

**Board of Directors Meeting Held in Public  
To be held on Tuesday 20 December 2022 at 09:30  
Via MS Teams**

Enc		Purpose	Time
<b>A</b>	<b>MEETING BUSINESS</b>		<b>09:30</b>
<b>A1</b>	<p>Welcome, apologies for absence and declarations of interest <i>Suzy Brain England OBE, Chair</i> 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</p> <p>Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting</p>		5
<b>A2</b>	<p>Actions from previous meeting (<b>no active actions</b>) <i>Suzy Brain England OBE, Chair</i></p>	<i>Review</i>	
<b>B</b>	<b>True North SA1 - QUALITY AND EFFECTIVENESS</b>		<b>09:35</b>
<b>B1</b>	<p>Maternity Update <i>Lois Mellor, Director of Midwifery</i></p>	<i>Assurance</i>	15
<b>B2</b>	<p>Mortality Measures (Hospital Standardised Mortality Ratio &amp; Summary Hospital-level Mortality Indicator) <i>Dr Tim Noble, Executive Medical Director</i></p>	<i>Note</i>	10
<b>C</b>	<b>True North SA4 – FINANCE &amp; PERFORMANCE</b>		<b>10:00</b>
<b>C1</b>	<p>Winter Plan Update including Ambulance Handovers <i>George Briggs, Interim Chief Operating Officer</i></p>	<i>Assurance</i>	15
<b>C2</b>	<p>Industrial Action Update <i>George Briggs, Interim Chief Operating Officer</i></p>	<i>Assurance</i>	5
<b>C3</b>	<p>Mexborough Elective Orthopaedic Centre (MEOC) Outline Business Case <i>Jon Sargeant, Interim Director of Recovery, Innovation &amp; Transformation</i></p>	<i>Approval</i>	10
<b>D</b>	<b>OTHER ITEMS</b>		<b>10:30</b>
<b>D1</b>	<p>Any other business (to be agreed with the Chair prior to the meeting) <i>Suzy Brain England OBE, Chair</i></p>	<i>Discussion</i>	

<b>D2</b>	Governor questions regarding the business of the meeting (10 minutes)* <i>Suzy Brain England OBE, Chair</i>	<i>Discussion</i>	10
<b>D3</b>	Minutes of the meeting held on 29 November 2022 Suzy Brain England OBE, Chair	<i>Approval</i>	5
<b>D4</b>	<b>Date and time of next meeting:</b> <b>Date:</b> Tuesday 31 January 2023 <b>Time:</b> 09:30 <b>Venue:</b> MS Teams	<i>Information</i>	
<b>D5</b>	<b>Withdrawal of Press and Public</b> 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. <i>Suzy Brain England OBE, Chair</i>		

**E MEETING CLOSE** **10:45**

**\*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, 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 by 5pm the day before 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:  
Updated:

Angela O'Mara  
29 November 2022



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

## Action Log

<b>Meeting:</b>	Public Board of Directors	<b>KEY</b>	
<b>Date of latest meeting:</b>	29 November 2022	<b>Completed</b>	<b>On Track</b>
		<b>In progress, some issues</b>	<b>Issues causing progress to stall/stop</b>

No.	Minute No.	Action	Lead	Target Date	Update
1.	P22/07/G1	<b><u>Risk Management</u></b> To provide a timeline for the revised risk policy and associated plan of work to review the Corporate Risk Register	TN	<del>September</del>  November  2022	<b>27.9.2022</b> – Risk Management Board stood down on 19.9.2022 due to national bank holiday for the Queen's funeral. Next meeting due 17.10.2022 – Executive Medical Director to provide an update at November's full board meeting <b>Included within Executive Medical Director Update (C4) – Close action.</b>
2.	P22/10/D1	<b><u>Medical Advisory Committee and Risk Management Board</u></b> To provide a visual governance structure to show the reporting structure of the Medical Advisory Committee and the Risk Management Board.	TN	November  2022	<b>Included within Executive Medical Director Update (C4) - Close action.</b>
3.	P22/10/D1	<b><u>Corporate Director Objectives</u></b> Mid-year review and discussion of corporate objectives to commence with the Executive Directors and the Chairs at the relevant Board Sub-Committees. Review if workshop required once process reviewed	All	November  2022	<b>Post meeting update</b> – the Chief Executive & Chair of the Board agreed that each executive director would meet with the non-executive directors to talk through their objectives, highlighting successes and challenges. Meetings were in the diary, with the exception of the Chief Operating Officer and Chief Nurse which would take place by the end of Q4 2022/2023, following their substantive appointments in January 2023. – <b>Close action</b>

Report Cover Page					
<b>Meeting Title:</b>	Board of Directors				
<b>Meeting Date:</b>	20 December 2022	<b>Agenda Reference:</b>	B1		
<b>Report Title:</b>	Maternity Update				
<b>Sponsor:</b>	Richard Parker OBE, Chief Executive				
<b>Author:</b>	Lois Mellor, Director of Midwifery				
<b>Appendices:</b>	Perinatal Surveillance Dashboard				
Report Summary					
<b>Purpose of report:</b>	To update the Board of Directors on performance, key issues, and developments in Maternity Service				
<b>Summary of key issues/positive highlights:</b>	<ul style="list-style-type: none"> <li>• Update on current Perinatal Mortality Review Tool (PMRT) reviews for the month and quarter 4 findings</li> <li>• Current Healthcare Safety Investigation Branch (HSIB) cases in progress and reports received.</li> <li>• Education and training compliance below the 90% target due to the pausing of training during the recent wave of covid 19</li> <li>• Trajectories / plans in place to recover the training position</li> <li>• Ongoing work with the maternity voices partnership (MVP) and improved collaborative working</li> <li>• Year 4 Clinical Negligence Scheme for Trusts (CNST) standards recommenced 7 May 2022</li> </ul>				
<b>Recommendation:</b>	None				
<b>Action Require:</b>	Approval	Information	Discussion	Assurance	Review
<b>Link to True North Objectives:</b>	<b>TN SA1:</b> <i>To provide outstanding care for our patients</i>	<b>TN SA2:</b> <i>Everybody knows their role in achieving the vision</i>	<b>TN SA3:</b> <i>Feedback from staff and learners is in the top 10% in the UK</i>	<b>TN SA4:</b> <i>The Trust is in recurrent surplus to invest in improving patient care</i>	
Implications					
<b>Board assurance framework:</b>					
<b>Corporate risk register:</b>					
<b>Regulation:</b>					
<b>Legal:</b>					
<b>Resources:</b>					
Assurance Route					
<b>Previously considered by:</b>	All parts of this report have been discussed at all levels in the Children & Families Division.				
<b>Date:</b>		<b>Decision:</b>			
<b>Next Steps:</b>	Support to continue improvements in maternity service, and achieve full compliance with CNST Year 4 standards and the Ockenden immediate actions				

## Monthly Board Report

### November 2022

*Additional information in support of this report is provided 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**

In November 2022 there were no reported stillbirths.

Two cases were reviewed and closed at perinatal mortality meeting.

Case 1 – Learning that there was missed opportunity to prescribe aspirin in early pregnancy and a missed scanning opportunity. This has been shared with an internal newsletter.

Case 2 – There were issues with accessing interpreting services for a non-English speaking family. This has been addressed, and contacts for interpreting services refreshed and shared in ward areas.

