	

ensure some patients had been reviewed via primary care instead of secondary care. Continued work was taking place across the SYB. Kath Smart added that a lot of time had been invested into the Quality Improvement and trauma and orthopaedics areas. The Chair added how new issues in trauma and orthopaedics would be raised. The Interim Director of Recovery, Innovation and Transformation explained that this would be escalated to Richard Parker OBE then to Finance and Performance. Understanding the trauma side and working with consultants was key.

The Deputy Chief Operating Officer for non-elective provided an update:

- The performance had been difficult throughout April, with a Covid-19 peak of 215 active cases at the highest. The figures were now declining.
- The 4hr attendance was at 71.49% within the Emergency Department
- The 12hr wait in the emergency department was now being reported and were recording about 3.6%
- There were two main reasons for breaches, the first was for review and early medical assessment via all specialties and the second was the flow out of the emergency department
- Continued work was taking place on the length of stay of patients
- There was improved data in the nerve centre with further investigations taking place on improving the no right to reside.
- Working with partners on the ambulance performance and handover work. Ongoing work was taking place across South Yorkshire on the ambulance performance and the triggers. This would allow the Trust to gain a better view of other trusts and their triggers.
- Same day emergency care pathways had been opened to ambulance services, east midlands ambulance services for Bassetlaw and working with the Nottinghamshire ICS.

Further to a question asked by Kath Smart regarding the discharge process, delays and working with partners, what was the outcome from this and were there any challenges within social care.
The Deputy Chief Operating Officer for non-elective explained that transitional beds were available and were used when patients were awaiting care packages.
Further work on figures was being carried out, as in December 2021 100 delays were reported internally with the figures now showing at 70. Benchmarking of the data along with shadow reporting would take place and would then be presented back to the Trust Executive Group meeting.
Kath Smart also requested some assurance on the 'positive steps' programme in Doncaster and working with Rotherham Doncaster and South Humber Foundation Trust.
The Deputy Chief Operating Officer for non-elective responded that transitional care was taking place where there were beds, they were filled, and 10 extra beds were opening until the end of June 2022. Rotherham Doncaster and South Humber Foundation Trust main issue was physiotherapy, a Chief Operating Officer meeting would take place to look at moving forward.

	Following a question from Mark Bailey regarding an end date on red to green discharge pathway once it's set in place. The Deputy Chief Operating Officer confirmed that there would never be an end date and it would be refreshed with further training as new people start. For next 6 months there would be continued work on training and imbedding this. The Interim Director of Recovery, Innovation and Transformation added that there was a project plan with smart objectives which were on plan for 6months this financial. Mark Bailey also asked about general performance and was there a recovery trajectory. The Deputy Chief Operating Officer confirmed that there was until end of the financial year. A stretch target had been put into place to achieve recovery for the end of quarter 3. As the Trust know that quarter 4 was a maintenance position and was difficult. The Interim Director of Recovery, Innovation and Transformation explained that a meeting had been set up with clinical leads from the emergency department. They had been booked into diaries 6weeks in advance to ensure attendance. Virtual wards were also being investigated within respiratory and elderly care. Work from the clinical commissioning group confirmed that potentially there was 150 beds in the schemes.	
	Action - ***Recovery trajectory report to be presented including up to the end of quarter 3***	**DP**
FP22/05/ C2	**Ambulance Handover Report** The Deputy Chief Operating Officer for non-elective discussed the ambulance handover report within the Integrated Performance report.	
	The Committee: - ***Noted the Ambulance Handover Report***	
FP22/05/ C3	**Radiology Recovery Plan** The Deputy Chief Operating Officer for Elective discussed the Radiology recovery plan within the Integrated Performance report. The Chair asked the committee if there were any further questions regarding the recovery plan. Kath Smart commented about the next steps and the progress. The Deputy Chief Operating Officer confirmed that a brief report should be presented at every Finance and Performance meeting.	
	The Committee: - ***Noted the Radiology Recovery Report***	
FP22/05/ D1	**Financial Performance – Month by Month** The Acting Director of Finance provided an update: • The planning resubmission and the additional national funding of £1.57 billion had been announced. • It was split into four different pots, general inflation of £680 million this reflects the higher level of inflation in the economy. Another £150 million for ambulance trusts for the significant spends on fuel and service pressures around call handlers not for ambulance turnarounds. £345 million for commissioner pressures mainly around the funding for nursing care and the settlement schemes for Ukraine and refugees. Specific	

	pressures for £400 million that was allocated to regions to target specific issues. First three of those were recurrent, last one was non recurrent. • South Yorkshire would then receive about £40.6 million; this means that the position was that the system had a deficit of £76.7 million at the time of April submission. If all additional income was excluded, this then left the ICS with a £40 million gap. • There was an issue that if the Trust don't agree to submitting in a balanced system plan the Trust wouldn't receive the £40 million. The ICS were currently investigating if the money sits at organisational or system level or a mixture of both. • The Chief Executives had discussed at the system leaders' group that a system balance would be submitted and discussed further on the 27th of May 2022. • The Trusts pre-pandemic level of agency spend would be investigated versus the current spend and the significant increases within nursing. An outlined plan would be received and presented at the next finance and performance meeting. • An internal audit would be carried out by 360 Assurance on the processes and procedures, organisations were implementing the infection prevention and control issues against others within South Yorkshire. • If the Trust didn't sign up to a system balance plan, then they can't sign off anything without NHS1/E and the capital may be restricted in some areas. The Chair added about the risks and whether they were at system level or Trust level and if NHSE/I would authorise them. The Chair also commented that NHSI/E would require a credible plan. The Acting Director of Finance referenced that a plan would need to be submitted within the next few weeks and would require Board sign off. The Acting Director of Finance provided an update on the financial performance for month one: • A £2.6 million deficit was slightly averse to plan of £258,000. This was due to a significant underspend which would become clearer next month. Due to the pay being averse the main issue was due to temporary staffing. • Sickness rates in the Trust were the highest in the Northeast and Yorkshire region which was why temporary staff were required. Sickness levels would be challenged if it wasn't reduced and would require a clear plan on a way forward with sickness. • Capital was on plan and about 3 months earlier than in previous years and would be investigated via the new governance structure. • Corporate Investment Groups first meeting involved a lot of estates schemes being signed off. • Cash balance dropped by £13 million to £33.4 million excluding and was capital expected to be around £31 million. Following a question from the Chair regarding agency staff and if the Trust doesn't always receive the correct number of staff within the Trust, who was then responsible. The Acting Director of Finance answered that the medical human resources and education team look at the rotation into the Trust. The divisions were then informed and look at gaps if any or any over subscription, this changes every 6 months. The Deputy Chief Operating Officer for non-elective confirmed that not only were there gaps on these rotations but on sickness and study leave. The Chair also asked who provides an overview of the numbers and compares it to the finance. The Acting Director of Finance answered that finance check once the Chief Operating Officers had advised of any issues.	
	Action –	**AT**

	- ***Update on safer staffing workforce and the outline plan for reducing agency spend on nursing.***	
	<u>The Committee:</u> - ***Noted and took assurance from the Financial Performance Month by Month Report***	
FP22/05/ D2	**<u>Going Concern</u>** The Acting Director of Finance explained why the Trust was a going concern, this was due to the Trust still being required to provide services to the local area. The Trust would have a positive cash balance however, it was much less than the Trust had operated with recently. Cash committee had been on hold during Covid-19 and would observe over the next 12 months how the Trust manages cash in the admin teams. An update would be delivered via finance and performance committee. Auditors were looking at the financial plan, however, were less concerned due to the Trust receiving money for inflation which reduces the risk.	
	<u>The Committee:</u> - ***Noted and took assurance from the Going Concern Report***	
FP22/05/ E1	**<u>Board Assurance Framework SA1 and SA4</u>** The Acting Director of Finance discussed the board assurance framework for SA4 which reflects year end position and the £2.6 million surplus. The board assurance framework covers areas for example, the £25 million deficit, temporary staffing and delivering work. This was scored as a 16 due to the current position including the levels of the deficit and the levels of risk within the plan. The Trust would be at this level for the first quarter but then reassessed. Corrective actions were added, which should show that the board assurance framework was fully complete with regular updates. The Deputy Chief Operating Officer for non-elective referenced the board assurance framework for SA1 and confirmed that it was too early to reduce the risk at present and further investigations would be requires on this regularly.	
	<u>The Committee:</u> - ***Noted the Board Assurance Framework***	
FP22/05/ E2	**<u>Corporate Risk Register</u>** The Chair invited the committee to make comments on the risk register. No comments were received, and all took assurance from the report.	
	<u>The Committee:</u> - ***Noted and took assurance from the Corporate Risk Register***	
FP22/05 /E3	**<u>Committee Annual Report</u>** Kath Smart referenced the standard committee effectiveness report and that this wasn't within the annual report. FD responded tot say this is being planned.	
	<u>The Committee:</u>	

	- **Noted and took assurance from the annual report**	
FP22/05 /E4	**Assurance Summary (Verbal)** The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting,*** ***- Progress against committee associated Executive's objectives,*** ***- Divisional compliance with the Trust's risk management process.***	
FP22/05/ F1	**Governor Observations** No governors present	
FP22/05/ G1	**Any Other Business** There were no items for any other business	
FP22/04/ G2	**Performance Report Appendixes**	
	The Committee - ***Noted the Performance Report Appendixes***	
FP22/05/ G3	**Minutes of the Sub – Committee Meetings (Enclosure)** ***The Committee noted:*** - ***Capital Committee –17th March 2022*** - ***Capital Committee – 21st April 2022***	
FP22/05/ G4	**Minutes of the meetings held on 25th April 2022** - ***The Committee approved the minutes of the meetings held on the 25th of April 2022***	
FP22/05/ G5	**Date and time of next meeting (Verbal)**	
	Date: Thursday 30th June 2022 **Time:** 09:00 **Venue:** Microsoft Teams **Meeting Close:** Meeting closed at: 11:40	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

PEOPLE COMMITTEE

Minutes of the meeting of the People Committee
Held on Tuesday 3rd May 2022 at 09:00am via Microsoft Teams

Present:	Mark Bailey, Non-Executive Director Anthony Jones, Acting Director of People and Organisational Development Sheena McDonnell, Non-Executive Director (Chair) Kath Smart, Non-Executive Director Abigail Trainer, Acting Chief Nurse
In attendance:	Jayne Collingwood, Deputy Director of People and Organisational Development Dr Sam Debbage, Deputy Director of Education and Research Claudia Gammon, Corporate Governance Officer (Minutes) Paula Hill, Freedom to Speak up Guardian (Item F1) Dr Nick Mallaband, Medical Director for Workforce and Speciality Development Angela O'Mara, Deputy Company Secretary Beccy Vallance, Quality Improvement Clinical Lead
To Observe:	Mark Bright, Public Governor – Doncaster Kay Brown, Staff Governor Alexis Johnson, Governor Zoe Linton, Director of People & OD Michelle McKenzie -Smith, Head of Education Dean Royles, Humber Trust
Apologies:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary Dr Tim Noble, Executive Medical Director David Purdue, Deputy Chief Executive & Chief Nurse

		ACTION
PC22/05/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	The Chair welcomed the members and attendees. Apologies for absence were given. No conflicts of interest were declared. Welcome to Zoe Lintin and Dean Royles who were observing the meeting. This was Sheena McDonnell's last People committee as she was moving to Barnsley to become the Chair.	
PC22/05/A2	**Requests for Any Other Business (Verbal)**	
	There were no requests for any other business.	
PC22/05/A3	**Actions from previous meeting (Enclosure A3)** **Action 1 – PC21/07/G1 - Performance Assurance Framework**	

	Closed **<u>Action 2 – PC21/11/D1 - People Strategy</u>** This was deferred until the new Chief People Officer was in post and would be brought back to the July People Committee meeting **<u>Action 3 – PC21/11/C6 - Pre – Registration Learners</u>** Part of this would be covered within the Education update but would be formally updated at the June meeting.	
	The Committee: - ***Noted the updates and agreed, as above, which actions would be closed.***	
PC22/05/ B1	**<u>Sickness Absence</u>** The Acting Director of People and Organisational Development gave an update on the sickness absence deep dive however the presentation was delayed due to Covid-19. The report would show the sickness picture for the organisation supporting the trust sickness and absence figures during pandemic and lower the figures. The new reporting system now provides real time data as per the old system that was 2/3 months old. Sickness absence was a continued theme throughout the pandemic, everything was recorded, gathered, and presented to the organisation. The new process had taken a lot of the sickness management burden away from the line managers, with a central telephone line being used. This was then recorded via ESR for managers to view. Proposals had been investigated as to how the Trust could fast track some services to the teams such as occupational health. The Trust target for sickness absence was 3.5% however, this had not been achieved in the past 6 years and was usually 4%-4.5% at Trust Level. Currently the sickness rates on Friday 29th April were at 7.6% including covid and non-covid isolation. Of this 2.7% was covid confirmed cases and 4.9% non-covid absence. The non-covid absences were mostly stress related (1.42%), secondly was musculoskeletal conditions and gastro conditions were third. This was the lowest increment it had been in months. As the pandemic was high in January this had an impact and resulted in staff absences being at 13%, this had decreased slowly until April. However, the levels did go back up to 11% at the time that the government relaxed the rules. Work was being carried out with the HRD Network around the coding and that sickness absence was coded correctly. Work was in progress for those staff members that have been Covid-19 positive but have continued to work from home. Some staff may have been coded incorrectly; a future update would be received. Looking at the % rates within divisional areas estates was high and a significant amount of resource was used in this area. There were 20 staff suffering from long covid, with work being investigated with ICB to look at pathways for each case and managing through the process. The Trust were continually asking the government for updates on the approach with living with covid. As there had been a refresh of the policy and the way sickness absence was reported it then made stage 1 easier to manage and more streamlined for individuals. Training and support would be provided to managers in a workshop style. The role essential specific training was being looked into as they were regarding the toolkit, it had also been discussed about making some of the training mandatory. A new tool had been purchased to provide a more proactive approach in the recording of absence in a more detailed way.	

	Health and wellbeing have recently won an award and nominated for another award. Working with ICS over the Health and Wellbeing to put things in place. Majority of the call volume around health and wellbeing was surrounding stress and anxiety. At present 98 staff off with this which was higher than in previous months and require support. Support for occupational health as present there was a wait time of 5 days to make contact and 10 days for an appointment. Health and wellbeing were also supported by a counsellor to assist with mental health issues and working alongside charities. The Acting Director of People and Organisational Development explained the focus on the next steps and the ongoing pieces of work: • Firstly – the review and update of the covid standards, operating procedures and the alignment and the regional approach to capturing the absence correctly. • Secondly – the work around occupational health development training and support offered to managers to ensure all referrals were appropriate. The Trust was currently building on the complexity of the data across all staff groups. Following a question from Kath Smart regarding Musculoskeletal being the 2nd highest reason for absence and how do we get those staff back to work and were there any moving and handling incidents and health and safety incidents that contribute to the high level of sickness absence. The Acting Director of People and Organisational Development answered that the new central reporting absence line receives call from staff, they can subsequently be fast tracked to service e.g., occupational health. This also means that anything Musculoskeletal can be supported quicker. Provide some immediate help links with occupational health and for them to support. Kath Smart also asked about the Quality Improvement project on the sickness absence policy and when would the committee receive feedback to see where improvements were required. The Acting Director of People and Organisational Development replied that part of the process, involved managers and what was and wasn't working well. There was currently a piece of work taking place to look at the data as the sickness policy was not always being followed and providing training and support. Ensure that improvements were being made and followed across the trust. The training had good engagement from operational managers. There were two challenges, one with the system and the other people not following the system requirements. Further discussions were being made and would then be presented at the committees. Following a question from Mark Bailey regarding the long-term absence rate, and if they were able to get back to the target. Mark Bailey also asked which absence rates were high and were there any that were in corelation and boarder line of staffing. Also, what was the wellbeing referral can we get on top of stress related absence amongst staff. The Acting Director of People and Organisational Development answered that a conversation was needed on the rate and previously reviewed it looking at high levels and setting more realistic rates. The Deputy Director of People and Organisational Development also commented about the correlation between the staff survey and experience. The Deputy Director of Education and Research commented about doctors in training and their health and wellbeing, that the offer of training on the sickness absence policy should extend to them. The Deputy Director of Education and Research requested that this be presented as a future deep dive. The Chair added that putting some upstream activities into supporting staff and that training was completed. The Chair expressed that she was surprised at the numbers and volumes on the call handling, and do we have the capacity to continue in the way we are. Work had commenced alongside NHS E/I to investigate into the peaks in covid and as to why the trust was an outlier in	

	South Yorkshire. What were the best trusts doing differently and what do their numbers look like? The Acting Director of People and Organisational Development confirmed that the ICS had been contacted to look at the figures from other trusts. Acting Chief Nurse explained that as part of Health and Wellbeing for all new starters including the international nurses and health care assistants that they undertake mandatory training. 10 practice development staff have been funded as part of the Chief Nurse Charitable Funds for 6 months to introduce/welcome/support new staff on and off the wards.	
	The Committee: - ***Noted and reviewed the Sickness Absence Report***	
PC22/05/ C1	**Board Assurance Framework – True North SA2&3** The Acting Director of People and Organisational Development confirmed that the staff survey actions would be reviewed, be presented to the board, and would then come back to the committee. Also, the guardian for safe working annual report was on the agenda and the payroll survey report would come back to people committee. Following a question from Kath Smart regarding SA2 as it states that there were still some risks to staff being redeployed. Kath Smart asked did this still apply and was it relevant. The Acting Director of People and Organisational Development answered that there was still some redeployment however it was a very small number of staff. Kath Smart also asked about the leadership development programme and did it include quality improvement leader training in level 1 and 2 to be presented at people committee. The Quality Improvement Clinical Lead answered that level 2 would be in September. Following a question from the Chair regarding the listening events/focus groups and if they were still taking place across the trust as a result of the staff survey results. The Acting Director of People and Organisational Development confirmed that feedback had been gained from the listening events within the divisions. Dates for these events were yet to be confirmed. The Chair also queried about the ongoing work of the 15+ workforce risks and were we sufficiently assured on them, and nothing was missing. The Acting Director of People and Organisational Development replied that a piece of work was being carried out to identify any issues with the risks. The piece of work still requires triangulation and investigating.	
	The Committee: - ***Noted and reviewed the*** **Board Assurance Framework – True North SA2 & 3**	
PC22/05/ C2	**Workforce Assurance Report including Widening participation** The Acting Director of People and Organisational Development referred to the retirement data as this wasn't in the report but would be presented at a future meeting. Further work was being invested in to looking at the vacancy rates, investments, and welcoming new starters. Staff turnover was below the 10% benchmark in Health Care Science and Medical and Dental areas. All other areas were over the 10%. Work was continuing to support new staff members. Links within the staff survey were important to improve retention rates and bring the numbers down. This then links into the work around retirement figures, looking back over the past 4 financial years (2017/18) and including current data. There had been a steady increase in the number, in 2017 there were 161 staff that retired compared to 243 staff members in 2021. In 2017/18 93 fully retired and 68 staff flexi retired. Each year over 30% of staff opted for flexi retirement. This	

	year until the end of April 42 staff wished to retire, with 29 retired fully and 13 took flexi retirement. Looking at the age profile over the past 5 years, in 2017 35% of staff were over 50 with 7% of this being over 60, there had been a steady increase over the years. This had now risen to 10%. The Acting Director of People and Organisational Development explained that in a recent publication the NHS had received more than 7000 resignations each month. Following a question from the Chair regarding exit data to enable a more accurate understanding of why people were leaving enabling the trust to retain people rather than re recruit. The Acting Director of People and Organisational Development answered that the exit questionnaire was now being used via ESR, it links staff feedback to the termination process. Data would be investigated and presented back to the People Committee in July 2022. Look at staff survey data alongside factor into risks. The Chair asked another question about how quickly it was to fill vacancies and that it was important to work with partners and were all Health Care Assistants now in post. The Acting Director of People and Organisational Development answered that there were some areas that needed further staff and required improvement in recruitment. There had been some delays due to checks in the recruitment of the Health Care Assistants. A lot of work was to be put in to ensure that the new Health Care Assistants stayed at the trust. The Acting Chief Nurse added that there was a large recruitment drive within the next 3/6 months. A radio campaign had been signed off about all vacancies and what the trust offers. Jobs fairs and the promoting of the trust within local colleges. <u>Widening participation</u> The Deputy Director of Education and Research discussed the widening partnership and that the team have been working on a project to attract local people and become the leading supplier of excellence. There was currently no data on the process prior to starting with the organisation. A 'We Care' event was planned for July 2022. In January the first cohort of NHS cadets joined the trust. The Trust was also working with the job centre and holding virtual career events. Apprenticeships were working well 123 last year planning 173 this year. Incentive payments by government for apprenticeships. Work experience would begin in June as it was temporarily paused. The trust would welcome its first cohort of t level students in June.	
	Action: - ***Review and present 3 months of the exit questionnaire data***	**AJ**
	The Committee: - ***Noted and took assurance from Workforce Assurance Report***	
PC22/05/ C3	**<u>Education Assurance Report (Includes SET, GMC & Pre-Reg Learners)</u>** The Deputy Director of Education and Research have recently worked with estates around accommodation and the challenges it upholds. The accommodation links to aspirations for the trust to become a Neonatal Life Support (NLS) provider. There was continued work on the quality data and quality strategy framework. Close links were made with the university of Sheffield, Hull, and Lincoln with an uptake in the workforce being seen. Investment received would be used for a website to be used for Drs in training. This would enable the education team to share the educational activity. It was agreed that once the accountability meetings were set up that the Deputy Director of Education and Research would present the KPIS and how they were managed to ensure further assurance.	