There remains the issue of families not being cared for in a suitable environment for bereaved families.

##### **1.2 Neonatal Deaths**

There were two neonatal death dues to extreme prematurity (less than 24 weeks gestation).

##### **1.3 Actions/ Learning from PMRT**

Creation of suitable environment for families that have lost a baby. This is an ongoing action, funding has been established and work is sequenced as part of the refurbishment of level 3, creating a bereavement suite.

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

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

### 2.1 Reports Received since last report

Two reports have been received.

**HSIB case number:** MI-009360

#### **Recommendation**

The Trust to ensure a structured neurological assessment takes place and is documented when hypoxic encephalopathy is suspected

**HSIB case number:** MI-010419

#### **Recommendation**

The Trust to ensure mothers with high risk factors for early onset fetal growth restriction receive low dose aspirin and ongoing surveillance in line with national guidance.

Action plan have been developed for both reports, including the finding and recommendations and will be monitored by the integrated care board to completion.

### 2.2 Current investigations

None

## 3. Serious Incident Investigations (Internal)

There is one ongoing SI investigation related to the term stillbirth.

#### 4. Training Compliance

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

##### CTG Study Day

- The training currently delivered is in line with the recommendations from CNST Y4, the Ockenden report and HSIB investigations.
- 90% of all staff have to have attended the fetal monitoring study day by the 5<sup>th</sup> January 2023. Including the numbers that have attended and booked to attend, the trajectory will be:

Consultants	100%
Doctors	75% (not currently inc GP trainees. Plan in place).
Midwives	77.1% (including all NQM's starting Oct 22).

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	12	8	66.7%	10	83.3%
Doctors	20	9	45.0%	10	50.0%
Midwives	211	179	84.8%	150	71.1%
NHSP Midwives	21	12	57.1%	6	28.6%
<b>Divisional</b>	<b>264</b>	<b>208</b>	<b>78.8%</b>	<b>176</b>	<b>66.7%</b>

Which has improved from 56.4% to 66.7%

## Practical Obstetric Multi Professional Training (PROMPT) Training (Obstetric Emergencies)

A trajectory has been set to achieve 90% compliance by December, and there has been an improvement in some roles but overall compliance remains static this month.

### PROMPT Data

MDT Role	Number	Number Compliant	Prompt Compliance
Consultants	12	9	75.0%
Doctors	32	17	53.1% ↑
Midwives	202	158	78.2% ↑
NHSP Midwives	25	11	44.0% ↑
Support Workers	70	17	60.0%
Theatre Staff	83	34	41.0%
Anaesthetists	38	8	21.1%
<b><u>Divisional</u></b>	<b><u>462</u></b>	<b><u>254</u></b>	<b><u>55.0%</u></b>

## 5. Service User Feedback

Several midwives met on the with the MVP service users in the first face to face meeting. There was honest and rich feedback from recent service users.

The areas that were decided to address and develop plans on are:

- Language used by professionals – using a more positive approach to discuss options, and risk related to care
- Forms of information and signposting to information. The maternity website is under development and the MVP will assist us with this
- Consultants approaches to discussions about plans of care in maternity
- The triage service, staff attitudes and waiting times

The work plan has been agreed and the equity and equality lead midwife is working closely with the MVP chair to progress the plan.



**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**

Work towards Year 4 CNST standards is ongoing.

A project manager has been recruited to assist the service with collating the evidence.

A review of safety actions 3 and 5 has been undertaken by 360 and feedback is expected in late October.

This review has assessed partial compliance with the evidence submitted. Full compliance can be submitted for some elements using different types of evidence.

Currently compliance with three standards remains a risk:

Safety Action 3 – ATAIN

Safety Action 5 – Midwifery Workforce (ongoing recruitment in place)

Safety Action 8 – Training (a trajectory to meet 90% training has been set)

**9. Progress in implementing Maternity 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 three building blocks described in the letter from Ruth May in September 2022 are in place:

- Adequate midwifery staffing
- Education and training
- Engagement of staff

**10. Board Level Safety Champion staff feedback from walkabout**

Dr Tim Noble will undertake this role in the interim until the new Chief Nurse has commenced in post.

A walkabout will be planned before December 2022.

# NE&Y Regional Perinatal Quality Oversight Group Highlight Report

MW to birth ratio :  
BR+ recommendation  
**1::28.25**

Vacancy  
rate (MW)

LW co-ordinator  
supernumerary  
(%)



LMNS: South Yorkshire and Bassetlaw

Reporting period: October 2022 – December 2022

**Overall System RAG:**

(Please refer to key next slide)

Oct	1:27.4	14%	
Nov			
Dec			

**Maternity unit** DBTH – Doncaster

KPI (see slide 4)	Measurement / Target		Doncaster Rate		
			October	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	18.3%	16.8%	
	Emergency	<15.2 %	20.1%	28.8%	
Preterm birth rate	≤26+6 weeks	0	0.37%	1.6%	
	≤36+6 weeks	<6%	8.4%	5.6%	
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4%	4.8%	
Term admissions to NICU		<6%	3.3%	5.6%	
3 <sup>rd</sup> & 4 <sup>th</sup> degree tear	SVD (unassist'd)	<2.8%	0.7%	2.6%	
	Instrumental (assisted)	<6.05 %	0%	5.9%	
Right place of birth		95%	95.37%	99.6%	
Smoking at time of delivery		<11%	13.1%	17.5%	
Percentage of women placed on CoC pathway		35%	0%		
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	
	Area of deprivation		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)
							2	1	0	0	0	0	0	0	0
2021/2022															
Oct	48	163	0	0	0	0	2	1	0	0	0	0	0	0	0
Nov	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Q3															

## Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	37	0	0
2	Delay in elective work	0	0	0
3	Unable to give 1-1 care in labour	0	0	
4	Missed/delayed care for > 60 minutes	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	1	0	0

# NE&Y Regional Perinatal Quality Oversight Group Highlight Report

MW to birth ratio :  
BR+ recommendation  
**1::28.25**

Vacancy  
rate (MW)

LW co-ordinator  
supernumerary  
(%)



LMNS: South Yorkshire and Bassetlaw

Reporting period: October 2022 – December 2022

Overall System RAG:

(Please refer to key next slide)

Maternity unit **DBTH – Bassetlaw**

KPI (see slide 4)3.9%	Measurement / Target		Bassetlaw Rate		
			October	Nov	Dec
Caesarean Section rate	Elective	<13.2 %	8.3%	10.07%	
	Emergency	<16.9 %	27.3%	28.06%	
Preterm birth rate	≤26+6 weeks	0	0.76%	0%	
	≤36+6 weeks	<6%	5.3%	5.04%	
Massive Obstetric Haemorrhage	≥1.5I	<2.9%	2.3%	3.6%	
Term admissions to NICU		<6%	3.03%	1.44%	
3 <sup>rd</sup> & 4 <sup>th</sup> degree tear	SVD (unassist'd)	<2.8%	2.8%	3.0%	
	Instrumental (assisted)	<6.06 %	15.4%	5.6%	
Right place of birth		95%	95.76%	100%	
Smoking at time of delivery		<11%	7.6%	13.5%	
Percentage of women placed on CoC pathway		35%	0	0	
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME				
	Area of deprivation	75%			

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	Oct	0	41	0	0	0	2	0	0	0	0	0	0	0
	Nov	0	0	0	0	0	0	0	0	0	0	0	0	0
	Dec	0	0	0	0	0	0	0	0	0	0	0	0	0
	Q3													