	Following a comment from the Chair regarding the progress on estates and facilities along with feedback from the students about the environment. The Chair also thanked the team on behalf of the board and asked for this feedback to be passed on. The Chair and The Deputy Director of Education and Research confirmed that they would email those staff involved.	
	The Committee: - ***Noted and took assurance from the Education Assurance Report***	
PC22/05/ D1	**<u>EDI Strategy</u>** The Deputy Director of People and Organisational Development shared a brief action plan, work around inclusion/health and equalities work. There were also framework initiatives in place within quit smoking, obesity, wellbeing, know your numbers across the local communities. Working alongside the patient experience team and services they provide. This was a work in progress and was aligned. Following a question from Kath Smart regarding patients' actions around accessibility and race equality. The trust had also been giving fair treatment for all and the adjustment for sickness absence and returning to work after long term sickness absence. The Deputy Director of People and Organisational Development confirmed that there was work to do around this area and having a proactive approach was important. The Acting Director of People and Organisational Development explained that there was a phased return to work after long term sickness created a reasonable adjustment report to support the return to work and capture the data. The main aim was to return people to their substantive posts. Following a question from Mark Bailey asked about if the trust saw a trust wide plan for any type of treatments in the future to avoid duplications. The Deputy Director of People and Organisational Development answered it brings everything all together in small areas, emerging topic at system level. Once brought together it would reduce duplications, keeping focus, this was a longer-term ambition. Following a comment from the Chair about whether there was enough focus on patients, the strategy across the board and does the trust understand the difference. What do the trust wish to achieve and where do they want to get to with the strategy. The Deputy Director of People and Organisational Development answered this would be investigated and discussed further with the patient experience team.	
	The Committee: - ***Noted and took assurance from the EDI Strategy***	
PC22/05/ E1	**<u>People Strategy Action Plan</u>** The Acting Director of People and Organisational Development explained that the new strategy would be developed once the new Chief People Officer was in post. This work would be then linked with the National People Strategy updated in 2021 and any place-based plans alongside the ICB. Work was being out to ensure the trust works more collectively and collaboratively. The Chair commented that the people strategy was required to be reviewed in the future against staff survey results. The New Chief People Officer would supply this moving forward.	
	The Committee:	

	- ***Noted and took assurance from the People Strategy Action Plan***	
PC22/05/ E2	**<u>Health and Wellbeing Update</u>** The Deputy Director of People and Organisational Development explained that the health and wellbeing team were successful in receiving funds via charitable funds for the garden room. The trust was also successful in obtaining a silver award and making progress in the ambition to obtain gold. The trust was also a finalised for the employee's benefits awards 2022, this was work around the staff employment position and the highfive recognition app. Proactive work was taking place around 'On Your Feet Britain'. The Deputy Director of People and Organisational Development explained that a more detailed paper on the Vivup app would be presented at the next people committee meeting. The Chair praised the team and progress that had been made, well done on shortlisting and the focus on physical activity. Following a question from Mark Bailey regarding the rainbow rooms that were used in the pandemic to rest in, were they still available. The Deputy Director of People and Organisational Development explained that there was one room available in the main block with the others had been recommissioned for service provision. They were a good idea to have for staff to experience and have time away. The Chair added that finding sufficient space was not always possible and to look at some of the staff and accommodation areas. Conversations had been made regarding this at charitable funds previously and that the staff changing rooms and kitchens required refurbishment.	
	Action: - ***Staff facilities within the kitchens/changing rooms to be refurbished and funded via Charitable Funds committee.***	**AT/JC**
	The Committee: - ***Noted the Health and Wellbeing Update***	
PC22/05/ F1	**<u>Freedom to Speak up Annual Review</u>** The Freedom to Speak up Guardian gave an update on the annual review and that the national guardians office had been informed that guardians were required to renew their training. Case reviews would be investigated as 9 had been raised and gap analysis had been raised across the trusts to then benchmark against. Health education England training had been investigated across level 3 and all senior leadership teams. Inductions were revised and the set package had freed staff up however, it didn't leave a lot of time for staff to do level 1 and 2. Level 3 was the strategic culture. Numbers have continued to grow, a peak in Quarter 4 was seen of polycystic ovary syndrome (PCOS) and the Covid-19 vaccinations, support was provided with this. Champions were still being recruited; a relationship had also been made with the Health and Wellbeing champions and the professional nurse advocate (PNA). More focus was required around the freedom to speak up forum. October was freedom to speak up month which created extra voice, having greater involvement and support following feedback was important. Significant difference from start to the finish and looking to improve this moving forward through the strategic review. Following a question from Kath Smart regarding resources and looking at what to reconsider during 2022/23. The Freedom to Speak up Guardian answered that all current guardians were	

	permitted to contribute 20hrs. The positions have been filled and business cases had been put together with how to support the case management in the future. Kath Smart also asked another question around assurance on learning and what was required if the trust needed to review any policies and procedures. The Freedom to Speak up Guardian answered that the data was reported for staff abuse and safety. Learning and asking staff to speak about challenging items. Freedom to speak up was also discussed about being included within sharing how we care. Following a question from Mark Bailey regarding Ockenden and how does it feed into freedom to speak up. The Freedom to Speak up Guardian informed that Ockenden was required via listening events and a report would come back to people committee. The Acting Chief Nurse commented about the sharing how we care newsletter and further work that was required on the freedom to speak up. It was confirmed that work had started on this. The Acting Director of People and Organisational Development commented that it was important that this was also delivered to the executive directors and board members, then added to a board workshop in the future. It was also around Compassionate Leadership and role specific training for our leaders. The Chair added about what we were doing as a trust regarding capacity and the challenges, also about the wellbeing champions and for people to have the opportunity to speak up. This was required to pick up within the people strategy and would be monitored via the people committee.	
	Action – - ***Include Freedom to Speak up within the sharing how we care***	**PH/MH**
	The Committee: - ***Noted and took assurance from the Freedom to Speak up Annual Review***	
PC22/05/F2	**<u>Freedom to Speak up Progress</u>** <u>Trauma and Orthopaedic update</u> The Medical Director for Workforce and Speciality Development gave information that there should have been three sessions that had been delayed due to Covid-19. There had been positive engagement on the course. Discussions were being made with the Director of Recovery, Innovation and Transformation to look at single site trauma unit and to make it a sustainable department, this was yet to be signed off. Alternatively, the unit would be put back to a dual site unit. The Acting Director of People and Organisational Development added that there had been a lot of good feedback and comments from the second session in mid-March. There had been a lot of discussions around how the team interact with each other. The team had been flexible with the sessions and offered to stay after shifts to not interfere with clinical time. The new freedom to speak up had an impact on the department and was awaiting a further update on this. The Deputy Director of People and Organisational Development added the importance of working together, understanding culture change and the monitoring of this. The Freedom to Speak up Guardian added that there was a new champion within the medical team also at theatre level. <u>Emergency Department Update</u>	

	The Deputy Director of People and Organisational Development highlighted that the department have been working hard at addressing employee voice, acknowledgment in recognition and team huddles. Strong work in culture changes, efficient care work, clinical governance structures were now in place and could be embedded. Efficient Patient Care group had been set up in medicine. An online survey was presented for the emergency department of which 97 staff completed it, good feedback regarding relationships with managers and working within the area. Enjoyment in work was at 96%, sense of achievement 91%, relationships with managers 69% and overall satisfaction 83%. The request to the committee was if this could this be embedded. Following a question from The Chair regarding was there any difference in staff survey in Trauma and Orthopaedics compared to other areas and was this the same for the Emergency Department. Also how does this impact on the values of the trust. The Deputy Director of People and Organisational Development explained that the staff survey results would need to be investigated, further conversations were also required with the Chief People Officer. The Freedom to Speak up Guardian added that there wasn't much change in the emergency department staff survey. However, there were a couple of new Freedom to Speak Up in the emergency department this month, continued support and focus was required. The Chair confirmed that this was brought back to the committee due to concerns. The Medical Director for Workforce and Speciality Development added that more work was required with the new medics since the new Clinical Director was appointed and more support was required. The trust anticipated that the General Medical Council report wouldn't be acceptable, this was due to learning and staff picking up extra shifts throughout Covid-19. Mark Bailey commented that the trust was a good learning organisation with good progress and to keep it going in a positive way. The Acting Director of People and Organisational Development added that work was carried out within the medical team, how it was progressing and referenced to the workforce role, how this links in across all staff groups not just the medics. The Chair confirmed that this item should be kept on the agenda for oversite until embedded.	
	The Committee: - ***Noted and took assurance from the Freedom to Speak up Progress Report***	
PC22/05/ G1	**<u>Corporate Risk Register</u>** The Chair confirmed with the committee that they would take this paper as read and the committee agreed and there were no questions to be asked. The Acting Director of People and Organisational Development informed the committee that there was another meeting proposed for the 4th of May with 360 assurance to discuss the register and the Board Assurance Framework further.	
	The Committee: - ***Noted the Corporate Risk Register***	
PC22/05/ I1	**<u>Governor Observations (Verbal)</u>** Alexis Johnson commented about the strategic plan in South Yorkshire and that the outcomes of the staff workforce objectives need to match. Alexis also asked if there were any plans around the British Sign Language act and what the trust would be doing in order to support this, as all	

	services were now required to be accessible to the deaf. The Chair confirmed that a response would be looked at and sent back to him. Kay Brown asked about the turnover of staff and the 7000 staff leaving every year, was there anything the trust can do differently to retain the staff. The Acting Director of People and Organisational Development confirmed that there was a lot of work around this theme. Sickness absence rates for non-covid were surprisingly lower than anticipated. Trying to improve work life balance and agile working was the challenge as we come out of this wave of the pandemic. The Chair added that agile working was important and how we attract and retain staff, opportunities, and challenges. The Deputy Director of People and Organisational Development commented that the trust had the opportunity to innovate, listen to staff and talk to them, shaping them, and doing things differently with the workforce. The Acting Chief Nurse referenced that there needs to be more kindness to each other, looking forward, feedback coming from leadership and understanding they were people and how we behave with each other. Mark Bright observed about the two culture change reports on the emergency department and trauma unit were informative. Mark Bright asked about the Emergency Department questionnaire would it be repeated periodically. The Deputy Director of People and Organisational Development confirmed that the survey would be repeated, this would allow the trend line to be investigated. Mark Bright also asked about how many people were eligible to answer the questionnaire. The Deputy Director of People and Organisational Development confirmed that it was about 250 possible staff and team huddles were important to gain feedback.	
	The Committee: - ***Thanked the Governors for their observations.***	
PC22/05/ J1	**<u>Minutes of the Sub-Committee Meeting (Enclosure J1)</u>**	
	The Committee noted: i. Freedom to Speak Up Forum – 25 January 2022 ii. Equality, Diversity & Inclusion Committee – 29 November 2021 iii. Health & Wellbeing Committee – 16 February 2022	
PC22/05/ K1	**<u>Any Other Business (Verbal)</u>** There were no items of any other business.	
PC22/05/ K2	**<u>Minutes of the Meeting held on 1st March 2022</u>**	
	The Committee: - ***Approved the minutes of the meeting held on 1st March 2022.***	
PC22/05/ K3	**<u>Items of escalation to the Board of Directors (Verbal)</u>**	
	There were no items of escalation to/from: i. People Sub-Committees	

	ii. Board Sub-committees iii. Board of Directors	
PC22/05/ K4	**<u>Assurance Summary (Verbal)</u>**	
	The Committee was asked by the Chair if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives, - Divisional compliance with the Trust's risk management process.	
	The Committee were assured on behalf of the Board of Directors on: ***- Matters discussed at this meeting, with the exception of the staff survey results which would be escalated to the Board for discussion,*** ***- Progress against committee associated Executive's objectives,*** ***- Divisional compliance with the Trust's risk management process.***	
PC22/05/ K5	**<u>Date and time of next meeting (Verbal)</u>**	
	Date: Tuesday 5th July 2022 **Time: 9.00am** **Venue: Microsoft Teams** Kath Smart congratulated Sheena McDonnell on her new role and thanked her for her contributions on the People Committee.	
	Meeting closed at: 12:12pm	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit and Risk Committee
Held on Tuesday 19th April 2022 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director	
In attendance:	Matthew Bancroft, Head of Financial Services Mark Bishop, NHS Accredited Counter Fraud Specialist Laura Brookshaw, 360 Assurance Alex Crickmar, Acting Director of Finance Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Claudia Gammon, Corporate Governance Officer (Minutes) Dr Noble, Executive Medical Director Hassan Rohimun, Ernst Young Dan Spiller, Ernst Young Ruth Vernon, Assistant Director 360 Assurance	
To Observe:	Dennis Atkin, Public Governor Linda Haglauer, Public Governor	
Apologies:	Sheena McDonnell, Non-Executive Director Neil Rhodes, Non-Executive Director	**ACTION**
AR22/04/A1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	Kath Smart welcomed the members and attendees. The apologies for absence were noted.	
AR22/04/A2	**Actions from previous meeting (Enclosure A2)**	
	Updates were provided on the below actions: **Action 1 – ARC21/10/D3** Closed - On the agenda **Action 2 – ARC21/10/C1** Closed & completed **Action 3 – ARC21/10/D1** Closed & complete **Action 4 – AR22/03/C1** Closed - On the agenda	

	Action 5 – AR22/03/D3 Closed - On the agenda **Action 6 – AR22/03/F2** Action not due until July Meeting **Action 7 – AR22/03/H2** Closed & complete as circulated outside of the meeting **Action 8 – AR22/03/G1** Closed – On the agenda & noted as complete **Action 9 – AR22/03/C1** Closed – Noted any further learning from other Trusts would be fed in by M. Bishop via his regular update to ARC **Action 10 – AR22/03/F2** Closed – On the agenda – Estates at 68% compliant, Chair to circulate further information after the meeting **Action 11 – AR22/03/F2** Closed - On the agenda Chair to circulate further information after the meeting **Action 12 – AR22/03/CG1** Closed – Updated on the Corporate Risk Register **Action 13 – AR22/03/D1** Ongoing work on Patient Safety Incident Response Framework (PSIRF) and patient safety managing different aspects. 360 Assurance were assisting with a piece of work on this. Reports would also be presented at Quality and Effectiveness committee. Timescales to be agreed and outcomes to be presented at a future Audit and Risk committee.	
	The Committee - ***Noted the updates and agreed, as above, which actions would be closed.***	
AR22/04/A3	**Request for any other business (Verbal)**	
	There were no requests for any other business.	
AR23/04/B1	**External Audit Progress Update (Verbal)** Hassan Rohimun gave an overview of the audit strategy focussing on the significant risks and other areas of audit focus. New risks in 2022 included the implementation of the new fixed asset register. Valuation of the land and building had a significant impact within the financial statements and this would be assessed further by EY during their audit. IFRS 16 was delayed nationally again this year, but the preparation notes would be reviewed. Previous years issue with the pensions disclosure within the Renumeration report were likely to change and further updates were expected nationally. The Chair asked the Acting Director of Finance to comment on 2 issues for the Committee:-	

	a) the fixed asset register that was highlighted in the previous year's ISA 260 and; b) on the capacity changes at director level. The Acting Director of Finance confirmed that there was a new fixed asset register, and this had been implemented, with final checks were being carried out ahead of the final accounts. Plans have been agreed with the auditors over the new system and once checks had been carried out the ADoF believed there would not be significant risks. The Executive Director capacity was discussed and confirmed changes had been managed and additional resource had been created with the new Directorate and therefore weren't an area of great concern for the DoF. Following a question from the Chair and whether the ISA 260 would be presented this year in a timely way. Hassan Rohimun confirmed that work was to begin shortly to meet timescales. Dan Spiller added that the report would be ready prior to the next Audit and Risk year-end meeting and Auditors annual report would be presented at a Council of Governors meeting in the future.	
	The Committee: - ***Noted and approved the External Audit Progress Update***	
AR22/04/C1	**<u>Local Counter Fraud Progress Report</u>** Mark Bishop asked if there were any questions as there was no further update since the previous Audit and Risk committee meeting. Further to a question from the Chair regarding mandate fraud and where DBTH were with this. Mark Bishop confirmed that we were in a good place ahead of other trusts as we have top level cover with SBS. SBS carry out the relevant checks but also have their own fraud team. Following a question from Mark Bailey regarding the level of risk and the National Fraud Initiative risk matches. Mark Bishop answered that they accessed the risk data and investigated into the grade data.	
	The Committee: - ***Noted the Local Counter Fraud Specialist Progress Report.***	
AR22/04/C2	**<u>Counter Fraud Functional Standard Return 2022/23 (Draft)</u>** Mark Bishop explained that it was the second year that the Counter Fraud Functional standards had been set by the cabinet office for those within the public sector. Risk owners were aware, and changes had been made to the corporate risk register. Next stage was that some of the wording would be updated as only a certain number of characters able to be submitted. In response to a question asked by Kath Smart regarding how the Trust compares to others were there any that within our collaborative system that were green across all areas. Mark Bishop answered that there aren't any trusts that were. DBTH were marginally top of the collaborative group. Kath also asked that if there was any movement with the rag status's that this was to be included within the quarterly report. It was noted that the return would be signed off by the LCFS, ADoF and Chair of ARC on behalf of the Committee.	