## Maternity Red Flags (NICE 2015)

		Oct	Nov	Dec
1	Delay in commencing/continuing IOL process	4	0	0
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	0	0	0
5	Delay of 30 minutes or more between presentation and triage (LWAU)	0	0	0

## Assessed compliance with 10 Steps-to-Safety

		Oct	Nov	Dec
1	Perinatal review tool	On Track	Complete	Complete
2	MSDS	On Track	Complete	Complete
3	ATAIN	At Risk	Complete	Complete
4	Medical Workforce	On Track	Complete	Complete
5	Midwifery Workforce	At Risk	Complete	Complete
6	SBLCB V2	On Track	Complete	Complete
7	Patient Feedback	On Track	Complete	Complete
8	Multi-professional training	At Risk	Complete	Complete
9	Safety Champions	On Track	Complete	Complete
10	Early notification scheme (HSIB)	On Track	Complete	Complete

## 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

		Oct	Nov	Dec
1	Reducing smoking	On Track	Complete	Complete
2	Fetal Growth Restriction	On Track	Complete	Complete
3	Reduced Fetal Movements	On Track	Complete	Complete
4	Fetal monitoring during labour	On Track	Complete	Complete
5	Reducing pre-term birth	On Track	Complete	Complete

## Assessment against Ockenden Immediate and Essential Action (IEA)

	Oct	Nov	Dec
Audit of consultant led labour ward rounds twice daily	On Track	Complete	Complete
Audit of Named Consultant lead for complex pregnancies	On Track	Complete	Complete
Audit of risk assessment at each antenatal visit	On Track	Complete	Complete
Lead CTG Midwife and Obstetrician in post	On Track	Complete	Complete
Non Exec and Exec Director identified for Perinatal Safety	On Track	Complete	Complete
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	At Risk	PROMPT	Complete
Plan in place to meet birth rate plus standard (please include target date for compliance)	On Track	Complete	Complete
Flowing accurate data to MSDS	On Track	Complete	Complete
Maternity SIs shared with trust Board	On Track	Complete	Complete

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

Maternity unit	Oct	Nov	Dec
Freedom to speak up / Whistle blowing themes	None	None	
Themes from Datix (to include top 5 reported incidents/ frequently occurring )	Weight unexpectedly below the 10 <sup>th</sup> centile PPH Shoulder dystocia Unexpected admission to NNU Staffing	Weight unexpectedly below the 10 <sup>th</sup> centile PPH >1500ml Unexpected admission to NNU Staffing Unexpected NNU admission Availability of Pumps	
Themes from Maternity Serious Incidents (Sis)	Guidance needed when professional opinions differ	Management and review of diabetic pathway and management of late diagnosis/unstable GDM	
Themes arising from Perinatal Mortality Review Tool	Increased SB rate No themes on toll further review being undertaken Bereavement facilities poor	Diabetic management of unstable GDM USS not plotted accurately Off pathway care Partogram not being completed Poor use of translation services CDS USS requires review and aim to upgrade	
Themes / main areas from complaints	Communication Delays in care	Communication Attitudes	
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	MVP ongoing, workplan in place CQC survey action plan to be developed	MVP Bereavement questionnaire	
Evidence of co-production	New CDS	New CDS and serenity suite appeal	
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	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 August	Ongoing OCR meeting Ongoing skills and drills scenarios Education lead now back in post supporting education needs of staff PROMPT Pastoral care team	
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 LMNS meetings Trust meeting	WHATS HOT Ward briefs and emails Face to face discussions with staff LMNS meetings Trust meeting	

## KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source			
S1	<b>Caesarean section rate</b> (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	<b>Preterm birth rate</b> (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	<b>Massive obstetric haemorrhage</b> (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	<b>Term admissions to NICU</b> ((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	<b>3<sup>rd</sup> &amp; 4<sup>th</sup> degree tear</b> (3 <sup>rd</sup> / 4 <sup>th</sup> 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)	% 3 <sup>rd</sup> & 4 <sup>th</sup> degree tear: NMPA SVD & Instrumental 3 <sup>rd</sup> & 4 <sup>th</sup> 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	<b>Right Place of Birth</b> (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	<b>Smoking at time of delivery</b>	% women smoking at time of delivery	6%	<11%		>11%	Trust / MSDSv2			
S8	<b>Percentage of women placed on Continuity of Carer pathway</b> 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	<b>Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway</b> (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 Report

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 care 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)



Report Cover Page					
<b>Meeting Title:</b>	Board of Directors				
<b>Meeting Date:</b>	20 December 2022	<b>Agenda Reference:</b>	B2		
<b>Report Title:</b>	Mortality Measures				
<b>Sponsor:</b>	Dr Tim Noble, Executive Medical Director				
<b>Author:</b>	Julie Butler, Senior Manager				
<b>Appendices:</b>	None				
Report Summary					
<b>Purpose of report:</b>	<p>To provide:</p> <ul style="list-style-type: none"> <li>a description of the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics</li> <li>information on how regular monitoring of these performance metrics is embedded within the Trust's culture and governance framework</li> <li>an update on mortality measures being undertaken, led by the Executive Medical Director</li> </ul>				
<b>Summary of key issues/positive highlights:</b>	<p>The close monitoring of HSMR and SHMI provide an indicator for further investigation.</p> <p>On a backdrop of Nationally increasing mortality, our most recent reports also show a trend of increasing mortality. This has triggered the need for further investigation, understanding that this may not necessarily indicate any deficiency in the quality of care provided.</p> <p>A working group will be established to investigate:</p> <ul style="list-style-type: none"> <li>The Trust processes and whether there is more we can learn, improve or change that would make a difference.</li> <li>Medical Examiner processes against peers.</li> <li>The selection process for Structured Judgement Review (SJR).</li> <li>The standard of SJRs to understand whether they are consistent with others.</li> <li>Further benchmarking clinical coding against the Trust's peer group.</li> <li>Impact of improvement work to support hospital flow on performance.</li> <li>Whether mortality has increased in certain key Healthcare Resource Groups (HRGs) areas more than others.</li> <li>Comprehensive data analysis, to see if the gradient of our increase is the same or different from the peer group and national picture.</li> </ul>				
<b>Recommendation:</b>	The Board of Directors are asked to note the content of the report.				
<b>Action Required:</b>	Approval	Information	Discussion	Assurance	Review

<b>Link to True North Objectives:</b>	<b>TN SA1:</b>	<b>TN SA2:</b>	<b>TN SA3:</b>	<b>TN SA4:</b>
	<i>To provide outstanding care for our patients</i>	<i>Everybody knows their role in achieving the vision</i>	<i>Feedback from staff and learners is in the top 10% in the UK</i>	<i>The Trust is in recurrent surplus to invest in improving patient care</i>
<b>Implications</b>				
<b>Board assurance framework:</b>	<i>No changes made</i>			
<b>Corporate risk register:</b>	N/A			
<b>Regulation:</b>				
<b>Legal:</b>	N/A			
<b>Resources:</b>	N/A			
<b>Assurance Route</b>				
<b>Previously considered by:</b>				
<b>Date:</b>		<b>Decision:</b>		
<b>Next Steps:</b>				
<b>Previously circulated reports to supplement this paper:</b>				

## 1. INTRODUCTION

The consideration and monitoring of key mortality data is a high priority for the Trust, in particular Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Regular monitoring of both performance metrics is embedded within the Trust's culture and governance framework, from Specialty and Divisional level, through the appropriate sub-committees and up to the Board of Directors.