	The Committee: - ***Noted and approved the Counter Fraud Functional Standard Return 2022/23 (Draft)***	
AR22/04/D1	**Internal Audit Progress Report and Recommendation Tracker (Enclosure D1)** Ruth explained that 360 Assurance were finalising reports on Divisional Governance, and Data Quality and issued the interim opinion. Quarter 1 22/23 plan had started and looking at the Data Protection & Security Toolkit (DPST) tool kit work, and the governance review of Race Equality audit.	
	The Committee: - ***Noted and took assurance from the Internal Audit Progress Report and Recommendation Tracker.***	
AR22/04/D2	**Stage 3 Head of Internal Audit** Ruth Vernon explained the Stage 3 Head of Internal Audit Opinion which had allocated "moderate" assurance on 2 of the 3 elements (Strategic Risk Management & Follow up of actions). 360 Assurance were not yet able to conclude on individual assignments due to outstanding work due to be completed before the overall HOIA. However, the overall opinion was likely to be moderate. The Chair commented that there was disappointment in the Stage 2 Internal Audit opinion however, this had been reported upto Trust Board for a discussion and it had been agreed there was much opportunity for things to move in the right direction. Some changes have been implemented within the Board Assurance Framework which was looking better. The Committee felt it was a fair assessment of progress, with 22/23 allowing the Trust to refresh and revitalise the risk management and to include all recommendations. The Acting Director of Finance agreed that the BAF and Risk Management needed to ensure this was more robust. Ruth Vernon confirmed that the final head of internal audit opinion would be presented at May's Audit and Risk meeting. Further to a question from Mark Bailey regarding how do the committee obtain information regarding the recommendations given, do we pick this up every year? The Chair confirmed that in October 2021 an update was provided by the Company Secretary. Ruth Vernon added that stage 1 of the upcoming 22/23 Head of Internal Audit Opinion would also be presented in October 2022, which would include updates on outstanding actions.	
	Action: - ***An update on the recommendations to be provided in October 2022 (Presentation)***	**FD/RV**
	The Committee: - ***Noted the Stage 3 Head of Internal Audit***	
AR22/04/D3	**Medicine Management Audit Report** The Medical Director explained that the Medicine Management Audit Report has been received at the meeting of the Quality and Effectiveness Committee in April, the Executive Medical Director acknowledged the identified good practice and areas of improvement. All 20 drugs to	

	wards were sampled and provided all evidence that policies and procedures were followed. Spot checks were now being performed as per the recommendations. Areas of improvement were for green prescriptions (from the GP) would be diminished and that only grey internal prescriptions would be used. An electronic prescribing system was being trialled for home delivery & this work was still in progress. The Chair asked about deadlines and if timelines and action dates are achievable. The Executive Medical Director confirmed that time lines should be looked at first however things arise and stop this from happening. The Chair also agreed with the committee that the report was required to be seen by the Governance Board due to the nature of it.	
	Action: - ***The Medical Management Audit Report to be raised with the Clinical Governance Board***	**TN**
	The Committee: - ***Noted the Medicine Management Audit Report***	
AR22/04/D4	**<u>Job Planning Update – March 2022</u>** The Executive Medical Director explained that the Allocate software was being used and required a lot of work to ensure correct. People and Organisational Development helped with adding people to the system. The job policy was updated for the Local Negotiating Committees (LNC) last year and a draft policy had been circulated amongst senior staff. The draft could then be used as a framework for job planning. From the guidance notes and training packages had been put together for Clinical Directors The Chair asked about the policy and what were the plans if it was not agreed by the LNC. The Executive Medical Director confirmed he had taken it to the LNC and it was not approved, however, he had circulated to medical colleagues and other Trusts to ensure it was reasonable and to medical directors within the region to gain feedback. It was then the plan to implement with our without LNC approval as it was a reasonable policy. Mark Bailed queried timescales and when would the Committee get assurances that the new policy and new Job Planning process was fully implemented. It was agreed this would be brought back to the July ARC with the intention that it could be confirmed that the recommendations were complete. A further question was asked by the chair about the 6 weeks pause in process due to Omicron and what effect this had and The Executive Medical Director confirmed that this has impacted timelines.	
	The Committee: - ***Noted and took assurance from the Job Planning Update – March 2022***	
AR22/04/E1	**<u>Governor Observations (Verbal)</u>** Dennis Atkin commented regarding safeguarding issues the Chair confirmed that safeguarding was discussed as part of patient safety via the Quality and Effectiveness committee. A presentation on safeguarding (previously delayed) would now be on the Trust Board agenda for May 2022. This would allow governors to ask further questions. Dennis Atkin also commented that it was good to see progression on the internal audits.	

	Linda Hagluer made no governor observations however, praised the actions.	
	The Committee - ***Noted the observations provided by the Governors.***	
AR22/04/F1	**Quarter 4 Local Security & Management Report** This item was deferred due to staff absence	
AR22/04/G1	**Corporate Risk Register** The Company Secretary commented that the only change was that the Counter Fraud were now listed within the Corporate Risk Register. The Trust was now able to track, look at grades, individual actions, and timescales to close the actions down. Since the last meeting actions had been updated by the risk owners. The Chair enquired about the progress of the 103 risks that were subject to review by the Trust Executive Group by the end of April 2022. The Company Secretary confirmed that April's Trust Executive Group meeting had been stood down, all owners had been asked to review and update the risks. The Chair acknowledged a significant number of risks had been updated, however, risk ID1517 regarding supplies and ordering of medicine was required to be referred to the Quality and Effectiveness committee. The Company Secretary confirmed that it was a national risk due to transport and covid and was being assessed by the medicine management committee and the CRR would be updated to reflect a more upto date position.	
	The Committee: - ***Noted the corporate risk register.***	
AR22/04/G2	**BAF – (Full)** The Company Secretary acknowledged this was the second month the full Board Assurance Framework had been received by the Audit and Risk Committee which included updates from the remaining sub committees of Board. Recommendations from Internal Audit in February were made to highlight changes, actions and add SA1 and 2. Detail should be discussed and interrogated at other sub committees before being presented to Audit and Risk. The Chair referenced that at the Finance and Performance Committee & People Committee had discussed key areas in the BAF, including People risks; agency spend; Capital; Culture and and many mitigations were on the agendas at sub committees. Mark Bailey recognised the improvement to the Board Assurance Framework and welcomed the updates received via the sub-committees of Board to gain a fuller picture. The Acting Director of Finance suggested that the Non-executive Directors could provide assurance after reviewing the Board Assurance Framework. Each Non-Executive Director Chair of each committee to then present the risk and score to Audit and Risk giving further detail. Shows assurance across all committees. SA4 would be updated at Finance and Performance and then be presented at Audit and Risk.	
	The Committee:	

	- ***Noted the BAF (Full)***	
AR22/04/G3	**<u>Review of Internal & External Audit (Verbal)</u>** The Acting Director of Finance updated the Committee that as 360 Assurance and EY were only part way through their first year of their new contracts and suggested that this should be received later in 2022 and he would consider what process was to be used and communicate to audit colleagues. The Chair added that this would be presented in October 2022 or January 2023 committee and a timeline was required from the ADoF.	
	Action: - ***Review of Internal & External Audits to be presented in either October 2022 or January 2023***	
	The Committee: - ***Noted and approved that the Review of Internal & External Audit performance would be presented at a future meeting***	
AR22/04/G4	**<u>Audit and Risk Terms of Reference</u>** The Company Secretary confirmed updates anticipated in May/June. The Acting Director Finance added the diagram showing where each sub-committee filtered into was required to be updated along with the membership details.	
	The Committee: - ***Noted and approved the Audit and Risk TOR once the adjustments were made.***	
AR22/04/H1	**<u>Single Tender Waiver Report (Enclosure H1)</u>** The Acting Director of Finance confirmed it was a standard report, no questions or comments were raised.	
	The Committee: - ***Noted the Single Tender Waiver Report.***	
AR22/04/H2	**<u>Losses and Compensations (Enclosure H2)</u>** The Acting Director of Finance confirmed it was a standard report, no questions or comments were raised.	
	The Committee: - ***Noted and took assurance from the Losses and Compensations Report.***	
AR22/04/II	**<u>Governor Observations (Verbal)</u>**	

	No Governor Observations were provided		
	The Committee: - ***Noted the observations provided by the Governors.***		
AR22/04/J1	**Health and Safety Committee Minutes –**		
	The Committee: - **Noted the Health and Safety Committee Minutes**		
AR22/04/K1	**Any Other Business (Verbal)** No other business was submitted		
AR22/04/K2	**Minutes of the meeting held on 24th March 2022** The Chair advised that the minutes of the March meeting needed some adjustments, hence would be approved at the May 2022 meeting		
AR22/04/K3	**Issues Escalated From/To (Verbal)** No items for escalation		
	Issues escalated from/to: **i) QEC Sub-Committees** **ii) Board Sub-Committees** **iii) Board of Directors**		
AR22/04/K4	**Assurance Summary** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives – Yes - Any new Emerging risks that have been identified from the meeting? – Audit recommendations		
AR22/04/K5	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Tuesday 20th May 2022 (Informal walk through of the accounts)** **09:30** **Microsoft Teams**	
	Date: Time: Venue:	**Tuesday 27th May 2022 (Year-end)** **09:30** **Microsoft Teams**	
	Meeting Close:	**11:35am**	

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 27th May 2022 at 09:30 via Microsoft Teams

Present:	Kath Smart, Non-Executive Director (Chair) Mark Bailey, Non-Executive Director Mark Day, Non-Executive Director Sheena McDonnell, Non-Executive Director	
In attendance:	Richard Parker OBE , Chief Executive Laura Brookshaw, 360 Assurance Alex Crickmar, Acting Director of Finance Fiona Dunn, Deputy Director of Corporate Governance/Company Secretary Claudia Gammon, Corporate Governance Officer (Minutes) Dan Spiller, Ernst Young Ruth Vernon, Assistant Director, 360 Assurance	
To Observe:	Dennis Atkin, Public Governor	
Apologies:	Neil Rhodes, Non-Executive Director	**ACTION**
AR22/05/A	**Private Meeting of Non-executive Directors, Internal Audit and External Audit**	
AR22/05/B1	**Welcome, apologies for absence and declarations of interest (Verbal)**	
	Kath Smart welcomed the members and attendees. The apologies for absence were noted.	
AR22/05/B2	**Actions from previous meeting (Enclosure A2)**	
	Updates were provided on the below actions: **Action 1 - AR21/10/D3 – Job Plan Dates** Reopened the action for the Executive Medical Director to provide a further update in July 2022 **Action 2 - AR22/03/C1 – Self-Review Tool** Closed as on the agenda **Action 3 - AR22/03/D4 – Medicine Management Audit Report** Closed as on the agenda **Action 4 - AR22/03/F2 – Violence Prevention Standards** Closed as on the agenda **Action 5 - AR22/03/H2 – Losses and Compensation – REF 22/2021** Closed as on the agenda and would be discussed further outside of the meeting	

	Action 6 - AR22/03/G1 – Corporate Risk Register Closed as on the agenda **Action 7 - AR22/03/C1 – Counter Fraud** Closed as on the agenda **Action 8 - AR22/03/F2 – SET Training under Estates Directorate** Closed as on the agenda – Estates now 68% compliant, Chair to circulate further information after the meeting **Action 9 - AR22/03/F2 – Local Security Management Report** Closed as on the agenda, Chair to circulate further information after the meeting **Action 10 - AR22/03/G1 – Corporate Risk Register** Closed as on the agenda **Action 11 - AR22/03/D1 – PSIRF Audit** Further update on this action would be at the July 2022 meeting **Action 12 - AR22/04/D3 – Medicine Management Audit Report** Clarification was required from the Executive Medical Director **Action 13 - AR22/04/D2 – Stage 3 Head of Internal Audit** No update as action was due in October 2022 **Action 14 - AR22/04/G3 – Review of Internal & External Audits** Review with internal and external auditors with a review of the timelines to be presented in October 2022.	
	The Committee - ***Noted the updates and agreed, as above, which actions would be closed.***	
AR22/05/B3	**Request for any other business (Verbal)**	
	There were no requests for any other business.	
AR23/05/C1	**DBTH Annual Report 2021/2022** The Chief Executive provided an update on the draft Annual Report and accounts, with the final report submission in June 2022. There would be minor changes to the report however, no changes would be made to the content of the report. Except for clarification on the numeration report to ensure information was correct. As per the previous year the report was slightly different due to Covid-19 requirements to manage the pandemic. The report begins with the Chair and CEO updates, performance of the Trust, items, and issues during the last financial year. The report was a true reflection of the capital and revenue developments. The report also details how the services had been impacted by some capital and other schemes that had been funded internally or by NHSE/I. Living with Covid-19 was also raised within the report and to regain the services back to a pre-Covid-19 level. The	

	renumeration tables were being investigated by the finance team to ensure the salaries were correct prior to signing off and submission. The Chair commented that the annual report had been circulated to all board members and feedback was provided to the authors. Looking at the finance committee and the significant financial and capital programmes that were delivered. The Chair asked if the report would be presented at the extra Audit and Risk meeting in June with the amendments made ahead of 22nd June 2022. The Chief Executive confirmed that the amendments would need to ensure there was consistency with the language used and changes were made prior to submission to ensure easy read. Also, to make sure the renumeration pages were correct. The updated report would then be presented at an extra audit committee ahead of the 22nd of June to finalise. The Chair added that the majority of the report had been scrutinised by the Audit Committee. Further to a question from Sheena McDonnell about the report being public facing and would the Trust produce a smaller document that would sit alongside this report providing key points. The Chief Executive added that we must make the report available to the public and had previously created a summary document with the key points highlighted. This smaller document was then used in a presentation to the governors. In previous years a YouTube video had also been used to engage with the public. The Chair asked Dan Spiller from Ernst Young about if there was anything that the committee were required to be aware of. Dan Spiller answered that all feedback had been provided to the communications team regarding wording that needed to be changed. The Acting Director of Finance added that the finance team were in the process of looking at the renumeration report. This had been tested by the external auditors and would be checked against ESR and the payslips. The Chief Executive confirmed that the report was examined thoroughly both internally and externally and some points required further explanation.	
	The Committee: - ***Noted the DBTH Annual Report 2021/22***	
AR22/05/C2	**<u>Annual Governance Statement 2021/2022 (Draft)</u>** The Chief Executive referenced the annual governance statement that was required to explain the internal controls and measures previously raised by governors as priorities. The document discussed the structure and processes, and anything referred to all the sub committees and was supported by the Charitable Funds Committee. There was still some work to be carried out ahead of the final submission of the report explaining how the Trust delivers a safe and sustainable service. The Chair highlighted some of the issues with the of internal audits that had been presented at Board, with a figure of 85% for one report. A moderate opinion had been provided which wasn't where the Trust wished to be moving into 2022/2023 and was documented within the annual governance statement. The Chief Executive added that had been no assurance rate which was disappointing, and the performance metrics should be taken post pandemic.	

	External support was undertaken with the risk management review and how the Trust would manage the outcomes moving forward via Monday.com to keep everything on track. The creation of the recovery directorate was about recovering the Trusts internal services and clinical aspects. Within the first quarter, the Trust would see the delivery of outcomes, the system structures, and processes. Laying strong foundations would ensure the Trust was able to produce outcomes. The Chief Executive hoped that questions would be addressed in quarter 1 and what was required was significant assurance at the earliest possible time. Mark Bailey commented how the Trust referenced the strength of the governance around the new directorate and would this be a further addition to governance. The Chief Executive answered that the Trust manages the way it reports risk to Board and that during the pandemic there were over 100 risks that hadn't changed in the previous two years. Investigations were carried out to ensure they were completed in a timely manner and that the board were aware. A Risk Management Committee was being implemented as a subcommittee of the Trust Executive Group to ensure everything was reviewed and mitigated to reduce the number of risks at corporate level to ward level. This allows the Trust to look at patient safety reviews and how work was carried out on claims. One report would be used to monitor and check if the Trust was on track with their plans and organise in a more structured way. Further to a question from Sheena McDonnell about if the Committee was being asked to approve the report prior to the external auditors adding their work. The Chief Executive confirmed that if there were no specific issues, final checks were complete, then the report would be noted as a draft at present. The Chair asked if a draft Annual Governance Statement report could be presented in January or March 2023. FD confirmed that this would be added to March Workplan 2023	
	The Committee: - ***Noted the Draft Annual Governance Statement 2021/2022***	
AR22/05/C3	**<u>Head of Internal Opinion & Annual Audit Report</u>** Ruth Vernon from 360 Assurance presented the full Head of Internal Opinion and Annual Audit Report for the year which follows the interim opinion via Audit and Risk and Executive Team meeting in April. 360 Assurance aim to give updates throughout the year, they had allocated a moderate assurance opinion overall. Opinions were also given to each element: • Strategic Risk Management (Board Assurance Framework and Corporate Risk Register) – Moderate Assurance given • Outturn of individual audit assignments – (Totality of audits throughout the year) - Significant Assurance given • Follow up of actions – Moderate Assurance given Ruth Vernon also referenced the 360 Annual report and that it sets out the service delivery. The Acting Director of Finance added that compared to 2 months previous this was an improved position with some work still to cover. The overall completion rate was now at 80% with most actions being closed in a timely manner. A risk meeting would be held moving forward which	

	360 Assurance would observe to ensure work was effective and progress to significant assurance. Further to a question asked by Mark Day as to how the opinion compares to previous years and had any follow ups been impacted by the pandemic. The Chief Executive replied that throughout the pandemic there had been issues with the redeployment of staff, this resulted in the outcomes of the audits suffering. There was a revised Trust Executive team structure around the risk management group, and that everything would be reviewed by the sub-committees. The Chair answered the question regarding how the opinion compares to previous years, it was a different methodology to the previous year as well as a change of auditors. The Stage 2 Internal Audit was presented in March and was escalated to Board due to being at moderate assurance, it was discussed that improvements were required for 2022/2023. Following a comment from Sheena McDonnell regarding work and what was still required on the report, the Committee require assurance on the importance, understand and appreciate the report. It had been different having two auditors within the same year both with different approaches, early warning signals from 360 Assurance had been beneficial. Sheena McDonnell asked about the patient safety incident response framework audit in plan for 2022/2023 how does it fit with the overall opinion. Ruth Vernon answered that the review on the patient safety incident response framework report was excluded from the report however, it would be included in 2022/2023. The Acting Director of Finance answered a previously asked question regarding the change from significant to moderate assurance this was due to the methodology being different and what was expected to receive significant assurance under the new audit provider. This means it was difficult to compare year on year. At present the Trust picks areas which were known for requiring support and improvement over a 3-year cycle. Following a question from Sheena McDonnell regarding areas in which the Trust chooses to improve on as a learning tool. This was a good reflection as the Trust wants to be a learning organisation and respond to the recommendations in a timely way. The Trust want to be a pushing organisation to be the best it can be.	
	Action: - ***360 Assurance to have access to the confidential Board minutes with any clinical case names removed.***	**FD**
	Action: - ***KPMG work on risk management to be presented a future meeting in July or October 2022***	**JS**
	The Committee: - ***Noted the Head of Internal Opinion & Audit Report***	
AR22/05/C4	**<u>Draft – DBTH Annual Accounts and Financial Statements 2021/2022</u>** The Acting Director of Finance mentioned there had been a walkthrough of the draft accounts on 20th May for the non-executive directors. With all key issues discussed, overall, the Trust shows a £2.6million surplus before impairments. Capital programme was delivered at £35.6million, this was in line with the plan including the modular build and the women and	

	children's incident. The Trust also ended the year with a £46.4million cash balance. Accounts were prepared on a going concern basis; this had been shared with the auditors. The draft accounts were subject to external audit, with a further meeting schgeduled in June. The Acting Director of Finance encouraged the non-executive directors to provide any feedback regarding the walk through of the accounts. The Chair asked if the governor observers could also attend the walk through of accounts next year. As the walk through wasn't minuted the Chair asked for some points to be noted: • Explained how the £11million deficit converted with a £2.6million surplus • Increase in staff and agency costs • IFRA 16 were discussed about the note in the accounts with verbal assurance provided as this had been delayed for a couple of years. • The large capital programme was referenced in the annual report • Also discussed the fixed asset register programme as this was the first year. • Recommendations were discussed from the previous year's ISA260, work was still ongoing. • Going concern, impairments, provisions, and valuations/revaluations of the large property portfolio were up to date. The Acting Director of Finance referenced the fixed asset register and that it was a new system with some issues that were being worked through. Until there were figures being added to the fixed asset register the Trust were unable to view the system fully. Dan Spiller added further detail would be presented within the ISA260, there were more issues amongst SBS than trust issues this had delayed the process. The Chief Executive added that looking at the income levels for 2021/2022 it changes the Trusts stratification from a medium trust to a large trust. Would this make a difference to the accounts. The Acting Director of Finance confirmed that the level of income doesn't impact on but unsure due to the size of the income against size of the trust, NHSI/E would be contacted as a check.	
	The Committee: - ***Noted the Draft – Annual Accounts and Financial Statements***	
AR22/05/C5	**DBTH Letters of Representation** Awaiting documents, would be presented at an extra Audit and Risk meeting in June 2022 for sign off	
AR22/05/C6	**External Audit ISA 260 Report** Awaiting documents, would be presented at an extra Audit and Risk meeting in June 2022 for sign off	
	Action: - ***Bring back information regarding how the Trust approaches 2022/2023 more efficiently to ensure the national submission date was met. This would be presented at the October 2022 meeting***	**AC**
AR22/05/C7	**DBTH Audit and Risk Committee Annual Report** Awaiting documents, would be presented at an extra Audit and Risk meeting in June 2022 for sign off	