Key headline mortality data is provided and discussed at the monthly Mortality Governance Group, then submitted to the Clinical Governance Committee, Trust Executive Group and Board of Directors, as is the quarterly Learning from Deaths Report.

The reports are divided into the 3 key metrics:

- Crude mortality rate

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted.

Whilst crude mortality rates are important, it is very hard to use this information to compare and contrast what is happening between hospitals. This is because every hospital is different, both in the treatments and operations that it offers and the make-up of its local population.

- Hospital standardised mortality ratio (HSMR)

The hospital standardised mortality ratio (HSMR) was developed to enable a more meaningful comparison of mortality rates between hospitals. The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors, such as population size, age profile, levels of deprivation, range of treatments and operations provided.

Nationally the expected HSMR score for hospitals is set at 100. A score of 100 means that the number of deaths is similar to expected levels. A lower score means fewer deaths, a higher score means more deaths than expected.

- Summary hospital-level mortality indicator (SHMI)

SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The key difference from HSMR is that SHMI includes deaths following a patient's discharge (within 30 days) and does not make an adjustment for palliative care or other factors outside the Trust's control. It is therefore more likely to reflect the socio-economic environment of our population rather than just the care the Trust provides.

In addition, under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017, the Trust is required to produce a quarterly 'Learning from Deaths' report.

- Learning from Deaths

The Learning from Deaths quarterly report details the following information:

- total number of inpatient deaths
- number of deaths that have been subject to case record review

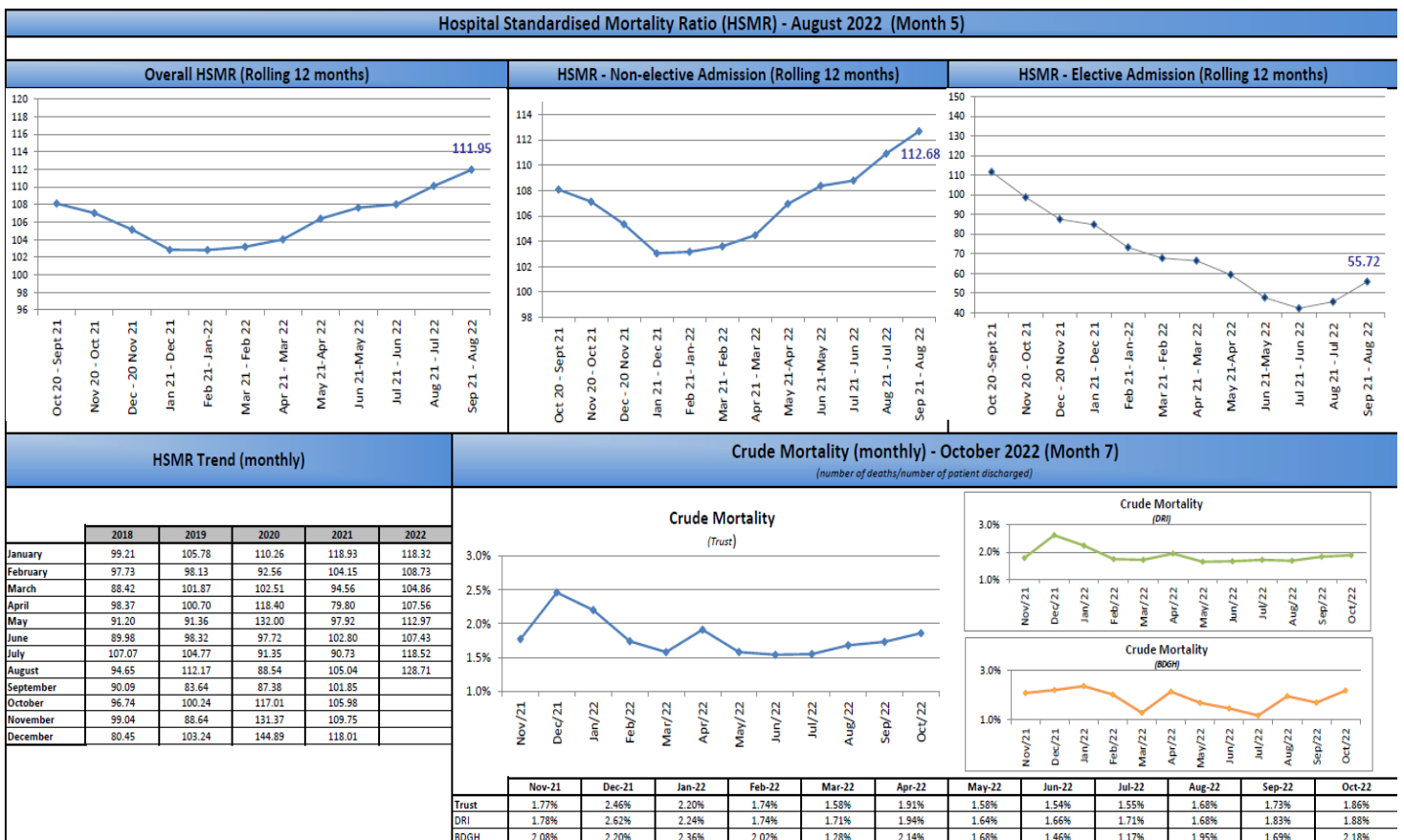
- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation

There is a fully established medical examiner team who scrutinise every hospital adult death, in addition to the appointment of a Learning from Deaths nurse to drive forward the Learning from Deaths agenda.

## 2. CURRENT POSITION

As outlined in the introduction, it's clear that the relationship between mortality rates and the quality of care that patients receive is complex. The close monitoring of HSMR and SHMI provides an indicator of Trust performance so that an elevated mortality rate is the trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care provided.

Over the past few months Trust HSMR and SHMI rates have continued to rise, although the national picture also shows an increase. The local public health perspective is that there is no clear intelligence at this stage as to why mortality is rising, and whilst there is an increase across the majority of Trusts nationally, there are areas within our peer group where the number of higher than expected deaths is not being seen.



August 2022 data

In terms of elective admissions, there has been several months in the last 12 month period where there have been no deaths which demonstrated a downward trend. Over time it has become apparent that the vast majority of “elective” deaths are not what we class as a “true” elective admissions. Most are very ill patients with significant comorbidities who attend hospital for pain relief or symptom management. It is essential that these cases are looked with this perspective to reassure the Trust regarding any potential elevation of the monthly and rolling elective HMSR.

The Medical Examiner team within the Trust scrutinise 100% of non-coronial adult deaths and no lapses in care have been identified. As an independent service, their work is reported and assured by the National Medical Examiner.

However, as the upward trend continues with monthly elective HSMR for August reported at 154.65 and the monthly non elective monthly HSMR at 128.24, the ratio is much higher than the expected level of 100, which has triggered the need to carry out an in-depth analysis.

In addition, during a recent visit by senior colleagues from South Yorkshire Integrated Care Board, discussions were held around the Trust’s mortality measures and how we are assuring ourselves that our processes are sound and whether there is more we can do to seek any learning, improvements or changes that would make a difference.

### **3. MORTALITY REVIEW**

Given the current position and views from external partners, the Executive Medical Director is leading an in-depth investigation to:

- Ensure the Medical Examiner processes are robust and quality assured against peers.
- Review selection process for Structured Judgement Review (SJR) to ensure that it is clear and in line with peers.
- Peer review the standard of SJRs to understand whether they are consistent with others.
- Benchmark clinical coding against the Trust’s peer group.
- Understand the Trust wide impact of improvement work to support hospital flow and whether this has influenced the data, such as number of consultant changes per inpatient spell or increase of symptom codes.
- Analyse key Healthcare Resource Groups (HRGs) to see whether mortality has increased in certain areas more than others.
- Undertake comprehensive data analysis, to see if the gradient of our increase is the same or different from the peer group and national picture.

In order to undertake this investigation a working group will be established consisting of Trust wide multi-professional staff, and partners from public health and primary care.

The group will seek to ensure the triangulation of available information from many sources including mortality data, structured judgement mortality reviews, coding reviews, and where applicable care in the community.

### **4. NEXT STEPS**

Communication has gone out to key areas and partners to assist in the analytical review and for representation in the mortality data assessment working group.

A Terms of Reference will be drafted for this group which will be agreed with the membership once established.

In terms of timescale, this is a time-limited piece of work with initial findings expected by the end of quarter four of this financial year. The factors influencing the HSMR (if found) will be considered by the working group with recommendations for further action as needed.

The mortality measures described in this paper will help to understand the Trust's underlying position in terms of HSMR. These measures will identify whether there are contributing factors such as data quality or process issues, which can be addressed with the development of action plans or whether, given the demography of the health population across the boroughs of Doncaster and Worksop, the denominator for the ratio of expected number of hospital deaths for DBTH is set at an appropriate level.

## **5. CONCLUSION**

In conclusion, the close monitoring of HSMR and SHMI provide a warning sign as a trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care provided. DBTH want to ensure learning from this investigation is widely shared across the organisation to support the vision of being "the safest Trust in England, outstanding in all that we do".

The Board of Directors are asked to note:

- The content of this report
- The mortality measures being undertaken, led by the Executive Medical Director.

Report Cover Page			
<b>Meeting Title:</b>	<b>Board of Directors</b>		
<b>Meeting Date:</b>	20 December 2022	<b>Agenda Reference:</b>	<b>C1</b>
<b>Report Title:</b>	<b>Ambulance Handover Update including Operational Performance</b>		
<b>Sponsor:</b>	George Briggs, Interim Chief Operating Officer		
<b>Author:</b>	Andrea Squires, Divisional Director of Operations (Emergency Medicine) Suzanne Stubbs, Interim Deputy Chief Operating Officer - Non-Elective		
<b>Appendices:</b>			
<b>Purpose of report:</b>	<p>The report will:</p> <ul style="list-style-type: none"> <li>• Deliver an executive summary of the operational context, performance headlines.</li> <li>• Share the detail regarding our key metrics on ED, and elective care.</li> </ul>		
<b>Summary of key issues:</b>	<p><b>Operational Context</b></p> <ul style="list-style-type: none"> <li>• ED attendance levels remain higher than previous 4 years with the majority of the increase in the minor's pathway</li> <li>• In common with all Trusts, emergency demand and staffing pressures have impacted on elective delivery, however, the Trust has maintained a reduced programme of elective work through November 2022.</li> <li>• Sickness levels has impacted performance during November 2022. Despite this the performance report will focus on the improvements we have seen in initial assessment and ambulance handovers.</li> </ul> <p>The ED team have:-</p> <ul style="list-style-type: none"> <li>• EAU implemented October 2022 (Emergency Assessment Unit)</li> <li>• Improved flexibility to meet demand</li> <li>• Week on week improvement to Ambulance handover and YAS hours lost</li> <li>• Capacity to implement care initiation area to see sickest first</li> <li>• Fit to Sit capacity created</li> <li>• Supported the front door flow – increasing EAU capacity - EAU assessments increased</li> </ul> <p>Escalation model followed when full capacity protocol triggered linked to the ongoing implementation of electronic prescribing and the utilisation of the EAU</p> <p>The attached graphs share the escalation model the ED team are following and show an improvement in numbers of patients using the EAU and a reduction in admissions to the EAU within a backdrop of increased admissions. A reduction in ambulance handover breaches and an improvement in the percentage of handovers approaching the target. The ambulance data shows a reduction in the time lost at handover which has shown a continual improvement over a 6 week period the time saved is small but the improvement is only 6 weeks old and continues to show improvement since the EAU concept in October. The final graph shows a reduction in the time the navigation nurse takes to see patients and shows an improvement in the red complex patients being seen earlier than none / less complex patients.</p>		
	The Board is asked to note and comment as appropriate on the attached.		

<b>Action Require:</b>	Approval	Information	Discussion	Assurance	Review
<b>Link to True North Objectives:</b>	<b>TN SA1:</b>	<b>TN SA2:</b>	<b>TN SA3:</b>	<b>TN SA4:</b>	
	<i>To provide outstanding care for our patients</i>	<i>Everybody knows their role in achieving the vision</i>	<i>Feedback from staff and learners is in the top 10% in the UK</i>	<i>The Trust is in recurrent surplus to invest in improving patient care</i>	
<b>Implications</b>					
<b>Board assurance framework:</b>	Changes made to SA1 and COVID 19 addition to SA1 to reflect risk and related to winter planning & also planning mitigation				
<b>Corporate risk register:</b>	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8. <ul style="list-style-type: none"> <li>• Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards</li> <li>• Failure to specifically achieve RTT 92% standard</li> </ul> Report outlines actions plan to make progress, no change to risks on CRR				
<b>Regulation:</b>	Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.				
<b>Legal:</b>	Report outlines concerns about the planned IA.				
<b>Resources:</b>	Impact on resources of delivering activity taken account of in Trust plans				
<b>Assurance Route</b>					
<b>Previously considered by:</b>					
<b>Date:</b>		<b>Decision:</b>			
<b>Next Steps:</b>					
<b>Previously circulated reports to supplement this paper:</b>					



# EAU Improvements

- EAU implemented October 2022
- Improved flexibility to meet demand
- Week on week improvement to Ambulance handover and YAS hours lost
- Allowed capacity to implement care initiation area to see sickest first
- Allowed Fit to Sit capacity to be created
- Supported the front door flow – increasing EAU capacity - EAU assessments increased
- Escalation model followed when full capacity protocol triggered

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## Escalation model

### EXIT BLOCK- ESA BLOCK

Stable bed waits can be put in to EAU with no clock stop to create whatever capacity required to allow Ambulance handover and flow.

ESA needs to be flexed up to meet ambulance demand.

### Ambulance Capacity not available

Select patients NEWS<5 potential for EAU but not yet had senior review or stable patients who have been seen awaiting review.

The clock should only stop for appropriate patients.

### EAU policy to be followed

NEWS<5. Patient had senior review and identified as needing a period of observation, treatment, diagnostics or review from speciality with the view to being discharged.