AR22/05/D1	**Internal Audit Progress Report & Update** Ruth Vernon from 360 Assurance provided an update on the work since the Audit and Risk Committee meeting in April. Two reports had been issued in that time, divisional governance report and the data quality report. Three actions had been implemented on their original due dates Laura Brookshaw from 360 Assurance provided an update on the job planning status which remained the same, further information was required to allow 360 Assurance to validate the report. There had been 3 extension deadline requests relating to the job planning, this was due to Omicron in January 2022. New due dates had been made and continued updates would be made on the risks reports and received at the new risk committee. The Chair added that the Executive Medical Director would be invited to attend the Audit and Risk Meeting in July to provide an update on the job planning progress. Mark Bailey commented about the governance structure change programmes and how it related to job planning. The Acting Director of Finance confirmed the importance of delivering the job planning alongside patient safety. Understanding the capacity to deliver activity with extra support externally. There were some links with job planning and formalising this without any gaps would assist with the strengthening of the capacity planning. The Chair also added that the link with the open audit recommendations were a risk to the organisation and how that links with the oversite of the overdue dates that aren't managed within the organisation. The Company Secretary added that Monday.com links everything together including the risks and the job planning audit. Divisional Governance Audit Report Ruth Vernon also discussed the divisional governance report which was investigated alongside the recovery directorate to look at the senior management teams within the divisions. Three divisions were observed, medicine, clinical specialties and children's and families. After speaking to key stakeholders, attending the meetings, and looking in further detail they were all medium risks. Reporting of specialties was variable and not always consistent. The end of the exercise was to review the audits, the recovery directorate had begun pulling together the framework, concluding findings, and relating to actions already agreed and align to the framework. The Chair asked if the audit report could be circulated wider, Ruth Vernon confirmed this would be discussed and feedback would be provided. Following a question from Sheena McDonnell about where does corporate and clinical governance align, what were we looking for around the structures how it fits together and was there some work to do around that area. The Acting Director of Finance answered that under the new governance structure, accountability would have clinical elements and financial elements. Also, the risk committee would have the clinical governance group and corporate risks in one place. All risks were impacted on patient services, care and would allow more visibility. Sheena McDonnell also asked about a visual representation of the structure on how everything aligned, as this may help to gain an understanding. The Chair added that there was a draft document that would be circulated once finalised. The Company secretary confirmed that the structure had been circulated in the Board paper from Director Recovery Innovation and transformation.	

	<u>Data Quality Report Audit Report</u> Andy Mellor from 360 Assurance presented the data quality audit report, looking at the Trust performance scorecard and at three areas: falls, pressure ulcers and mortality. The report looked at how the issues were recorded at source and if they were appropriate. The Integrated Quality Performance Report was investigated against the outputs and looked at by division, this data quality audit report was given limited assurance. A key factor of the report was the falls and the accuracy of them being reported via datix. There were also some points raised regarding the mortality rates. The Chair added that this should be received at Board and Quality and Effectiveness Committee to allow them to view the findings. Sheena McDonnell raised about the number of falls and how assured the committee can be on that data. When there was limited assurance who was responsible for this and how was it received in terms of recommendations proposed. Andy Mellor answered that the feedback had been positively received on mortality and falls. The Recovery Directorate was keen for the executives to receive feedback and be responsible for their own areas. Andy Mellor added that there were differences in the information received and needed consistency. The Chair added that there was a plan in place along with kite marking to work through the integrated quality performance report. Indicators and pointers were provided on what methodology to use. The Chair added this needed to be raised at Board and executive director level. Sheena McDonnell also asked about datix with things that haven't worked as well around training and access to the system. As there had been some work with this and did it need to be factored in for the future. The Company Secretary added that as data was received from different sources then fed into datix, this then meant it had an impact on other systems. Patient safety data review was being investigated as part of the review. Sheena McDonnell referenced the health care assistants and access to datix around falls, was this being addressed in other areas and highlighted within the report. The Company Secretary referenced the patient safety work and that it all came from datix and was investigated. The Chair added that at the Finance and Performance meeting on the 26th May it was discussed that the Acting Chief Nurse would attend the June meeting to discuss further. Further to a question from Mark Bailey regarding the variations of coding and was there an issue. Andy Mellor from 360 Assurance answered that the Trust does conduct its own clinical coding audits and then shared with 360 Assurance. The early reports that were provided were of a below minimum standard, the 2nd review showed an improvement, but standards still needed to be met. The third review was in the process of being finalised. The Chair added that this was something that should be investigated by the executive medical director. The Chair concluded that as this was a limited assurance audit report it didn't feature in the Annual Governance Statement or the Head of Internal Audit Statement. Ruth Vernon confirmed this would be added to the annual governance statement.	
	Action: - ***Escalate the Data Quality report to June Board***	**KS**
	The Committee: - ***Noted the Internal Audit Progress Report & Update***	

AR22/05/F1	**<u>Quarter 4 Local Security & Management Report</u>** Matthew Gleadall provided the key points of the report: • The Trust haven't been able to get a single point of contact from the Nottinghamshire police as they don't feel there was a need for this at Bassetlaw. • There was continued work alongside South Yorkshire police and the Doncaster Royal Infirmary. • Working in partnership with SABA to improve and reduce the amount of police interventions. • There was an increase in lone worker devices in all areas and work were continuing to provide more. • Door access systems work was continuing. • Conflict resolution training was 82% compliant. • A previous incident had been raised regarding mask challenges within the report with variable data reviewed. Shenna McDonnell referred to the violence and aggression standards and where we were with them. Questions raised: Would the conflict resolution training that was a requirement for SABA be a contractual requirement? How many lone working had been issued to staff. Violence and aggression were prominent on some wards, with challenging patients, are we supporting staff and patients. Sean Tyler answered that the conflict resolution training was available for the SABA staff, there had been an increase over 12mths in the amount staff used for bed watch. Work was being carried out for patient safety and the delivery of more advanced training with all areas of the Trust being re risk assessed. The Acting Director of Finance would be the executive lead on violence and prevention. Sheena McDonnell added if there was an action plan and training on violence and aggression incidents. As SABA security were providing bed watch, what does it looks like and were we training people. This was something that the Quality and Effectiveness Committee should be aware of. The Acting Director of Finance advised that after discussions with the executive directors, and it was concluded that it would sit under the Acting Director of Finance on an interim basis and would continue via Audit and Risk until the new Chief People Officer starts. Sean Tyler added that there were currently around 189 lone working units being used and had been a 50% improvement within the community midwifery area. The Chair added that the committee needed assurance that lone workers were using the PPE that was provided to do their job and completeness of people doing work. Also, violence prevention standards and ensuing staff know that violence wasn't part of the job. There had been a group set up for staff to discuss their experiences. This required publicity to ensure staff knew of this. Sean Tyler added that this links with a quality improvement piece that was taking place to ensure the health and safety project had enough communication. Following a question from Mark Bailey regarding the operational meeting and was violence mentioned. Sean Tyler answered that violence and was discussed within areas as standard. Dennis Atkin raised that he was disappointed there was no single point of contact from Nottinghamshire police at Bassetlaw. Sean Tyler added that although the Trust don't have a lot of incidents at Bassetlaw police presence was required when they do. They were in the process of trying to set up a meeting with the police inspector to discuss this further.	

	Action: - ***Follow up to ensure that any violence issues were raised at operational management meetings***	**AC**
	The Committee: - ***Noted and took assurance from the Quarter 4 Local Security & Management Report***	
AR22/05/G1	**<u>Monitor Provider License</u>** The Company Secretary added that the annual provider license self assessment required approval by the committee. This is no longer submitted to NHSE/I and only required approval by the board. Audit and Risk were required to approve the license ahead of the Board meeting in June 2022. The Chair referred to a statement within the license regarding the governors and was the license sent to them. The Company Secretary confirmed that the governors don't receive it however, it was published on the website and available via the minutes. The statement refers to the training given. The Chair concluded that a list could be shared with the training that was provided.	
	The Committee: - ***Noted and took assurance from the Monitor Provider License***	
AR22/05/I1	**<u>Governor Observations (Verbal)</u>** Dennis Atkin raised about the transparency around the wage increases and would there be under scrutiny by the public, the Chair confirmed that this would be made clear in the renumeration report. Dennis Atkin also asked in line with the Doncaster city status and would this make the trust become a larger trust. The Chair added that the Trust were unsure on this and were hoping to receive further updates on the new hospital build in June. There was a total of 227 new hospital bids. The Acting Director of Finance added that it hadn't been mentioned about the impact of the city status and if the new build wasn't announced in June, then parliament would go into summer recess, and an update would be in the Autumn.	
	The Committee - ***Noted the observations provided by the Governors.***	
AR22/05/J1	**Information Governance Committee Minutes from the 28th of February & 28th March 2022**	
	The Committee: - ***Noted and approved the minutes from the Information Governance Committee on the 28th of February and 28th March 2022***	
AR22/05/K1	**<u>Any Other Business (Verbal)</u>** No other business was submitted	
AR22/05/K2	**<u>Minutes of the meeting held on 19th April 2022</u>** ***The Committee:***	

	- ***Noted the minutes from the meeting on the 19th of April 2022*** The Chair mentioned that additional comments were to be added for March and April 2022.		
AR22/05/K3	**<u>Issues Escalated From/To (Verbal)</u>** No items for escalation		
	Issues escalated from/to: **i) QEC Sub-Committees – Violence and Aggression report and the Data Quality report** **ii) Board Sub-Committees** **iii) Board of Directors - Data Quality report**		
AR22/05/K4	**<u>Assurance Summary</u>** The Committee was asked if it was assured, on behalf of the Board of Directors on the following matters. Any matters where assurance was not received, would be escalated to the Board of Directors: - Matters discussed at this meeting, - Progress against committee associated Executive's objectives – Yes - Any new Emerging risks that have been identified from the meeting? – Audit recommendations		
AR22/05/K5	**<u>Date and time of next meeting (Verbal)</u>**		
	Date: Time: Venue:	**14th July 2022** **09:30** **Microsoft Teams**	
	Meeting Close:	**12:00pm**	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 14th March 2022 via Microsoft Teams

Present:	Ken Anderson - Chief Information Officer Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Antonia Durham-Hall – Divisional Director – Surgery and Cancer Kirsty Edmondson Jones – Strategic Director of Estates & Facilities Eki Emovon - Divisional Director - Children and Families Anthony Jones Acting Director of People and OD Dr Tim Noble - Executive Medical Director David Purdue - Chief Nurse (Chair) Dr Jochen Seidel - Divisional Director - Clinical Specialities	
In attendance:	Richard Canetti – Deputy Director of Strategy and Improvement Dr Sudipto Ghosh – Associate Medical Director for Professional Standards and Revalidation Dr Joseph John - Medical Director for Operational Stability and Optimisation Mark Luscombe – Anaesthetics Consultant (C3) Nick Mallaband – Medical Director for Workforce and Specialty Development Gill Marsden – Deputy Chief Operating Officer – Elective Debbie Pook - Deputy Chief Operating Officer – Non-Elective Andrew Potts - Divisional Director of Operations (Clinical Specialities) Emma Shaheen – Head of Communications and Engagement Dr Alasdair Strachan - Director of Education & Research Abigail Trainer - Director of Nursing Claudia Gammon – Secretarial Support Officer (Minutes)	
Apologies:	Dr Anurag Agrawal - Divisional Director – Medicine Alex Crickmar - Acting Director of Finance Richard Parker - Chief Executive Marie Purdue - Director of Strategy and Improvement Jon Sargeant – Interim Director of Recovery, Innovation & Transformation	
		ACTION
TEG22/03/ A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees to the meeting. The above apologies for absence were noted.	
TEG22/03/ A2	**Matters Arising / Action Log**	
	An update was received: Action 1: Action deferred to April 2022 as the Director of Recovery, Innovation and Transformation was not present.	

	The Committee: - ***Noted the update and Claudia Gammon updated the action log***	
TEG22/03/ A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/03/ A4	**Requests for any other business (Verbal)** No requests for any other business were made	
TEG22/03/ A5	**CEO Update (Chief Nurse presented on behalf of the CEO)** The Chair explained that the Acute Federation would work differently with an Acute Federation Board, the delivery group would consist of nurses, medicine professionals, Chief Operating Officers and Chairs. There was a meeting on the 15th of March to discuss the finances further.	
	The Committee: - ***Noted the CEO Update***	
TEG22/03/ B1	**DBTH Strategy Development and Service Line Review (Verbal)** The Deputy Director of Strategy and Improvement explained that there was additional support from the 34 specialties. The Service Line Review was very data driven. 5 specialties had been planned however, 3 were rescheduled due to cancellations. The remaining had a target deadline of mid-May, this was high priority. The Medical Directors directorate attends each meeting to gain an insight into the future of the ICS along with the Community Diagnostic Centre at Mexborough. Following a question from the Director of Education & Research about the interlocking of the services across the sites, short timescales appeared to be disjointed and how would this be enabled amongst specialities. It was answered that some specialties were closely linked with feedback being sent to Clinical Directors. During a regional Getting it Right First Time Meeting chaired by Sheffield Teaching Hospitals the backlog for elective surgery was discussed and that it was under control. There were 5 surgical specialties, 2 of which were on a Trust level basis they were Ophthalmology and Ear Nose and Throat. The Divisional Director for Clinical Specialities asked if they had been reviewed which it was answered that they had been with follow up meetings to be discussed. Further to a question from the Strategic Director of Estates & Facilities about site strategy and if this meant that some services would come from Doncaster to Bassetlaw. It was confirmed that it was the intention to be able to operate the Service Line Reviews. Following a question from the Acting Director of People and OD about incorporating the workforce planning tool with the strategic review sessions it was confirmed that with the reviews that as the 1st hour was to discuss workforce that the workforce planning tool could be discussed within this.	
	The Committee:	

	- ***Noted the update on the DBTH Strategy Development and Service Line Review***	
TEG22/03/ C1	**<u>Operational Update</u>** The Deputy Chief Operating Officer for Non-Elective gave an operational update: - Emergency Department performance in February was at 70.88% and was at 70.05% to date - Average wait time in the Emergency Department was at 234 minutes but had been reduced to 216 minutes. - 12hrs in department had come down from 254 to 167 - Ambulance handovers have reduced from 45 minutes to 30 minutes but was higher at the weekend. - Right to reside was at 55 and was usually at 70/80 - Covid-19 numbers have risen by 20 over the past week, with 68 active patients, 98 in total and 3 in Intensive Care. - 104-week waits have dropped to 15 patients with a target for all to be seen by the end of March. The Divisional Director for Clinical Specialities asked about the 50% bed waits within the Emergency Department and was a speciality being reviewed. It was answered that it was the 1st consultation specifically overnight. A detailed report would be written and distributed moving forward to a specialty level. It was also confirmed that there was an escalation plan although this wasn't always followed. It had been escalated within operational meetings. In response to a question from the Divisional Director for Children and Families about if there was currently an issue with staffing gaps, the Deputy Chief Operating Officer confirmed that there was an issue. Out of hours and weekends were the worst times for escalation to divisions not being carried out correctly. Following on from this Director of Education & Research asked if the 1st consultation was required to be a Dr and could they be an advanced practitioner. It was answered that they could be or a nurse consultant. The Company Secretary added that the risks should be logged. There was currently a risk logged around the shortage of Dr's, this required an update and should be escalated via the risk register. When any discussions were made, they were escalated and captured via the risk log. It was confirmed by the Deputy Chief Operating Officer for Non-Elective that they would be raised at Executive Team meeting and subsequently presented at Trust Executive Group. The Chair asked if the 15 patients on the 104 week wait list all had appointment dates prior to the end of March, this was confirmed. The Chair also confirmed that the Trust has the Infection Prevention and Control report and that they were awaiting the new national guidance regarding mask wearing, visiting, and testing kits, this would be looked at by region. Also, not all divisions had new Clinical Directors in post, this would be something that would be communicated once confirmed. With the restructure of Obstetrics and Gynaecology this had been delayed in that division.	
	The Committee: - ***Noted the Operational Update.***	

TEG22/03/ C2	**<u>Restoration, Innovation and Transformation Update</u>** There was no update on this item as the Director of Restoration, Innovation and Transformation had given apologies.	
TEG22/03/ C3	**<u>Discharge from Department of Critical Care – RISK ID 2449</u>** Mark Luscombe explained that the Trusts morality rating should be at 1 and was at 1.5 for critical care. There were two factors 1). 2018 the model changed 2) Covid-19. A regional average of critical care beds used for patients more than 24hrs after discharge should be at 1.5 however, our Trust was at 10. Discharge of patients within Doncaster was extremely difficult. The % of patients discharged more than 24hrs after a decision to discharge was at 38.6 with an average of 12.9. There was a great need to act upon delayed discharge rates in Accident and Emergency with patients waiting a long time for beds. 50% of critical care patients were ward ready but there weren't sufficient beds for them. The Divisional Director of Clinical Specialities observed that it was inappropriate to have an end of life patient on critical care awaiting a bed on a ward. More patients required critical care that were awaiting surgery because of Covid-19. Critical care should flag more complex patients and ensure enough information was given by healthcare assistants. A suggestion was made that a nursing forum at matron level should be held to inform staff 72 hrs prior of discharge especially within medicine and surgery.	
	The Committee - ***Noted the Discharge from Department of Critical Care – RISK ID 2449***	
TEG22/03/ D1	**<u>Items for Escalation to the Corporate Risk Register and Review of Risks rated 15+</u>** i) Divisional Directors a. Children & Families b. Surgery c. Medicine d. CSS ii) Corporate Directors a. Digital Transformation b. Estates & Facilities The Executive Medical Director gave a follow up on the Corporate Risk Register and that this item had been moved up the agenda to ensure it was discussed and scrutinised. The risks would be reviewed division by division and down graded if required. The Chair commented that although there had been changes there was still work to be completed in updating the risks. Children's and Families risks within the division were discussed and reflected in the department, the Divisional Director asked if there was a standard way in which to write the risk descriptions and whether out Trust would benefit from outside, independent assistance. As what was deemed as high priority to one person might not be to someone else and therefore mark it differently on the register.	