- Nurse led model- with operational oversight.
- Well sky to be implemented in ED to support movement of bed wait patients.
- Area of opportunity to only move EDD 24-48 hour patients for rapid ward round
- Area of opportunity for overnight use of patients where decision to admit is questionable- EAU review by ED

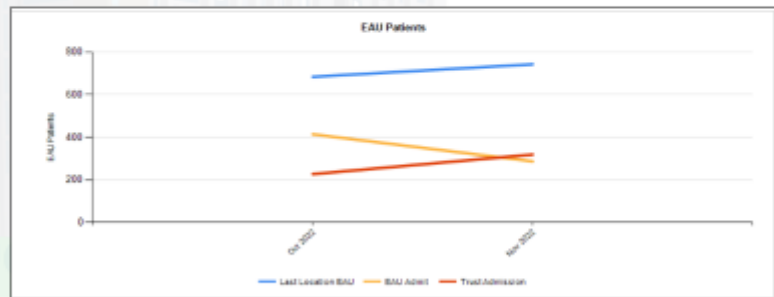
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# EAU Data

Month	Admission	LoS
June	246	28
July	246	29
August	193	39
September	234	32

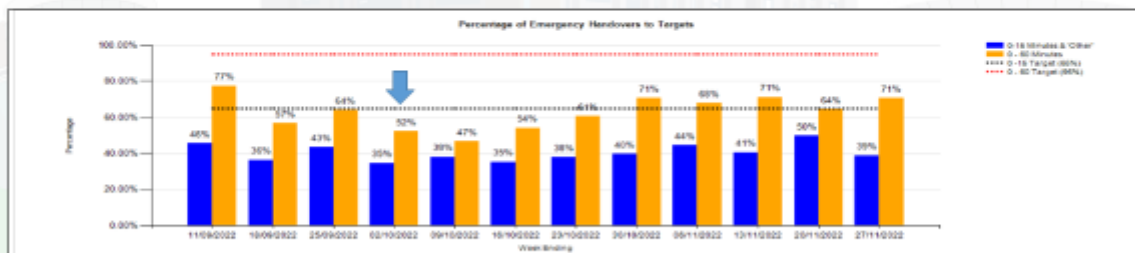
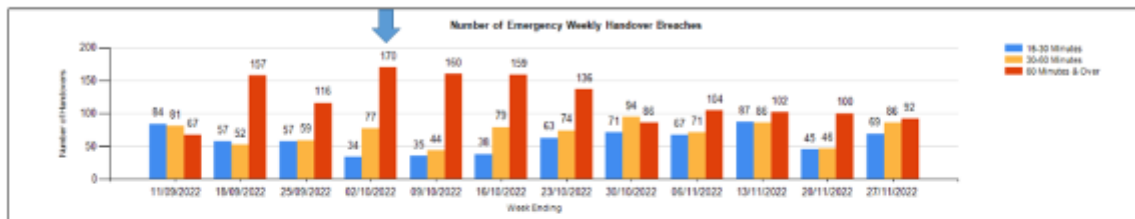
LoS	October	November
Gen Med	42.3	45.4
Social	39.9	32.8
Urology	24.5	46.1
T&O	30	35
Surgery	31.5	31.9
Frailty	23.1	37.8

Month	EAU Location	EAU Count	Admitted	AV los Admitted	Av LoS non-admitted
October		684	414	14.42	9.1
November		743	297	16.55	10.1



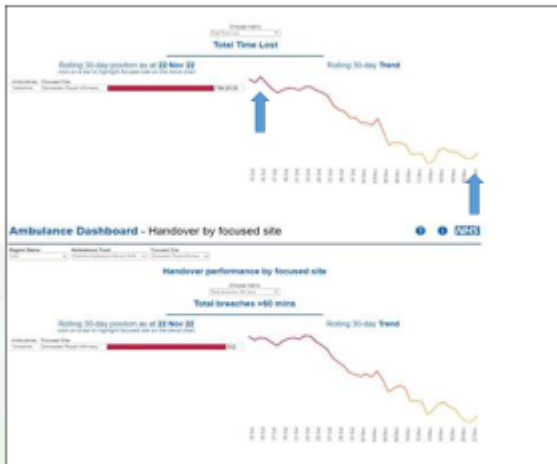
[www.dbth.nhs.uk](http://www.dbth.nhs.uk)

# Ambulance Data



[www.dbth.nhs.uk](http://www.dbth.nhs.uk)

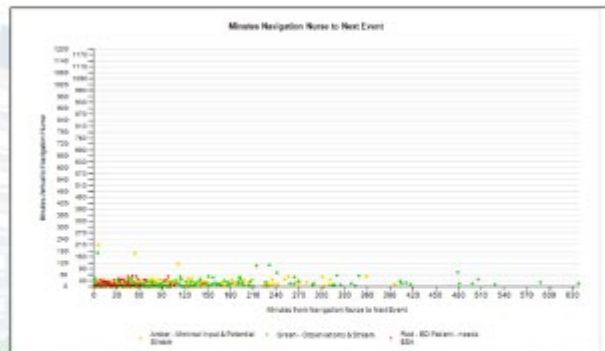
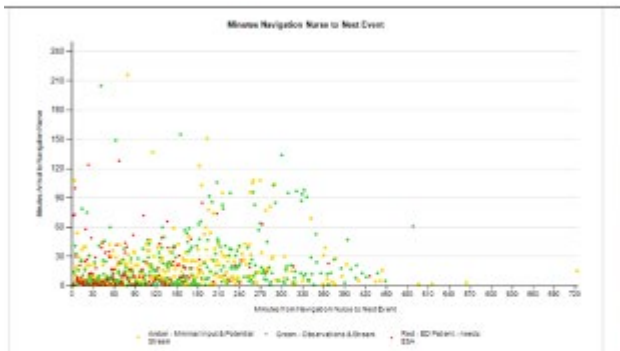
# Ambulance Data



- Arrow 1 shows EAU implementation
- Expected further improvement Arrow 2- implementation of care initiation area - 20 F2S chairs
- Decreased ambulance delays and cohort
- Reduced lost YAS hours
- QI work ongoing at PLACE level
- 8.1% Ambulances arriving since new process (June) streamed to other areas on arrival or from queue.

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# Quality Improvement



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Report Cover Page			
<b>Meeting Title:</b>	<b>Board of Directors</b>		
<b>Meeting Date:</b>	20 December 2022	<b>Agenda Reference:</b>	<b>C2</b>
<b>Report Title:</b>	<b>Industrial Action Preparedness Update</b>		
<b>Sponsor:</b>	George Briggs, Interim Chief Operating Officer		
<b>Author:</b>	Jeannette Reay, Emergency Planning Officer		
<b>Appendices:</b>			
<b>Purpose of report:</b>	<p>The report will:</p> <ul style="list-style-type: none"> <li>• Deliver an update on the actions DBTH is undertaking in preparation for industrial action.</li> <li>• Share the latest national and local updates re planned action.</li> </ul>		
<b>Summary of key issues:</b>	<p>As discussed previously, the RCN vote at Doncaster did not result in a high enough number of members voting therefore there will not be any formal RCN backed action at DBTH. We have had a number of results from other unions which have indicated that there will not be any action across the Doncaster and Bassetlaw teaching hospitals sites. However, the GMB union UNITE and Unison have confirmed paramedics, emergency care assistants, call handlers and other staff are now set to walk out in the following trusts:</p> <p style="text-align: center;">           South West Ambulance Service            South East Coast Ambulance Service            North West Ambulance Service            South Central Ambulance Service            North East Ambulance Service  <b>East Midlands Ambulance Service</b>            West Midlands Ambulance Service            Welsh Ambulance Service  <b>Yorkshire Ambulance Service</b> </p> <p>Two of the services support our population and this may result in some local action and disruption. The planned dates so far are the 21<sup>st</sup> of December linked to this the RCN is planning action on the 15<sup>th</sup> and 20<sup>th</sup> of December but not in our region.</p> <p>We are planning for further requests for information from the regional and national teams as well as knock on effects of the strikes. It is highly unlikely the RCN strikes will affect us but the Ambulance ones will affect all of our sites. We have asked private transport suppliers for additional cover to support non-emergency journeys the Teams are looking at potential high demand after the strikes have finished and will be reviewing cover in our emergency department and assessment areas as well as all emergency access areas.</p> <p>Overall, the Trust is planning business as usual with the exception of the 21<sup>st</sup> and 22<sup>nd</sup> alongside the strikes we continue to experience significant operational challenges and will continue to focus on safety, and support for our patients and staff.</p>		

	The Board is asked to note and comment as appropriate on the attached.				
<b>Action Require:</b>	Approval	Information	Discussion	Assurance	Review
<b>Link to True North Objectives:</b>	<b>TN SA1:</b>	<b>TN SA2:</b>	<b>TN SA3:</b>	<b>TN SA4:</b>	
	<i>To provide outstanding care for our patients</i>	<i>Everybody knows their role in achieving the vision</i>	<i>Feedback from staff and learners is in the top 10% in the UK</i>	<i>The Trust is in recurrent surplus to invest in improving patient care</i>	
<b>Implications</b>					
<b>Board assurance framework:</b>	Changes made to SA1 to reflect risk and related to winter planning & also planning mitigation				
<b>Corporate risk register:</b>	Report regards Risks ID 6 and 2349 on the Risk Register - F&P 6 and F&P 8. <ul style="list-style-type: none"> <li>• Failure to achieve compliance with performance and delivery aspects of the SOF, CQC and other regulatory standards</li> <li>• Failure to specifically achieve RTT 92% standard</li> </ul> Report outlines actions plan to make progress, no change to risks on CRR				
<b>Regulation:</b>	Report links to national quality and access standards. Performance against the standards contributes to the CQC regulatory framework.				
<b>Legal:</b>	Report outlines concerns about the planned IA.				
<b>Resources:</b>	Impact on resources of delivering activity taken account of in Trust plans				
<b>Assurance Route</b>					
<b>Previously considered by:</b>	Confidential Trust Board				
<b>Date:</b>	29.11.2022	<b>Decision:</b>			
<b>Next Steps:</b>					
<b>Previously circulated reports to supplement this paper:</b>					



The Rotherham  
NHS Foundation Trust



Barnsley Hospital  
NHS Foundation Trust



Doncaster and Bassetlaw  
Teaching Hospitals  
NHS Foundation Trust

**REPORT TO BOARD OF DIRECTORS**

REF: **C3**

**SUBJECT:**

**Mexborough Elective Orthopaedic Centre (MEOC)**

**DATE:**

December 2022

**PURPOSE:**

	Tick as applicable		Tick as applicable
<i>For decision/approval</i>	✓	<b>Assurance</b>	
<i>For review</i>	✓	<b>Governance</b>	✓
<i>For information</i>		<b>Strategy</b>	✓

**PREPARED BY:**

**James Nicholls, Project Director, DBTH**

**SPONSORED BY:**

**Jon Sargeant, Deputy CEO**

**PRESENTED BY:**

**Jon Sargeant, Deputy CEO**

## STRATEGIC CONTEXT

### **Strategic Rationale**

The 'Elective recovery planning supporting guidance', April 2022, sets out a clear strategic context for the NHS.

*"The pandemic has placed considerable strain on planned service delivery, which was already under pressure before the pandemic. Consequently, there are now significant waiting lists across the country and potentially more patients still to come forward. Our plans will need us to do things differently, creating additional capacity and changing for the better the way services are delivered, while giving patients more control over their experience in the NHS."*

It describes a delivery plan and the key ambition, to which MEOC responds, relating to the reduction of waiting lists: "Eliminating the longest waits of over two years, except when it is the patient's choice, by July 2022. Following this, the ambition is to eliminate waits of over 18 months by April 2023 and waits of over one year by March 2025, except where patients choose to wait longer or in specific specialties".

Orthopaedics is the largest component of the waiting list for South Yorkshire ICS making up approximately 60% of the total. MEOC will play a key role in delivering required improvements by March 2025, specifically in relation to orthopaedic waiting lists. To achieve the required waiting list reductions the volume of activity required at a national level is an increase of 30% over 2019/20 levels.

GIRFT provides guidance on best practice pathways and expected standards of performance. Developing local approaches to address shortfalls against GIRFT standards is an important strategic driver for this project.

### **The case for change**

The South Yorkshire ICS will not be able to achieve the future plans for elective recovery without intervention. There is insufficient inpatient capacity for the volume of orthopaedic patients needing treatment. Trusts have made very limited progress in ring fencing orthopaedic infrastructure on their acute sites and cannot guarantee patients uninterrupted admission to elective surgery. Orthopaedic staffed beds often underpin medical capacity to the detriment of elective patients. Additionally, there is insufficient theatre capacity to meet the required demand. Rises in trauma workload often result in cancelled lists and de-prioritisation of elective cases. The lack of dedicated elective orthopaedic facilities inhibits the development of best practice pathways and frustrate productivity and efficiency initiatives. There are gaps in the staffing required to deliver the intensity of workload required and disruption to the consistent running of elective orthopaedic services adds pressure and impacts detrimentally on staff and patient experience. Acute site provision of elective orthopaedics often results in sharing arrangements for equipment again prevents smooth running of the service.

## EXECUTIVE SUMMARY

MEOC is a proposed investment in a 'cold site', ring fenced, elective orthopaedic hub with dedicated beds, theatres and staffing delivering waiting list and waiting time reductions for patients in line with the Elective Recovery Plan (ERP). DBTH has developed the business case on behalf of the ICS together with its partners: The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH). Future developments may include capacity for Sheffield patients, potentially including paediatric activity. The partners and ICS see this Targeted Investment Fund (TIF) investment as a 'Proof of Concept' and have a broader vision for an Elective Orthopaedic Centre of Excellence in the future.

The main aims of the MEOC investment are:

- To reduce elective orthopaedic waiting lists and waiting times
- Improve productivity and efficiency
- Increase quality and effectiveness of surgical interventions
- Improve access and eliminate cancellations due to bed pressures

The facility will deliver inpatient and day case activity:

- Inpatient activity will focus on HVLC hip and knee arthroplasty targeted at increasing numbers of 0 and 1 day discharges against a current average of 2.75 day length of stay for these patients.
- Day case activity will include upper limb, shoulder, hand, wrist, foot and ankle surgery together with various other 'filler' interventions such as injections and carpal tunnels.