	The Chair explained that all risks rated 15+ would be reviewed by the Trust Executive Group ahead of inclusion on the Corporate Risk Register. Then at every meeting the divisions would be required to provide explanations for their risks. The Company Secretary confirmed that some divisions had been approached by 360 Assurance for updates with the remaining being reviewed by KPMG. KPMG were looking at everything, if logged correctly, supporting information, some that have been logged at 15+ but not on the corporate risk register. Following a question from the Acting Director of People and OD regarding working with KPMG and any duplicates that sit within multiple subject areas. The Company Secretary confirmed that a deep dive would be presented to review the risks in further detail. KPMG would also review the descriptions and whether they required anything further, this would be captured within Datix. In the description the cause and the impact was required.	
	The Committee - ***Noted the items for escalation to the Corporate Risk Register and Review of Risks rated 15+***	
TEG22/03/ E1	**<u>Finance Update</u>** The Chair confirmed that our Trust was on track to achieve the surplus of £2.5 million at the end of the financial year with a deficit next year of £52 million. There was a lot of work to carry out alongside the ICS. Following a question from the Executive Medical Director it was confirmed that the £52 million included CCG, ICS, cost pressures and would require further negotiations with the ICS.	
	The Committee: - ***Noted the Finance Update***	
TEG22/03/ E2	**<u>Consultant Vacancies</u>**	
	There was nothing raised for this item	
TEG22/03/ F1	**<u>Any other Business (Verbal)</u>** o Repatriation of Critically Ill patients within SYB The Divisional Director of Clinical Specialities wished to alert the Trust to the Critical Care protocol that was due for ratification in the next few weeks. It should take 48hrs from when a request for a patient to be moved takes place however if a patient doesn't come in via an ambulance this can take longer as no consultant would be assigned to the patient. Patient repatriation can take longer to secure them to a ward if isolation was also required. Once the report had been ratified with in the next few weeks it would then be sited by the Executives and should also feature on the bed plan every 6/12 months. o Maternity Diverts	

	The Chair spoke about an incident within maternity services during a divert to other Trusts in which other Trusts didn't follow the ICS policy. Therefore, new guidance had been written to prevent this in the future. The Divisional Director of Clinical Specialities asked about the level of ratification within the trust for them to divert. The Chair confirmed that a large amount of scrutiny takes place. o Ward Clerks Additional ward clerks were needed however, due to cost pressures this wasn't possible and was being raised at CIG.		
TEG22/03/ G2	**Sub-Committee Reports/Minutes (Enclosure G2)**		
	No minutes were received for information due to the decision to stand them down		
TEG22/03/ G3	**Minutes of the Trust Executive Group meeting dated Monday 14th February 2022**		
	The Committee: - ***Noted and approved the minutes of the meeting dated 14th February 2022.***		
TEG22/03/ G4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Monday 11th April 2022** **14:00 – 17:00** **Via Microsoft Teams**	
	The meeting closed at 15:38		

DRAFT

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 9th May 2022 via Microsoft Teams

Present:	Ken Agwuh - Interim Divisional Director Clinical Specialties Ken Anderson - Chief Information Officer Alex Crickmar - Acting Director of Finance Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Kirsty Edmondson Jones – Strategic Director of Estates & Facilities Anthony Jones Acting Director of People and OD David Purdue - Chief Nurse (Chair) Jon Sargeant – Interim Director of Recovery, Innovation & Transformation	
In attendance:	Julie Butler - Senior Manager to the Executive Medical Director Richard Canetti - Deputy Director of Strategy, and Improvement Sam Debbage - Deputy Director of Education and Research Debbie Pook - Deputy Chief Operating Officer – Non-Elective Claire Ainsley – Strategic Programmes Manager Andrew Liles - Consilium Partners (Item B1) Andy White - Head of Capital Projects (Item C3)	
Apologies:	Dr Anurag Agrawal - Divisional Director – Medicine Antonia Durham-Hall – Divisional Director – Surgery and Cancer Eki Emovon - Divisional Director - Children and Families Nick Mallaband – Medical Director for Workforce and Specialty Development Gill Marsden – Deputy Chief Operating Officer – Elective Dr Tim Noble - Executive Medical Director Richard Parker - Chief Executive Emma Shaheen – Head of Communications and Engagement Dr Alasdair Strachan - Director of Education & Research Abigail Trainer – Acting Chief Nurse	
		ACTION
TEG22/05/ A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees to the meeting. The above apologies for absence were noted.	
TEG22/05/ A2	**Matters Arising / Action Log**	
	An update was received: Action 1: - Closed The Chair provided an update that the quality framework and strategy would be discussed within the new meeting structure at a future Trust Executive Group meeting.	

	The Committee: - ***Noted the update and Claudia Gammon updated the action log***	
TEG22/05/ A3	**Conflict of Interest (Verbal)** No conflicts of interest were declared.	
TEG22/05/ A4	**Requests for any other business (Verbal)** No requests for any other business were made	
TEG22/05/ A5	**CEO Update (Interim Director of Recovery, Innovation and Transformation presented on behalf of the CEO)** The Interim Director of Recovery, Innovation and Transformation confirmed that an issue at Bassetlaw within the Emergency Department was now resolved. The ICB financial plan was high therefore the Director of Finance had been asked to advise if further savings could be made.	
	The Committee: - ***Noted the CEO Update***	
TEG22/05/ B1	**DBTH Strategy Development and Service Line Review (Verbal)** The Deputy Director of Strategy, and Improvement explained that views were sought with regards to the sustainability of services across each site. All information and outcomes would be collated and discussed at a further Trust Executive Group meeting.	
	The Committee: - ***Noted the update on the DBTH Strategy Development and Service Line Review***	
TEG22/05/ C1	**Operational Update** The Deputy Chief Operating Officer gave an operational update: • Level 4 at Bassetlaw on the 9th of May with 14 bed waits • level 3 at Doncaster on the 9th of May with 12 bed waits – a review on whether there was a requirement for a divert • Covid-19 position was 105 patients in total, 47 active patients and none in Intensive Care • 7% sickness levels at the end of April • Right to reside figures at Doncaster were 74 patients over 7 days, 31 patients over 21 days • Right to reside figures at Bassetlaw were 25 patients over 7 days and 8 patients over 21 days. • Easter was planned well with normal sickness/absence and Covid-19 numbers • Ambulance delays been on level 4 a few weeks, progress was being made with 15 minutes improvement on handover times. • Some performance improvement but slow progress. The Interim Divisional Director for Clinical Specialties commented on the sickness percentage being at 7%. Was the Trust an outlier in the region or were we the same as others. In response to a question for better flow the Acting Director of People and	

	Organisational Development confirmed this was a total sickness rate and that the total percentage for the 9th May was 6.76%, within that 2.10% were Covid-19 confirmed cases this equates to 141 staff. The Trust were beginning to come more in line with others and were still reducing. The Deputy Chief Operating Officer added that for the late May bank holiday the same plans were being used as those used for Easter 2022. The plan was to not open any further beds for that weekend however, this would be closely monitored. The Chair also commented that he anticipated that the Level 4 incident would be lowered this week to a level 3. This would then mean that visiting would go back to normal. The Trusts anticipates that it would be at pre-covid times within the next week. Bassetlaw have been trying out a new covid-19 way of testing with the outcomes being positive. This had affected the amount of patients and lowered numbers maximising beds.	
	The Committee: - ***Noted the Operational Update.***	
TEG22/05/ C2	**<u>Capital Program 2021/2022 Review (Verbal)</u>** The Strategic Director of Estates & Facilities explained that last year they provided a summary of the delivery of the capital programme for the year and were successful. Additional funding had been received with feedback being given to NHSE/I, it was proving difficult to spend money when funding was received mid-year. The Head of Capital Projects provided an update about what had been happening over the past year. With the Estates Capital headlines for 2021/22 there was a total commitment of £25,494,000 against a budget of £25,203,000. This was made up of Capital Resource Limit (CRL) allocation of £10,364,095 and the supplementary Women & Children's funding of £14,683,000. Made up of over 120 projects with a variance to the final plan of £291,000 equating to 0.1% over the budget. The Women & Children's electrical incident, recovery and reinstatement had a total of £14,683,000, split into: Initial response and service repatriation £250,571 New electrical east riser £1,123,971 Enabling works to modular £4,296,736 Modular wards and theatres £8,214,809 South block plant room and pipework upgrade £688,913 Backlog and critical infrastructure risk had a total of £7,827,936 split into: Electrical infrastructure £1,770,000 Fire precautions 4,181,000 Water safety prevention of legionella £250,000 Care Quality Commission/minor work £335,000 Site rationalisation – south site at Bassetlaw £117,000 Roads and footpaths upgrade £171,000 Roof upgrades £37,000 Medical gas at Bassetlaw £39,000 Window Replacement and Upgrade £227,000 Nurse call upgrades and replacement £6,000	

	Asbestos abatement (on going trust wide) £115,000 Lifts £370,000 Ventilation £300,000 A further £620,000 was spent on Covid-19 to ensure safe working. A further £100,000 had been put aside for 2022/2023 but this shouldn't all be required. During the first wave there were 72 projects altogether including Doncaster switch board, provision of ventilation and air scrubbers. There were divisional priorities equating to £1,380,000, some of the schemes that were included were: - Doncaster Orthopaedic theatre storage reconfiguration - Doncaster academic hub - Doncaster endoscopy office - Bassetlaw Intensive care wet room - Bassetlaw anaesthetics on call room and S11 offices - Mexborough Union offices - Trust wide space utilisation – portacabins The infrastructure had £535,000 spent on it, this included security, site utilisation surveys and space utilisation enabling and portacabins. As well as the Capital schemes there was also the Public Dividend Capital schemes development and ongoing support for the Bassetlaw emergency village, Bassetlaw Community Diagnostic Centre, and the Mexborough Elective Orthopaedic Centre.	
	The Committee - ***Noted the Capital Program 2021/22 Review Update***	
TEG22/05/ D1	**<u>Items for Escalation to the Corporate Risk Register and Review of Risks rated 15+</u>** i) Divisional Directors a. Children & Families b. Surgery c. Medicine d. CSS ii) Corporate Directors a. Digital Transformation b. Estates & Facilities The Company Secretary confirmed that no new risks had been reported, the aim was for the divisions to report any new risks. The Directors were required to review their risks and report anything required. The Deputy Chief Operating Officer mentioned that when going through the risks there needs to be further training with the Divisional Directors as some of the risks were old and some of the scoring wasn't correct. Therefore, some were not a true reflection. The Interim Director of Recovery, Innovation and Transformation added that there was large piece of work required for the training as a lot of the risks were old, some were incidents and miss understanding on. The Interim Director of Recovery, Innovation and Transformation advised a piece of work to review risk management had been undertaken	

	and as training programme would be developed for roll out. The Chief Nurse added that this should be raised at governance committees and then reviewed and followed correctly.	
	The Committee - ***Noted the items for escalation to the Corporate Risk Register and Review of Risks rated 15+***	
TEG22/05/ D2	**<u>Governance Review (Verbal)</u>** The Interim Director of Recovery, Innovation and Transformation gave an update about the resetting of duplicate meetings and processes to work on the same plan. A way forward was to bring all those at the trust inline and ensure decision making was kept streamlined and transparent. Also, to reinstate formal communication between the executive team and divisional team. Ensure that everyone was working to the same plan and that it was consistent with any changes monitored and understood. Address shortcomings in the Trusts approach to risk management and mitigation to also check consistency. To bring the Trusts education and training work into the mainstream and increase visibility. The Interim Director of Recovery, Innovation and Transformation then described the first of two meeting structures. Meeting structure 1, currently the executive team meet every Wednesday where formal minutes were recorded, and decisions were made then filtered to the organisation. Trust Executive Group may undergo a change in name this was yet to be agreed. Trust Executive Group was currently once a month and would be more of a workshop/information meeting. Firstly, the Trust Executive Group would become a central meeting where all other meetings would feed into. Therefore, Executive Team meeting would be informal and only minuted if a quick decision was required, this would then be discussed by the directors and presented at the subsequent Trust Executive Group. Due to the nature of the meetings numbers would be required to be at a manageable level, including Divisional Directors and Directors with others to be discussed. Reporting into the Trust Executive Group would be the Capital Investment Group (CIG), this was chaired by the Acting Director of Finance, anything required for approval over the threshold (to be finalised) would be referred via Trust Executive Group. The Accountability meeting would be starting and added to diaries shortly, they would run weekly with different Divisions presenting on a rolling basis. The accountability team from the Executives side would be the Executive Directors they would review planned activities and discuss assurance areas. The areas were Quality and Strategy, People and Organisational Development Assurance, Finance Assurance and Operations Assurance. Issues would be discussed at the accountability meetings. This would include the Performance framework and would be chaired by the Director of Recovery, Innovation and Transformation. Capital and Programmes would filter into the Transformational board (elective recovery, recruitment, complaints processes, corners courts, risk programme and QI) would all go through the Transformational Board. The Emergency Village programme would also go via the Transformational Board. Once any programmes were approved, they would then go via the Accountability Board. Teaching board (form of) with a formal report set up, the Chief People Officer would chair this.	

	The risk board, to be chaired by the Executive Medical Director would look at scoring risks, the Acting Director of Finance would deputise. Meeting structure 2: nothing would go to sub-committees of the board until it had been seen at the Trust Executive Group meeting. The Trust Executive Group can't sign off papers instead of Board, a version must be presented at Trust Executive Group for information prior to Board. Therefore, all the Directors and senior leadership team were aware of what the Non-Executive Directors were told. A discussion must be made at Trust Executive Group prior to board, it then doesn't stop items being raised and gives an opportunity for issues to be discussed. All decision making was then visible via the Trust Executive Group. Following a question from the Deputy Chief Operating Officer regarding if everything was to now be presented at Trust Executive Group do, we need to look at the time in the month and do we need to run the meeting more frequently. The Interim Director of Recovery, Innovation and Transformation answered that this would be covered in the last part of the presentation. The Interim Director of Recovery, Innovation and Transformation gave an overview of the next steps: • To finalise the Terms of Reference for the new groups and reflect on the standing orders and to finalise the name of the group. • Meeting scheduling and start booking meetings. The frequency of the Trust Executive Group meetings depends on the representation across all areas and for the Divisional Directors to be available. It may become a 2-weekly meeting. • Check current assurance systems were working with no duplicates. • Restructure the elements of the New Directorate to support the new ways of working. • Commission and develop work on roles and responsibilities resetting the delegated powers to divisions and managers including the role of the senior leadership team. • Ensure all appropriately trained. The Acting Director of Finance asked when the changes would be going live, it was answered that hopefully in June on the basis that there were enough members to attend after checking availability. It was noted from the Deputy Chief Operating Officer that the sub committees were prior to the Board meetings.	
	The Committee: - ***Noted the Governance Review***	
TEG22/05/ E1	**<u>Finance Update</u>** The Acting Director of Finance gave a finance update on the year-end financial position for 21/22: • At year-end there was a £2.6m surplus with a forecasted amount of £2.8m • The ICS had a surplus of £23.3m	

	• Capital had been delivered at £35.6m and was on plan, with an overspend of £12,000 • The ICS underspent by £1.3m • The Trusts cash position was at £46.4m • There was an increase in temporary staffing spend in month 12 of £1.9m (agency staff) vs £0.9m pre Covid-19. This requires investigating as it would be looked at further. • External audit currently reviewing accounts completing by end of May/early June • Internal audit updating regularly and should be at moderate assurance opinion likely. Follow up was to ensure the Trust was following the outcomes of the audits. The high risk 2022/2023 financial plan was very challenging and had been submitted with a £25m deficit and a £19.3m cost improvement programme. The ICS had submitted a plan with a £76m deficit, they have requested a resubmission of the plan to be submitted in May-June to challenge and to reduce the deficit. Overall, the 22/23 financial plan showed the Trust had a deficit of £44.3m before the cost improvement programme and £25m after a 4% cost improvement programme. The South Yorkshire ICS position was at £76.7m deficit further improvement was required. The Interim Director of Recovery, Innovation and Transformation updated that there had been a discrepancy with the capital allocations and created new cases for the new build. The estates team have received money from the ICS for the back log maintenance issue. This was required to be spent on back log issue otherwise this would have to be given back to the ICS.	
	The Committee: - ***Noted the Finance Update***	
TEG22/05/ E2	**<u>CDS Business Case</u>** The Acting Director of Finance confirmed the Capital Investment Group would recommence in May 2022. The business case would be noted at Trust Executive Group and then signed off by board. This business case was for a full refurbishment and further work within the Women and Children's areas, including fire works. The Strategic Director for Estates and Facilities explained that it had been delayed due to the Women & Children's incident, it would be a midwifery led birthing centre. Overall, the costs were £2.5m and £500,000 on the fire plan. Work was due to start on the 23rd of May and would be a 6-month programme. This would leave the Trust clear for Winter and completed by October 2022.	
	The Committee: - ***Noted the CDS Business Case***	
TEG22/05/ E3	**<u>Consultant Vacancies</u>**	

	There was nothing raised for this item		
TEG22/05/ F1	**Any other Business (Verbal)** None		
TEG22/05/ G2	**Sub-Committee Reports/Minutes (Enclosure G2)**		
	No minutes were received for information due to the decision to stand them down		
TEG22/05/ G3	**Minutes of the Trust Executive Group meeting dated Monday 14th March 2022**		
	The Committee: - ***Noted and approved the minutes of the meeting dated 14th March 2022.***		
TEG22/05/ G4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Monday 13th June 2022** **14:00 – 17:00** **Via Microsoft Teams**	
	The meeting closed at – 16:25		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

TRUST EXECUTIVE GROUP

Minutes of the Meeting of the Trust Executive Group
Held on Monday 13th June 2022 via Microsoft Teams

Present:	Ken Agwuh - Interim Divisional Director Clinical Specialties Ken Anderson - Chief Information Officer Dr Anurag Agrawal - Divisional Director – Medicine Fiona Dunn - Deputy Director Corporate Governance / Company Secretary Zoe Lintin – Chief People Officer Jon Sargeant – Interim Director of Recovery, Innovation & Transformation (Chair) Emma Shaheen – Head of Communications and Engagement	
In attendance:	Simon Brown – Deputy Chief Nurse for Corporate Sam Debbage - Deputy Director of Education and Research Lucy Hammond – Divisional Director of Operations (Surgery and Cancer) Joseph John – Medical Director for Operational Stability and Optimisation Nick Mallaband – Medical Director for Workforce and Specialty Development Lois Mellor – Director of Midwifery Anuja Natarajan – Acute Paediatrics Clinical Director Angela O'Mara – Deputy Company Secretary Nicki Sherburn – Deputy Director of Nursing for Surgery Howard Timms – Acting Operational Director of Estates and Facilities Andy White - Head of Capital Projects	
Apologies:	Alex Crickmar - Acting Director of Finance Antonia Durham-Hall – Divisional Director – Surgery and Cancer Kirsty Edmondson Jones – Strategic Director of Estates & Facilities Eki Emovon - Divisional Director - Children and Families Gill Marsden – Deputy Chief Operating Officer – Elective Dr Tim Noble - Executive Medical Director Richard Parker - Chief Executive Debbie Pook - Deputy Chief Operating Officer – Non-Elective Dr Alasdair Strachan - Director of Education & Research Abigail Trainer – Acting Chief Nurse	
		ACTION
TEG22/06/ A1	**Welcome and Apologies for Absence (Verbal)**	
	The Chair welcomed the members and attendees to the meeting. The above apologies for absence were noted.	
TEG22/06/ A2	**Matters Arising / Action Log**	
	An update was received: Action 1:	

	Deputy Chief Nurse for Corporate gave an update that this action was currently in progress to investigate the quality strategy. It was decided by the Chair that this would be discussed further outside of the meeting to set project timelines.	
	The Committee: - ***Noted the update and Claudia Gammon updated the action log***	
TEG22/06/ A3	**<u>Conflict of Interest (Verbal)</u>** No conflicts of interest were declared.	
TEG22/06/ A4	**<u>Requests for any other business (Verbal)</u>** There was one request for any other business discussed prior to the meeting.	
TEG22/06/ A5	**<u>CEO Update (Interim Director of Recovery, Innovation and Transformation presented on behalf of the CEO)</u>** The Chair explained that there would be no Chief Executive Update however, there would be a discussion regarding the new meeting structure for Trust Executive Group. Interviews had taken place for the new Chief Operating Officer with further discussions to follow.	
	The Committee: - ***Noted the CEO Update***	
TEG22/06/ B1	**<u>Meeting Structure & TORS</u>** The Chair explained that within the new directorate adjustments had been made due to the ease of Covid-19 restrictions. Trust Executive Group was now the key meeting for sharing data and decision making. Several meetings would then filter into this monthly: • **Clinical Investment Group (CIG),** • **Accountability – new Performance Overview Support Management (POSM)** – Quality and Safety, POD Assurance, Finance Assurance and Operations Assurance would sit underneath • **Transformational Board** - Capital projects (new build and orthopaedic centre) and programmes (recruitment and theatre would sit underneath • **Teaching Board** • **Risk Board** The Chair referenced that all directors would attend the Accountability Board apart from the Chief Executive. The Clinical Investment Group meetings would continue for the larger cases and be presented at Trust Executive Group before final approval. The weekly Executive meetings would be informal, not minuted and therefore would not make decisions however, they would be presented at Trust Executive Group. The Chair explained that there were terms of reference for each of the meetings. The terms of reference had been circulated for the Trust Executive Group with changes to the current	

	membership. The Deputy Director of Education and Research asked about the structures and the teaching hospital board and that it would also cover research and education. The Deputy Chief Nurse raised that within the terms of reference for Trust Executive Group the Divisional Directors of nursing weren't included to attend. The Chair confirmed that they could attend instead of Divisional Director. The Medical Director for Workforce and Specialty Development asked on behalf of the Executive Medical Director about the Chair of the Risk Board. The Chair confirmed that until there was a substantive Chief Operating Officer in post the Executive Medical Director would chair the meetings. The Medical Director for Workforce and Specialty Development also commented that this was a lot of meetings for the Divisional Directors and could they be shared amongst the Divisional nurses. This was answered that the requirement was for a single representative from each division with the same member of staff at each meeting. The transformation board would monitor the progression of all projects and the capital, with the governance structure being put into place and implementing monday.com. The Chief People Officer commented about the Performance Overview Support Management and that this could also be used for positive comments. The Chair added that this would be beneficial to the divisions, looking at success, prioritising work that had stopped due to Covid-19. The Acting Operational Director of Estates and Facilities asked about the medical equipment work and if it was reported anywhere. The Chair confirmed that it would report into capital, then transformational board with the risk scores being updated regularly. The Deputy Chief Nurse for Corporate asked about the risk management board terms of reference and the membership as the governance lead wasn't included. It was confirmed that this would be included to then balance and assess the risks across all divisions. The Medical Director for Workforce and Specialty Development asked if any of the new committees had any financial authority and would items be raised at Clinical Investment Group. This was confirmed. The Chair concluded that the Trust Executive Group agenda would be reviewed after a month or two.	
	The Committee: - ***Noted the Meeting Structure & TORs***	
TEG22/06/ C1	**<u>Clinical Update (Verbal)</u>** The Deputy Chief Nurse for Corporate gave an update on behalf of the Acting Chief Nurse: • There were now two Interim Deputy Chief Nurses one for Workforce and one for Workforce. • Outcome of the quality review was due at the end of July with reference to patient safety and complaints. • Workforce plan was in progress to reduce the number of bank and agency staff. • Work was being carried out on the quality framework and strategy • Ockenden external visit was positive with only advisory comments received.	

	The Medical Director for Workforce and Specialty Development added that medical staff were still different to recruit and therefore required locums to fill the gaps. There were currently issues with the discharge letters and them not being received by GPS's. Normally once a discharge letter was complete If a doctor was to go back into it to change anything, the letter doesn't send to the GP. This was a known national issue with the system and was being investigated.	
	Action – - **Chase update on discharge letters and the progression of the backlog**	**DP**
	The Committee: - ***Noted the Clinical Update.***	
TEG22/06/ C2	**<u>Finance Update (Verbal)</u>** The Chair provided an update on behalf of the Acting Director of Finance for month 1: • £2.6million deficit which was a £258,000 adverse to plan • Cash balance was £33.4million dropped from £46.4million the previous month from capital payments from year-end • ICS requested a meeting with the regional chief executive and the regional finance director, where they were informed to improve the ICS position. • Following a meeting with the CCG's the Trust were asked to improve the financial position. With a deficit of £16million down to £13.6million plan in with £10million deficit.	
	The Committee - ***Noted the Finance Update***	
TEG22/06/ C3	**<u>Operational Update (Verbal)</u>** The Chair highlighted the pressures currently at the Trust and the requirement to look at virtual wards and extra beds, this would be discussed with the Interim Chief Operating Officer. The Medical Director for Workforce and Specialty Development commented about the increase in flow within the Trust, a workflow dashboard was circulated prior to the pandemic to show this. The Chair added that the teams required the availability of beds to be looked at along with the reopening of ward 22. The Medical Director for Workforce and Specialty Development also asked if there a workstream on the virtual wards along with a lead. It was answered that there was extra support and discussions were taking place. The Interim Divisional Director Clinical Specialties raised a concern around antibiotic use, with a lot of patients in hospital being kept in the Trust longer than required, this would be reviewed outside of the meeting.	
	The Committee - ***Noted the Operational Update***	

TEG22/06/ C4	**<u>People Update</u>** The Chief People Officer gave a people update on the mileage rates, this was discussed at Executive Team and was decided that a recommendation would be received at Trust Executive Group, then present to the ICS committee on the 14th of June. The proposal was to change: • Anything up to 3,500 miles from 25p a mile to 56p • After 3,500 miles from 56p to 35p a mile. • Also, hotel rates were discussed about increasing them due to cost-of-living pressures.	
	The Committee: - ***Noted and approved the People Update***	
TEG22/06/ D1	**<u>CIG Update</u>** The Chair reminded the committee that monthly Clinical Investment Group meetings would take place with a timeline to submit cases and requests for funding.	
	The Committee: - ***Noted the CIG Update***	
TEG22/06/ E1	**<u>Strategy Update (Verbal</u>** The Chair commented on the work for the service line review and clinical strategies within all divisions in meetings. The Chair referenced the meeting on site within the maternity unit and the modular build. The importance of the new build and levelling up the agenda were discussed with the Acting Chief Nurse. There had been a meeting with the MPs as there was still no update on the new build.	
	The Committee: - ***Noted the Strategy Update***	
TEG22/06/ E2	**<u>Innovation Update (Presentation)</u>** The Chair provided an innovation update and explained that the quality improvement team were putting together a paper to look at the quality improvement and length of stay issues. The Deputy Director of Education and Research commented about working collaboratively. The Chair added about the introduction and improved services from the autumn with pilots being carried out in the summer.	
	The Committee: - ***Noted the Innovation Update***	
TEG22/06/ E3	**<u>Capital Update (Presentation)</u>** Andy White presented the capital update: • The estates capital for 22/23 was £14.968m • Additional work for the Bassetlaw emergency village was £17.9m	

- Additional work for the Montague Elective Orthopaedic Centre was £19.5m including building regulations
- Additional work for the community diagnostic centre was £9.4m
- Additional work for the reinforced aerated concrete issue at Bassetlaw was for £10.3m however, costs had risen to £14.6m
- The total estimate for the pre commitments for 22/23 were £2,436,000, this included fire precautions and electrical infrastructure.

Bassetlaw Emergency Village

- The scheme budget was £17.6m and was required to be spent by March 2024
- Scheme was required to be completed by March 2024
- The outline business case submission date was the end of July 2022.
- The full business case submission date was the end of January 2022.

Montague Elective Orthopaedic Centre

- 8 options had been identified all above £15m
- The preferred way forward would have 24 bed inpatients wards and 2 laminar theatres and cost £19.5m
- Pre-planning application submitted on 7th June 2022

DRI Replacement – New Build

- Short-list announcement yet to be confirmed
- Planning for remediation starts in July 2022 to be completed in March 2024
- Doncaster council commenced intrusive surveys on basin site in March 2022

Community Diagnostic Centre – Phase 2

- Establish two endoscopy suites
- Relocation of the pain clinic
- 2 new ultrasound rooms
- Business case submitted to national team on the 26th of May 2022
- Discussions at present were for a third phase and a permanent MRI, CT and a third endoscopy unit

Medical equipment plan

- The capital allocation for 22-23 was at £2.76m
- The £2.76m was made up of two groups, group 1 – rolled over business cases 2021-2022 £283,000 and group 2 – the plan £2.46m

Digital Transformation Capital Expenditure 22/23

- 2021/2022 total was £4,235,795m made up of 4 parts:
- Revised budget - £2,445,795m
- TIF Capital - £1,572,000
- UFT Capital - £308,000
- 2022/23 total was a budget of £1,100,000m
- There were some capital projects in progress for windows 11 and a data warehouse and reporting tool.

The Deputy Chief Nurse for Corporate asked the medical equipment was there anything that was a risk and would impact on priority lists for allocation. The Acting Operational Director of Estates and Facilities explained that there was work being carried out in the background.

	The Chair added that there was a piece of work around this, and it would be reviewed by the end of March 2023. The Deputy Director of Nursing for Surgery asked about patient safety and the new services within pain management, was everything sufficient with the lifts in the area. Andy White confirmed that this was on this year's programme for the Trust to resolve. The Medical Director for Operational Stability and Optimisation enquired about the time frame for the electronic patient record, and would it be rolled out even if the Trust received a new hospital. The Chief Information Officer answered that the league time would be to go to tender at the end of 2022. The work would then begin in late 2023 for 18mths by then the Trust would have an update on the new build. Further discussions were to be had with NHSE/I as some of the money was time limited. There had been on going work on the Montague Elective Orthopaedic Centre programme with issues on the power substation, concerns around the inflation rates and the increase of prices. Due to this the outline business case was being investigated against a short form business case however, following the outline business to a full business case route would increase the timescale by 12-14 weeks. The Medical Director for Workforce and Specialty Development asked about the Mexborough orthopaedics site and if there had been a decision on single site trauma. It was confirmed that this was currently being investigated within trauma and included scrutinising the data.	
	The Committee: - ***Noted the Capital Update***	
TEG22/06/ F1	**<u>Risk Management Board Update (Verbal)</u>** No update for this item as Risk Management Board were yet to meet.	
TEG22/06/ G1	**<u>Education and Research Update (Verbal)</u>** The Deputy Director of Education and Research provided an update: • Explaining about the teaching board and the partnership with other teams. • The team were developing the strategy and the local expertise's and had been invited to the annual members committees. • A research cohort study was to be discussed and allowed the Trust to showcase Doncaster and its city status. • The Trust had a 'we care' event on the 1st of July at the Doncaster Dome, with 1400 young people registered to attend. It would be a simulated corridor with 50 stands including estates and facilities. • SET compliance had improved with Dental and Medical colleagues still low. SET training completion percentage had increased across the estates and facilities team.	

	The Chief People Officer asked if there was any help required for the SET training focus work and was there any assistance required from the Committee. It had been confirmed that this was being looked at and supported by the Clinical Directors.	
	Action - ***Update on SET training focus work to be presented in July***	**SD**
	The Committee: - ***Noted the* Education and Research Update**	
TEG22/06/ H1	**ICS Update (Verbal)** The Chair mentioned the current issues with the expenditure and further updates would be received at the next Trust Executive Group.	
	The Committee: - ***Noted the* ICS Update**	
TEG22/06/ I1	**Place Update (Verbal)** The Chair confirmed that there was no update on this item	
TEG22/06/ J1	**Any other Business (Verbal)** The Acute Paediatrics Clinical Director presented Preparing for Progress after being asked by the Children's and Families Board to present the change in curriculum of paediatric training and the number of junior doctors to run the service. A summary of this was: • Opportunity to review the training and training structure • Move away from doing things the way in which they have previously been implemented. • The plan would result in better training, less gaps resulting in better patient care The Chair invited the Acute Paediatric Clinical Director to clarify what was required by the committee. This was confirmed that the requirement was the financial input, budgets and delivering the plan. The Medical Director for Workforce and Specialty Development added that there were different issues with the lower end doctors and leaving a gap within the middle grade doctors. The Chair added that for the next meeting with the deanery would need the following to attend: Medical HR, the Medical Director for Workforce and Specialty Development and the Acting Director of Finance.	
TEG22/06/ J2	**Meeting Reflection** The Chair requested feedback on the new meeting layout if the agenda worked. The committee received this positively.	
	The Committee: - ***Noted the meeting reflection***	

TEG22/06/ J3	**Minutes of the Trust Executive Group meeting dated Monday 9th May 2022**		
	The Committee: - ***Noted and approved the minutes of the meeting dated 9th May 2022.***		
TEG22/06/ J4	**Date and time of next meeting (Verbal)**		
	Date: Time: Venue:	**Monday 11th July 2022** **14:00 – 17:00** **Via Microsoft Teams**	
	The meeting closed at – 16:35		

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	26 July 2022	**Agenda Reference:**	H8
Report Title:	**South Yorkshire & Bassetlaw Acute Federation –Annual Report for 2021/2022**		
Sponsor:	Richard Parker, Chief Executive Officer		
Author:	Fiona Dunn, Deputy Director Corporate Governance/Company Secretary		
Appendices:	• South Yorkshire and Bassetlaw Acute Federation Annual Report for 2021/2022		

Report Summary	
Purpose of report:	To provide information to the Board on the recent activity from the South Yorkshire & Bassetlaw Acute Federation Board in the form of the 2021/2022 Annual Report
Summary of key issues/positive highlights:	The SYBAF annual report enclosed highlight key issues, discussions and decisions taken by the South Yorkshire and Bassetlaw Acute Federation Board during 2021/2022. 1. 1The report covers a number of exciting developments within our hospital networks and key programmes as well as highlighting some significant achievements that were accomplished during the Covid-19 pandemic. 2. The report also outlines key areas of focus and specific objectives for SYBAF teams in the coming year. •
Recommendation:	The Board is asked to receive and note the annual 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:	SA1-SA4
Corporate risk register:	N/A
Regulation:	Monitor's code of governance for NHS foundation trusts
Legal:	Compliance with 2022 Health and Care Act
Resources:	N/A

Assurance Route			
Previously considered by:	N/A		
Date:		**Decision:**	N/A
Next Steps:	NA		
Previously circulated reports to Supplement this paper:	None		

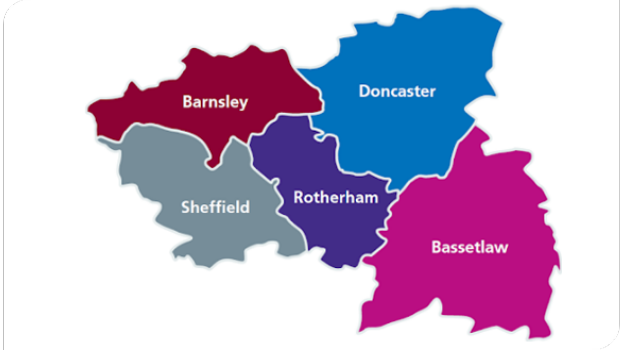
NHS

South Yorkshire & Bassetlaw

Acute Federation

Annual Report

2021/22



Barnsley Hospital NHS Foundation Trust

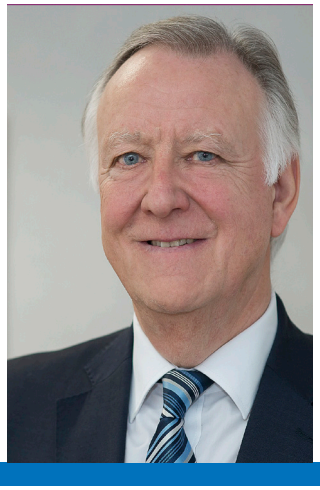
Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Children's NHS Foundation Trust

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

The Rotherham NHS Foundation Trust

Lead Chair and Lead Chief Executive's Statement



We are pleased to share with you the first Annual Report of the South Yorkshire and Bassetlaw (SYB) Acute Federation. We are a collaboration of the Acute Trusts across SYB and our aim is that, by working more effectively together, we can improve clinical standards and the care outcomes for our patients, as well as making our organisations better places to work.

In the last twelve months the Acute Federation has overseen a range of improvements, examples of which are described herein. We have also worked together to respond to the additional challenges and pressures imposed by Covid-19. Our staff across the whole of South Yorkshire & Bassetlaw have been amazing and we want to take this opportunity to thank them for their hard work and dedication at such a difficult time. The spirit of collaboration that we have witnessed between our organisations throughout the pandemic demonstrates the positive benefits of working together.

Overall, as we reflect upon 2021/22, we believe it is clear that our achievements as an Acute Federation have been significant. This is a testament to the commitment of our teams and speaks volumes for the willingness to make improvements through the innovation and new thinking which we can count on from our colleagues.

We would like to thank our colleagues at Barnsley Hospital, Doncaster and Bassetlaw Teaching Hospitals, Rotherham Hospital, Sheffield Children's Hospital and Sheffield Teaching Hospitals and everyone else who has worked with us over the past year. Their positive support has been overwhelming and has contributed to what has been a successful, as well as challenging, year for the Federation.

As we look towards some new goals for 2022/23, we are assured in the knowledge that the dedication and support of our colleagues will assist us in unlocking new achievements for the next 12 months and beyond.

We have an exciting year ahead as our Acute Federation is set to undergo a period of significant development. We are looking forward to closer integrated working across our partners as we support each other to recover from the COVID 19 pandemic and continue to develop new ways of collaborative working for the future.

Martin Havenhand
Lead Chair

Richard Parker OBE
Lead Chief Executive

Our Chief Executives and Chairs

At the South Yorkshire and Bassetlaw Acute Federation we are supported by the Chairs and Chief Executives of our Hospital Trusts.

Dr Richard Jenkins, Chief Executive

Sheena McDonnell, Chair

NHS
Barnsley Hospital
NHS Foundation Trust

Dr Richard Jenkins, Chief Executive

Martin Havenhand, Chair

NHS
The Rotherham
NHS Foundation Trust

Richard Parker OBE, Chief Executive

Suzy Brain England OBE, Chair

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Kirsten Major, Chief Executive

Annette Laban, Chair

NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Ruth Brown, Chief Executive

Sarah Jones, Chair

NHS
Sheffield Children's
NHS Foundation Trust

Who we are and what we do

In South Yorkshire and Bassetlaw (SYB), our hospitals have been working together for a number of years to improve clinical standards and care outcomes for our patients. We have also been striving to make our organisations better places to work.

Since 2013 the trusts have worked together delivering projects to improve patient care by looking across organisational boundaries.

Following a detailed review of five challenged hospital services, our hosted clinical networks were established to enable us to deliver improvements. The networks focussed on Urgent and Emergency Care, Maternity, Paediatrics, Stroke and Gastroenterology.

They work in three ways:

- Level 1 - A focus on shared approaches to workforce, clinical standards and innovation
- Level 2 - To involve a higher level of sharing resources across the system
- Level 3 - A closer relationship, with one Trust providing or supporting services on another Trust's site(s)

An overview of our activity within our Networks

Stroke:

In the last 12 months, the network has developed an SYB Stroke Survivor and Carer Panel to listen and learn from those with lived experience of stroke.

There has been a regional implementation and expansion of stroke artificial intelligence which is supporting various aspects of stroke care, including detection and monitoring to aid diagnosis and decision making.

Trusts have also collaborated on the development and delivery of a new SYB Stroke Telemedicine system to allow those with advanced training in treating strokes to treat people in another location. This will support 24/7 thrombolysis treatment across our sites, giving patients the best chance of recovery and significantly improving patient outcomes.

Key priority:

Our focus next year will be on Urgent Diagnosis & Treatment, Needs-based Stroke Rehabilitation, and Stoke prevention. In particular, we want to identify those most at risk and reduce health inequalities by raising awareness within those population groups.

From April 2022 we will have extended access to Mechanical Thrombectomy services which will give more patients vital access to this life saving treatment.

Gastroenterology:

Significant achievements have been made within the Gastroenterology network by sharing best practice and enabling mutual aid working between the service sites to support delivery of clinical care.

As a result, there has been a significant reduction in patient waiting lists at Barnsley, Rotherham and Doncaster & Bassetlaw, with all three trusts expecting to have all new referrals seen within six weeks by the end of April 2022.

The network also developed a system-wide, out-of-hours Gastrointestinal bleed rota which enables all trust sites to have access to specialist expertise and appropriately trained staff in the event of a patient suffering such a bleed. This improves patient safety and ensures that services can offer endoscopy to patients 24/7 if required.

Key priority:

Going forward, we will look how further mutual aid working and sharing of our staff resources across the system can help us respond to increasing demand. A focus will also be placed on making our system resilient to avoid bottle necks within our services due to unavailability of staff.

Maternity:

Our maternity network has been listening to the needs of our service users across South Yorkshire and Bassetlaw with a special focus on seldom heard from groups. They have recruited a Service User Voice lead to ensure that improvement works are informed by the needs of our patients and their families.

In 2021/22, many quality improvements have been made including, winning funding to develop a new maternity digital strategy and a project implementing continuous glucose monitoring for pregnant women with Type 1 diabetes was established to encourage optimal glucose control for this high-risk group. This has significantly improved obstetric and neonatal health outcomes. The project has been expanded in February 2022 to offer this monitoring to those with Type 2 or gestational diabetes.

Key priority:

Anticipating further requirements of our maternity services across our Trusts, we will need to consider the additional recommendations for change made in the second Ockenden report. Scrutiny on maternity services is likely to continue for some time with a number of additional enquiries due to be published in the coming year but we have no doubt that our teams will respond effectively to any recommendations made.

Paediatrics:

Following a soft launch in January 2021, the South Yorkshire and Bassetlaw Healthier Together website was revamped to provide better information for patients and their families. User numbers have gone from around 100 visitors a week to now well over 1,000. By having accurate information on which to base clinical decisions, the right children are seen at the right time, in the right place.

During the height of the Covid-19 pandemic in 2020, the Acute Federation supported an Emergency Surgery pathway which provided children with access to emergency surgery at Sheffield Children's Hospital. This allowed our other hospitals to focus on treating the high volumes of unwell adults with Covid-19. This pathway was stepped up again in April 2021 to support Doncaster and Bassetlaw Teaching Hospitals following a major incident at the Doncaster site.

The SYB Children & Young People Alliance has been established focussing on enhancing life outcomes, reducing health inequalities and tackling wider issues which impact the health of children. Over 200 professionals from across the region are now involved.

Key priority:

During the next 12 months, as well as focussing on asthma, diabetes and epilepsy, we will be improving services for Children & Young People with obesity. Obesity can severely impact a child's longterm health, so we are working across the region to support healthy weight management programmes in schools. We also want to improve support services for young people who access emergency care services due to violence by working on a pilot Violence Reduction Navigators programme.

Urgent and Emergency Care:

Within our Emergency Departments across SYB, a new tool (EDDI) has been implemented so that the NHS 111 service can book patients into ED.

The network has also begun the roll out of the Streaming and Re-direction digital App to the front doors of Emergency Departments so that patients who self-present can use the tool, if demand appropriate, and can be streamed to alternative hospitals for their urgent care needs.

This system is currently live at Doncaster Royal Infirmary and Bassetlaw Hospital.

Key priority:

Streaming and redirection across the rest of SYB will be a key priority for the coming year as well as improving access to Same Day Emergency Care to reduce pressure on emergency departments.

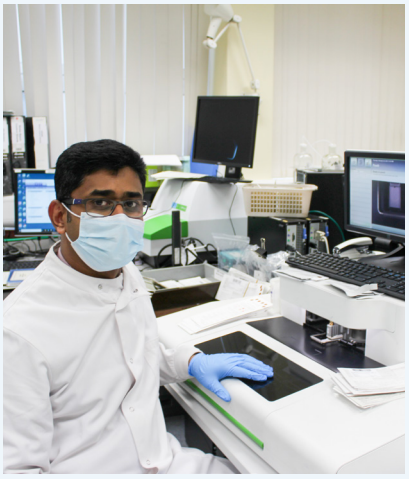
Other key programmes

Outside of our hosted networks, the Acute Federation has made significant strides in a number of other areas and work programmes geared towards improving services for patients and reducing workforce pressures.

Pathology:

In line with national guidance, we are considering how we can consolidate our Pathology services to ensure future resilience and to enable us to invest in the leading-edge technologies.

Under the appointment of the SYB Pathology Clinical Director and Operational Director, the network has successfully won £654k to fund this work over the next two years, and has received capital funding for the implementation of a single Laboratory Information System (£510K) and a digital pathology system (£218K) for the region.



Key priority:

In the coming 12 months, a full Business Case will be developed and all those in the existing services across our hospitals will be engaged in how to best develop the service of the future.

Imaging:

In Imaging, we have successfully completed recruitment of two cohorts of Reporting Radiographers through the South Yorkshire and Bassetlaw Imaging Academy. These new recruits are already helping to reduce the strain on imaging workforces and enabling timely diagnosis of patients at hospitals within the federation.

The imaging workstream has also secured funding for iRefer at two places, a clinical decision support tool which will provide referring clinicians with evidence-based advice on the best imaging tests or investigations to request when referring a patient to imaging services.

Our Imaging function supported operational delivery of services throughout 2021/22 by accessing and distributing central resources for mobile and static capacity.

Key priority:

A key priority for us is addressing workforce challenges in ultrasound and plain film X-Ray with new models of delivery, working with the South Yorkshire and Bassetlaw Imaging Academy and undertaking a detailed capacity and demand review, supported by the NHS England/Improvment Elective Intensive Support Team.

Community Diagnostic Centres:

The Community Diagnostic Centres (CDC) programme has welcomed significant achievements in the last twelve months with the securing of £3 million in funding for two CDC centres in Barnsley and Mexborough.

The new sites, which completed phase one of development back in February, will help to speed up diagnostic tests for patients in the area with suspected conditions such as cancer.

We have engaged all system partners in CDC planning for Year 2 and beyond, in order to ensure that we maximise the potential benefit from the National CDC Programme for SYB to aid recovery and enable us to meet the anticipated future growth in diagnostic demand.

Key priority:

We are expecting a substantial growth in diagnostic demand and so we are working with partners across the region to develop a system wide approach. This will require us to secure external funding, identify the right solutions and develop the workforce of the future.

Procurement:

In 2021/22, with the challenges of the pandemic, our Procurement function ensured stability of supply across our hospitals. A resilience group was established to achieve this with mutual aid and joint working in place.

We also established the Integrated Care System (ICS) Procurement Collaborative with other partners.

Joint working between organisations is progressing with an 88.21% participation rate in collaborative working during 2021/2022. This achieved £0.6m of realised savings. A plan to deliver £2.3m of savings during 22/23 is underway with scope for this to increase.

During 21/22 each organisation adopted a joint e-Tendering platform called Atamis, better enabling collaborative working, data sharing and work planning.

Key priority:

With procurement teams working together, we can save money, improve quality and reinvest these benefits into other services. Our aim is to provide the best social value to the population of South Yorkshire and Bassetlaw.

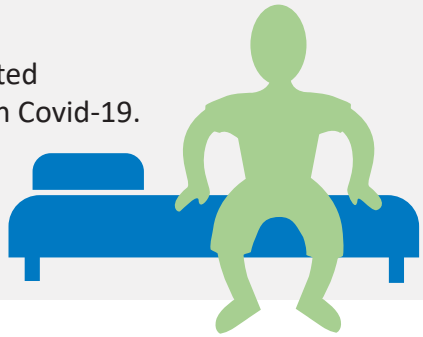
Working Together to Tackle Covid-19

Covid-19 was an enormous challenge for each and everyone of us. Through collaboration, we faced these unprecedented challenges together and provided the best care possible for the people of South Yorkshire & Bassetlaw.

Together we treated

25,591

patients admitted to hospital with Covid-19.



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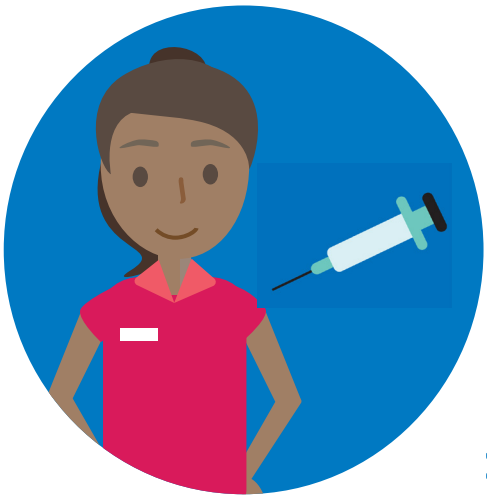
Children were transferred to Sheffield Children's for their emergency surgery, helping our other hospitals to focus on the care of unwell adults.



>96%

Of our hospital workers received the first dose of the Covid-19 vaccine at all of our hospitals. More than 93% also took up the second dose and 86% have received the booster.

At Sheffield Children's alone,

3,549,327.12

travel miles were saved due to virtual appointments which equates to

96.26 tonnes of CO2

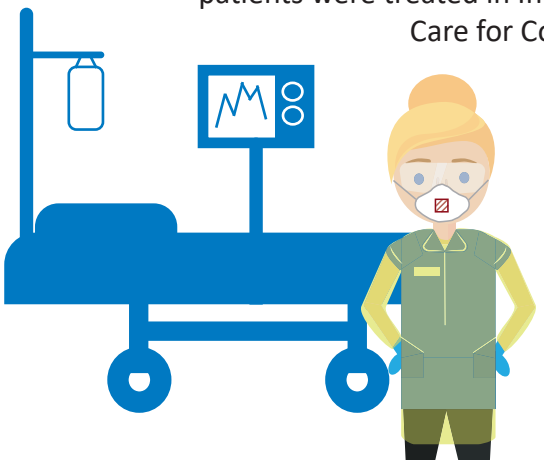
20,783

People were discharged home following successful treatment for Covid-19

Our regional Embrace transport service helped with the transfer of very ill patients from the Mid-lands to specialist beds in South Yorkshire.

1,000

patients were treated in Intensive Care for Covid-19 *

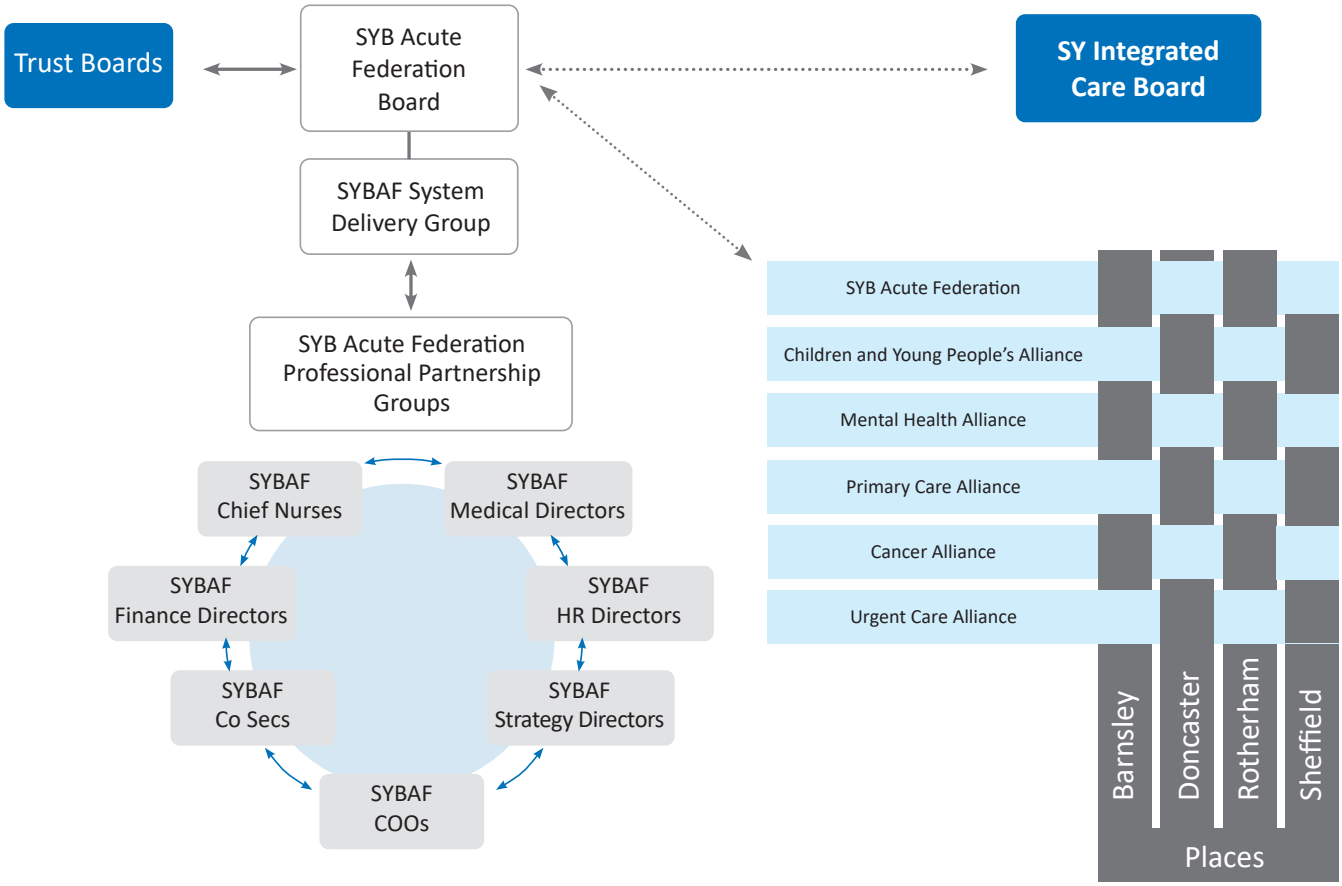


*excluding Rotherham and Sheffield Teaching Hospitals who don't report this data.

A look forward to 2022/23

As we take pride reflecting on the last twelve months, we find the Acute Federation at the forefront of integrated working across SYB. We are also working with colleagues nationally to influence policy and guidance.

As a Provider Collaborative, the SYB Acute Federation will transition from operating in shadow form to operating under a Board with an effective governance structure which is integrated into our organisations. The South Yorkshire and Bassetlaw Acute Federation has a clear ambition to be a high performing and successful Acute Federation within a high performing Integrated Care System. To support us with these new ambitions, we will be introducing a new governance structure from April 2022.



This new governance structure, alongside the appointment of a substantive Managing Director, will give the Acute Federation the capacity and expertise to expedite its responsibilities and to be held accountable for its delivery.

As a muturing Acute Federation, we need to focus on creating capacity and space to develop our priorities for 22/23 and beyond. This will need to have sufficient breadth to start to consider a full spectrum of our responsibilities from resolving operational & staffing issues through to understanding the impact on health inequalities across our shared population.

Post-Covid, we know that we will need to place significant focus on elective recovery and reducing elective surgery wait times across our services. There is already a wealth of innovative new service models being applied in our hospital Trusts and we will need to look at how we can use our networks and resources to deliver these, or similar models, in other areas to help return our waiting lists to pre-covid levels. In addition to this we really need to consider how as Acute providers, the Acute Federation can support our ICB to make a real impact in the reduction of health inequalities.

Glossary of terms

- CDC - Community Diagnostic Centre
- CO Secs- Company Secretaries
- EDDI – Emergency Department Digital Integration
- HR – Human Resources
- ICS - Integrated Care System
- SYB - South Yorkshire and Bassetlaw

NHS

South Yorkshire & Bassetlaw

Acute Federation

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 28 June 2022 at 09:30 via MS Teams

Present:	Suzy Brain England OBE - Chair of the Board (Chair) Mark Bailey - Non-Executive Director Alex Crickmar - Acting Director of Finance Mark Day - Non-executive Director Zoe Lintin - Chief People Officer Dr Tim Noble - Executive Medical Director Richard Parker OBE - Chief Executive Neil Rhodes - Non-executive Director Jon Sargeant - Interim Director of Recovery, Innovation & Transformation Kath Smart - Non-Executive Director Abigail Trainer - Acting Chief Nurse
In attendance:	Ruth Bruce - Doncaster Provider Alliance Lead (agenda item F1) Fiona Dunn - Deputy Director Corporate Governance/Company Secretary Anthony Fitzgerald - Director of Strategy and Delivery, Doncaster CCG (agenda item F1) Esther Lockwood - Falls Lead Practitioner & Holistic Care Team Lead (agenda item B1) Angela O'Mara - Deputy Company Secretary (Minutes) Debbie Pook - Deputy Chief Operating Officer – Non-Elective Adam Tingle, Senior Communications & Engagement Manager
Public in attendance:	Henry Anderson - Member of the Public Dennis Atkin - Public Governor Doncaster Hazel Brand – Member of the Public Angela Chapman - Public Governor Doncaster Mark Bright - Public Governor Doncaster Lisa Gratton - Staff Governor George Kirk - Public Governor Doncaster Lynne Logan - Public Governor Doncaster Andrew Middleton - Public Governor Doncaster Vivek Panikkar - Staff Governor Pauline Riley - Public Governor Doncaster Lynne Schuller - Public Governor Bassetlaw
Apologies:	George Briggs - Interim Chief Operating Officer Sheena McDonnell - Non-Executive Director Lois Mellor - Director of Midwifery Emma Shaheen - Head of Communications & Engagement

P22/06/A1	**Welcome, apologies for absence and declaration of interest (Verbal)**	
	The Chair of the Board welcomed everyone to the virtual Board of Directors meeting, including governors and those members of public in attendance. The above apologies for absence were noted, including those of Non-executive Director, Sheena McDonnell, who would leave the Trust on 30 June. The Chair of the Board acknowledged Sheena's contribution during her term of office and wished her well in her new role. No declarations of interest were received, pursuant to Section 30 of the Trust's Constitution. The Chief Executive extended his sincere condolences to the family, friends and colleagues of Harry Gration, who had sadly passed away last week. Harry had supported the Trust's annual Star Awards as a guest presenter for many years, devoting time to recognise individual and team contributions and a wider appreciation of the NHS. Harry's involvement in this important event had been very much welcomed by all and his wife, Helen and children were in our thoughts.	
P22/06/A2	**Actions from Previous Meetings (Enclosure A2)**	
	Action 1 - Safeguarding Information to Board This action had now been closed. **Action 2 – Principles for 2022/2023** Corporate Objectives would return to July's Board of Directors meeting following refinement and subsequent review at the sub-committees of Board.	
	The Board: - ***Noted the updates to the action log.***	
P22/06/B1	**Falls Prevention Initiative**	
	The Chair of the Board welcomed Esther Lockwood, Falls Lead Practitioner & Holistic Care Team Lead to the meeting. Today's presentation would focus on the initiative "See yellow – think falls", where the use of yellow blankets and slipper socks had been trialled as part of the triage process in the emergency departments at Doncaster and Bassetlaw. The use of slipper socks and blankets provided the benefit of non-slip footwear and a comforter for those with cognitive impairment, Importantly, they acted as a visual indicator of those at risk of a fall, rather than pure reliance upon system-based indicators. At the present time the impact had been difficult to assess due to the increase in activity and workforce challenges. Appropriate training and education of colleagues was in place. As slipper socks and blankets had been available at a reduced cost during the trial there were some issues to resolve around recurrent cost and the matter of storage going forwards, but the benefits were recognised by both emergency departments (ED)and the receiving wards and an initial survey to assess impact had received positive feedback. As	

	there were embedded risk assessments in the receiving wards there was no plan to extend the use across the Trust, noting that the impact in areas such as the frailty ward would be reduced due to widespread use. Kath Smart thanked the Falls Lead Practitioner for her presentation, which had been received at the Quality & Effectiveness Committee, as a quality improvement initiative. In in respect of next steps and plans to validate the impact, the Chief Executive confirmed that due to the change in infection, prevention and control measures patients had not been escorted by family into the emergency department and once the system settled there would be an opportunity to analyse change over time, including the use of statistical process control charts. Mark Bailey recognised the simplest ideas were often the best innovations and as safety was the primary concern, the cost of blankets and slipper socks should be considered against the hidden cost of falls. The Executive Medical Director expressed his thanks to the Falls Lead Practitioner and confirmed that the work would be tracked through the Clinical Governance Committee and subsequently reported to the Quality & Effectiveness Committee. The Chair of the Board shared her appreciation of the presentation, which was a useful addition for the purpose of board members, governors and members of the public to demonstrate continued learning.	
	The Board: - ***Noted and took assurance from the Falls Initiative Presentation***	
P22/06/C1	**<u>Maternity Update (Enclosure C3)</u>**	
	The Board received the Maternity Update which provided the findings of perinatal deaths, Health Safety Investigation Branch (HSIB) referrals, training compliance, service user voice feedback and compliance in respect of the Clinical Negligence Scheme for Trusts (CNST) 10. This month the Board also received a comprehensive workforce report and a Continuity of Carer update. The workforce paper highlighted the ongoing challenge of managing the vacancy position, which currently stood at 36 midwives and 15 midwifery support workers. All solutions were being actively pursued, including international recruitment, as expected midwives were in high demand and in addition to enhancements paid to existing staff to cover additional shifts, funding to support two agency midwives had been secured until the recruitment of the newly qualified midwives in October. The Chief Operating Officer was closely monitoring the situation, which was not exclusive to the Trust, via twice weekly review meetings. From a continuity of carer perspective, provision had been paused at the Trust since July 2021, due to staffing levels. The situation was reviewed on a quarterly basis and plans for national recruitment support were in place. The service would not be provided until such time as staffing levels were safe and sustainable.	

	In response to a question from Mark Day, with regards to the availability of national support, the Director of Midwifery acknowledged the place-based work with the Local Maternity and Neonatal System, alongside that of the national bodies. Recruitment of midwives was a national challenge and the Trust continued to be involved in the national programme to support both recruitment and retention. The Trust also worked closely with the Universities in order to attract an appropriate level of newly qualified recruits. The Chief Executive acknowledged the steps taken to recruit, including international recruitment, but with an increase in colleagues taking full retirement, as compared to the retire and return option, there was a need to consider a longer-term solution. The workforce needs would be assessed, and opportunities explored to develop a strategy to support a safe and sustainable workforce solution, supported by a multi-disciplinary leadership team. Post 1 July, the legislative changes in respect of system working would encourage system thinking and approach across the integrated care systems. The Acting Director of Finance (ADoF) confirmed the high vacancy rate continued to impact on finances, due to the significant staffing spend required to maintain a safe service. The ADoF also drew the BOD attention to the assumption, which had been included in the financial plan that the Trust would be compliant with the Clinical Negligence Scheme for Trusts (CNST) standards, additional resource to support delivery of the plan was now in place. In his capacity as interim maternity safety champion NED, pending the appointment of the clinical NED, Mark Bailey recognised the efforts of the Director of Midwifery and the drive of the senior leadership team to improve training compliance levels. As compliance was reported on a monthly basis this would be closely tracked to ensure progress in line with the trajectory of 90% by December 2022. He welcomed the administrative support in respect of monitoring performance and compliance standards. Kath Smart recognised the positive start of the Maternity Voices Partnership Chair who had developed an action plan for 2022/23 and was actively involved in meetings and activities. In response to a question seeking clarity on the assurance route for CNST and the referenced Prevention from Future Deaths Report (PFDR) the Director of Midwifery confirmed they would be presented to the Quality & Effectiveness Committee. A review of lessons learnt would be undertaken in respect of the PFDR, to include representative of the Quality & Effectiveness Committee and a non-executive director. There had been no matters of concern raised in respect of clinical practice. Staffing levels on M1 and M2 were being closely monitored and a twice weekly review, meeting, supported by the Chief Operating Officer had been arranged. As the summer months approached, further pressure was anticipated due to annual leave ahead of the newly qualified practitioners and international recruits commencing in post. The provision of continuity of carer would only be taken when there was confidence in the team's ability to deliver appropriate levels of staffing to ensure delivery of safe and sustainable care. The Chief Nurse confirmed the need for a system solution in respect of enhanced pay and agency rates, the Trust was working closely with partners and NHS Professionals to minimise the expenditure where possible. A reduction in the expected number of newly qualified midwifery colleagues was reported, down from 25 to 16. The recruitment midwife maintained weekly contact with the cohort, to ensure a good level of engagement and to facilitate a smooth transition.	

	The Board: - ***Noted and took assurance from the Maternity Update.***	
P22/06/D1	**<u>Our People Update (Enclosure D1)</u>**	
	The Chair of the Board welcomed the Chief People Officer to her first board meeting following her official start date of 6 June 2022. The People Update highlighted plans to introduce a more formal approach to organisational wide monthly board visits, jointly represented by executive and non-executive colleagues. This approach would ensure board members had the opportunity to see and hear first-hand the support provided to patients and service users (both internal and external). Colleagues would also be able to communicate in a more informal way with members of the Board on matters of importance to them. In accordance with NHSE guidance "A new approach to non-executive director champion roles", published in December 2021 the non-executive directors would continue to undertake agreed champion roles and once finalised this would be communicated to Board. The Trust had recently been shortlisted in a prestigious national employee benefits award in recognition of its health and wellbeing offer and the Vivup programme. On this occasion the Trust had not been successful, but the recognition as a worthy finalist amongst significant multi-national companies was agreed to be a success in itself. Finally, the Chief People Officer advised of a review in relation to mileage rates, arising due to the increasing cost of fuel and cost of living pressures. A proposed rate had been considered but to ensure a consistent approach across South Yorkshire Integrated Care System and the broader national position, agreement would be reached via the HR Directors Network. The Chief Executive welcomed the proposed change to mileage rates, which if agreed, would bring the Trust back in line with Agenda for Change terms and conditions framework. Mark Day acknowledged a return in line with agreed terms of condition was a positive step and in terms of the cost implication, he enquired of the associated budget pressures. As the approach was to be formalised across the system it was noted this would be a system pressure and ultimately would be dependent on the level of usage. As there remained some uncertainty re travel plans going forward, the impact of Covid and more flexibility to work remotely it was difficult to quantify, this would be monitored, and feedback provided via the Finance & Performance Committee. Mark Bailey confirmed his commitment to the informal board visits, which would provide an excellent opportunity to both the visitors and those being visited, allowing colleagues to raise concerns in a safe environment where the board members can listen, respond and if required signpost across the organisation.	

	The Board: - ***Noted and took assurance from the Our People Update.***	
P22/06/E1	**<u>Ambulance Handover (Enclosure E1)</u>**	
	The Board received the monthly ambulance handover report, the Deputy Chief Operating Officer highlighted that performance in May for patients waiting less than 15 minutes for ambulance handover remained extremely challenging but had improved slightly from 41.69% to 41.16%, with a decrease from 14.33% to 13.62% of patients waiting over 60 minutes. Doncaster Royal Infirmary was the third highest reporting Trust for 60-minute ambulance handover breaches in Yorkshire. A number of actions had been implemented, including ambulance direct referrals, early senior assessment as part of triage and referrals to the same day emergency care centre. An improved position was noted in respect of cohorting with only two instances throughout the month. Despite a wide range of implemented actions Neil Rhodes noted the Trust's largely static performance, as compared to its peers. The Chief Executive confirmed alongside the national focus there was a clear focus from the executive team and Board to provide the best possible service to our patients. Pre-covid performance had been much better and the impact on performance at this time was multi-factorial, there continued to be significant and sustained pressure on the emergency department, a complex pathway for patient flow due to the ongoing presence of Covid-19 and a higher than average sickness absence. An example of the pressure would be that attendances yesterday were the second highest ever recorded yesterday in the emergency Department at Bassetlaw. It was noted that we were seeing different patient attendance patterns, some of which could be linked to the backlog of patients built up during the pandemic and the slower than expected recovery of elective work, in addition to the public's perception of available healthcare services in the communities were also a likely factor. There are increasing challenges with patient flow because of patients remaining in hospital when medically fit and a system, rather than Trust solution was needed to improve and resolve the challenges ahead of the expected challenges of the autumn and winter months. The Interim Director of Recovery, Innovation & Transformation recognised that the current plans had not delivered the required improvement and additional actions were in train including a bid to increase virtual ward bed capacity by December 2022. Internal work to improve site management and patient flow would also be progressed and a recent workshop to consider improved medical, surgical and clinical opinions to aid flow had taken place. In view of the lack of a statistically significant change and following the review in 2021 of the Emergency Care Intensive Support Team, Kath Smart suggested it would be helpful for the Finance & Performance Committee to consider a deep dive into the refreshed improvement plans. The Chief Executive acknowledged the necessary outcomes had not been seen from the plans, the Interim Chief Operating Officer would be able to review the approach with a fresh pair of eyes.	

	The Board: - ***Noted and took assurance from the Ambulance Handover Delays Report***	
P22/06/E2	**<u>Estates Returns Information Collection 2021/22 (Enclosure E2)</u>**	
	The Estates Return Information Collection (ERIC) formed the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the financial year ending 31st March 2022. ERIC data provided the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estates and also supported work to improve efficiency. An increase of £0.5m had been seen in the overall backlog maintenance. The information had been provided from the six-facet annual survey, undertaken by external provider, Oakleaf, and a desk top review by Estates management. The main factors which influenced this position were an annual increase in cost due to inflation and capital investment to support the backlog reduction. No questions were received in relation to the paper.	
	The Board: - ***Approved the Estates Returns Information Collection 2021/22***	
P22/06/F1	**<u>Integrating Care Update (Enclosure F1)</u>**	
	Anthony Fitzgerald, Director of Strategy and Delivery at Doncaster Clinical Commissioning Group and Ruth Bruce, Doncaster Provider Alliance Lead were welcomed to the meeting. Anthony would take up his appointment as Doncaster Place Director for NHS South Yorkshire Integrated Care Board with effect from 1 July 2022. Anthony highlighted that partnership working in Doncaster was already well established and the purpose of the paper was to provide an update on the status and role of the Doncaster Integrating Care Partnership Board and the key proposed changes to the existing Place Agreement, and to seek the Trust Board's approval in principle of the terms of the revised Place Agreement, subject to further minor amendments to finalise the Place Agreement for signature. There was a huge potential for change, with a genuine desire for open dialogue and the Chair of the Board signalled the Trust was a willing partner and would be actively engaged in sourcing system solutions. The Chief Executive recognised place development plans were work in progress and there was a continued need to develop a place response to place challenges. The ability to develop place and system thinking would need to be addressed and would likely be supported by an organisational development piece of work, to be progressed by the HR directors, to ensure that maximum benefits and best value for money was achieved.	

	Considering the levels of deprivation at place the demand on the Trust's emergency departments would be expected to rise, as would subsequent discharges into the community. Addressing health inequalities would be a key piece of work. Kath Smart recognised the move from competition to collaboration and in response to future tendering arrangements, Anthony Fitzgerald confirmed commissioning would be focused upon achieving the required outcomes and a move away from previous methodologies would be seen. Neil Rhodes acknowledged that change was naturally challenging, however, it was incumbent upon all parties to make the legislative changes work and a change in mindset would be required. He offered his support to move forward, as proposed. Board approved in principle the terms of the updated Place Agreement and agreed to delegate authority to the Chief Executive to agree any necessary inconsequential amendments to the final version, and to enter into the updated Place Agreement on behalf of the Trust. The Chair of the Board thanked Anthony Fitzgerald and Ruth Bruce for attending today and confirmed the Trust's engagement and commitment to the new ways of working.	
	The Board - ***Approved in principle the terms of the Doncaster Place Agreement***	
P22/06/G1	**<u>NHS Provider Licence Self-certification 2021/22 (Enclosure G1)</u>**	
	Following consideration at the Audit & Risk Committee on 27 May 2022, the report was provided as a statutory requirement for annual self-certification against the Provider Licence provisions. Following the revision of the Trust's deficit plan for 2022/23 the continuity of services condition 7 at 3C should be amended to read £10m, instead of £25m. Subject to this change, approval was provided, and the amended final copy would be published on the Trust's website.	
	The Board - ***Approved the NHS Provider Licence Self-certification 2021/22***	
P22/06/H1	***Governor Questions regarding the business of the meeting (10 minutes) ****	
	The following questions were received from governors, presented by the Lead Governor: **<u>Maternity Workforce - The report on page 27 of the bundle includes data on the maternity workforce, which is below the desired standard. The Ockenden Report links staffing levels to mother/baby safety. Would there be a sustainable increase in staffing levels and thus safety if all births were consolidated onto the DRI site, accepting that such a move would require capital investment?</u>**	

	The Chief Executive confirmed that staffing levels were continually assessed to ensure the acuity and dependency of expectant mothers was matched to appropriate staffing levels. In addition, proactive steps to improve recruitment and retention to manage the vacancy position were being taken. If, for safe staffing reasons, it was considered that the merger of the maternity units needed to be considered, the impact on expectant mothers, partners/family and staff would need to be considered as would factors like travel costs, system wide implications and the potential impact on recruitment and retention. It was recognised that over the summer months the position would be very challenging, until the newly registered colleagues commenced in post in October. In terms of keeping up to date, a monthly maternity update was received at Board, governor observer reports from the Quality & Effectiveness Committee were accessible via the governor portal and the Chief Executive reassured governors that any change to provision would be communicated to Board and the Council of Governors. **ICS Developments. The rationale for Integrated Care Systems and provider collaboratives is that joint working and shared commitment will lead to better use of resources and more effective services against the 4 overarching system aims. Could Richard Parker identify the system priorities against these aims, involving DBTH, to be driven by the ICS and Place Board, accepting that not all desired service improvements are achievable in the short term, and some require national action.** The Chief Executive confirmed that the Trust was a partner in two ICS's, NHS Nottinghamshire, and NHS South Yorkshire, which become statutory organisations on the 1st of July 2022 and was also a partner in the two Place Boards, Bassetlaw, and Doncaster. The ICS's working arrangements, plans and objectives are available via their websites, as are the plans for the two Places. **Amanda Pritchard has endorsed proposals by Dr Clair Fuller, from Surrey Heartlands, for better integration of secondary and primary care, in out-of-hospital settings - typically in neighbourhoods. Reportedly all 42 ICS CEOs support such developments. What are the priority pathways in the areas served by DBTH for such transformation, and are DBTH leaders involved in such discussions in both South Yorkshire and Nottinghamshire?** The Chief Executive confirmed that the Trust was an active partner in the Nottinghamshire and South Yorkshire ICS's supporting the priorities set out in the plans for 2022/ 2023 which were available on the ICS's websites. DBTH was also a partner in the South Yorkshire and Bassetlaw and Nottinghamshire Acute Federations which have identified several priorities for 2022/ 2023 which were set out in the Acute Federations Annual Report, to be shared at July's Board of Directors. **In relation to the Integrated Care Update: 'Is it intended that there will be a governor observer presence at the relevant Board/Committees once implementation of the systems are undertaken'** It was confirmed there was no provision for governor observers at operational meetings. However, the board meeting of the South Yorkshire Integrated Care Board was a meeting	

	held in public. The inaugural meeting had taken place on 1 July 2022 and this could be viewed at www.southyorkshire.icb.nhs.uk The Chair of the Board would continue to champion the role of governors and indicated there was the potential for a governor conference to be arranged by NHS South Yorkshire. **The maternity report outlines information and staff attitude as the primary cause for complaint. What work has been undertaken to understand more fully what information and what about attitude is the problem - is there any thoughts that this links back to staffing issues (stress)?** The reduction in the number of complaints remained a priority for all areas, considered by the Quality & Effectiveness Committee. A reduction had been evidenced as a result of concerted effort to effectively communicate, including the proactive sharing of information. **In terms of the Nottinghamshire Integrated Care Board and Partnership Board do you assume that the establishment will be broadly similar?** The Chief Executive confirmed that overall, the same architecture would be in place to improve health and social care outcomes for patients but that there were differences in the Governance and meeting structures which reflected the development of both systems. The core purposes of Integrated Care Systems were to: • Improve outcomes in populations health and healthcare • Tackle inequalities in outcomes, experienced and access • Enhance productivity and value for money • Help the NHS support broader social and economic development The Chair of the Board thanked everyone for their contribution, including today's presentation which allowed those in attendance to see the actions taken to continue learn and improve practice.	
	The Board - ***Noted the governor observations, question and feedback provided.***	
P22/06/H3	**Minutes of the meeting held on 24 May 2022 (Enclosure I1)**	
	The Board: - ***Approved the minutes of the meeting held on 24 May 2022.***	
P22/06/H2	**Any other business (to be agreed with the Chair prior to the meeting)**	
	No items of other business were raised.	

	The Board: - ***Noted the governor observations, question and feedback provided.***	
P22/06/H3	**Any other business (to be agreed with the Chair prior to the meeting)**	
	No items of any other business had been received.	
P22/06/H4	**Date and time of next meeting (Verbal)** **Date:** Tuesday 26 July 2022 **Time:** 09:30am **Venue:** MS Teams	
P22/06/I5	**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.***	
P22/06/J	**Close of meeting (Verbal)**	
	The meeting closed at 11.31	