The breakdown of activity proposed for the first full year of operation is as follows:

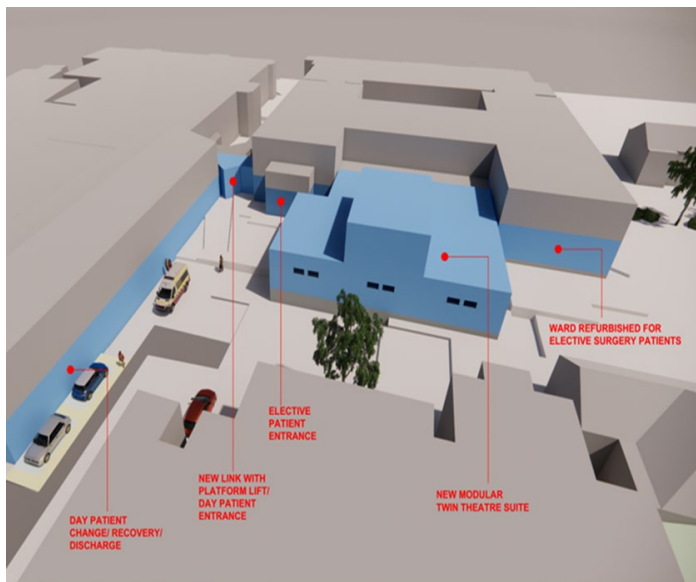
Procedure	IP/DC	Activity			Total
		Barnsley	Doncaster	Rotherham	
Hand & Wrist	DC	20	252	312	584
Foot & Ankle	DC	66	104	37	207
Arm & Shoulder	DC	165	136	0	301
Carpals	DC	0	72	0	72
Injections	DC	0	168	0	168
<b>DC Sub Total</b>		<b>251</b>	<b>732</b>	<b>349</b>	<b>1332</b>
Knee	IP	116	315	132	563
Hip	IP	83	162	108	353
Other	IP	40			40
<b>IP Sub Total</b>		<b>239</b>	<b>477</b>	<b>240</b>	<b>956</b>
<b>Grand Total</b>		<b>490</b>	<b>1209</b>	<b>589</b>	<b>2288</b>
<b>Percentages</b>		<b>21%</b>	<b>53%</b>	<b>26%</b>	<b>100%</b>

The opening hours for the theatres will be:

- 48 weeks per year
- 5 days per week
- 2 (4 hour) sessions per day

Beds will be open 24 x 7 x 365.

The productivity of the unit shown above is based on agreement between lead clinicians across the three partner providers who have expressed cautious views around what is possible when the facility opens. However, GIRFT guidance recommends a 6-day week (increasing activity to 2745 cases per annum) and 2.5 sessions per day (increasing activity to 3431 cases per annum). Additionally, the basis for lower limb arthroplasty is 4 cases per 8-hour list and some of the best performing surgical hubs are delivering more than this. Our aspiration is to move to higher levels of productivity over time as the service becomes embedded.



The facility, based at Montagu Hospital, Mexborough, will include:

- two new modular lead lined and laminar flow operating theatre suites adjacent to the existing Rehabilitation Block, with dedicated access and reception.
- An improved link to the main hospital to provide direct access to the existing Rockingham Day Case Unit admission and discharge lounge facilities, incorporating a new platform lift.
- 14 existing bedspaces will be refurbished to create 12 orthopaedic inpatient beds, and further internal works will create new staff change and storage areas with remaining areas to be retained for rehabilitation services.
- The future Mexborough Development Control Plans include provision for an extension to the



MEOC project, hydrotherapy pool, and Clinical Diagnostic Centre, supported by a revised site and road layout, extended car parking, and infrastructure development.

The key benefits delivered by MEOC include:

- Ring-fenced elective bed capacity on a 'cold-site' preventing cancellations due to medical outliers.
- Greater throughput for hip and knee arthroplasties through increasing the number of 0 & 1 day discharges.
- Released capacity and funding at host sites for maintaining existing provision of orthopaedics to ensure that MEOC workload is additive.
- Implementation of best practice GIRFT care pathways with standardised peri-operative care and preassessment co-designed with clinicians to reflect management of care between hosts sites and MEOC.
- Elimination of on the day cancellations through consistent and coordinated pre-assessment processes.
- Standardisation of equipment and consumables to minimise unwarranted variation in practice and improving cost effectiveness.
- Very high levels of patient and staff satisfaction through consistent and predictable processes, excellent communications and training and specialisation opportunities.

The development of the clinical, operating and staffing model has been the subject of close engagement with clinical and operational leads across the three partner trusts and ongoing engagement and involvement is planned to support further development and refinement of the agreed principles prior to opening. The key principles agreed are as follows:

1. Waiting lists and referral to MEOC managed by hosts based on criteria
2. Capacity would be allocated 50% to Doncaster & Bassetlaw and 25% each to Rotherham and Barnsley with annual review
3. GIRFT pathway in MEOC (and emerging best practice)
4. Post operative care provided by ACP with Anaesthetic support
5. No post operative surgical review unless by exception
6. Standardised pre-assessment and peri-operative care
7. Maximised standardisation of equipment and consumables
8. Surgeons follow their own patients OPD > MEOC > Follow Up
9. Profoundly ill patients transferred by ambulance to DRI
10. Data sharing (bloods, medical records, x-rays, etc) through existing ICS wide systems and access to DBTH systems as appropriate
11. Patient transport in extremis based on pre-assessment
12. Released capacity at host sites will be used to maintain current activity levels and ensure that MEOC activity is additive

Funding of £15m for capital costs has been allocated via the TIF process and the profile of capital spend is shown below:

CAPITAL EXPENDITURE PROFILE								
FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
DHSC PDC funded capital expenditure			420	1,348	1,767	13,153	0	14,921
Other ( <i>specify</i> )	0	0	0	0	0	0	0	0
<b>Total</b>			<b>420</b>	<b>1,348</b>	<b>1,767</b>	<b>13,153</b>	<b>0</b>	<b>14,921</b>

Estimated revenue costs based on the agreed operational model are shown below:

STATEMENT OF COMPREHENSIVE NET INCOME					
Incremental Impact of Scheme on the I&E of Lead Organisation					
	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 – 2031/32 £'000	Total £'000
Operating income from patient care activities	0	3,089	7,500	71,505	82,094



Other operating income	0	752	871	0	1,622
(Employee expenses)	0	(1,424)	(2,908)	(22,140)	(26,472)
(Operating expenses excluding employee expenses)	0	(8,850)	(5,089)	(38,113)	(52,052)
<b>Less Cash Releasing Benefits</b>	0	0	0	0	0
<b>Operating surplus / (deficit)</b>	<b>0</b>	<b>(6,433)</b>	<b>374</b>	<b>11,252</b>	<b>5,192</b>
Finance Income	0	0	0	0	0
(Finance Expense)	0	0	0	0	0
(PDC Dividends Payable)	0	(180)	(300)	(3,225)	(3,705)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
<b>Retained surplus / (deficit)</b>	<b>0</b>	<b>(6,613)</b>	<b>74</b>	<b>8,027</b>	<b>1,487</b>
Adjustments (including PPA, IFRIC 12 adjustment, and impairments)	0	6,814	0	0	6,814
<b>Adjusted financial performance retained surplus / (deficit)</b>	<b>0</b>	<b>201</b>	<b>74</b>	<b>8,027</b>	<b>8,301</b>

Management of the arrangements between the three partner trusts will be via a contract and an MoU is in development. The key principles are that no organisation should be any worse off financially and surpluses will be shared equitably between the trusts subject to agreements to reinvest these funds in future development of the service. The MoU and contract will be finalised post business case approval.

The key risks associated with the delivery of the MEOC are summarised as follows:

Key Risk	Mitigation	RAG
Inability to recruit to MEOC staff model	Temporary use of agency and locums and acceleration of system wide recruitment plans	High
Impact of emergency pressures and trauma pathway	Ring fenced resources and 'cold site' location	Low
Peripatetic staff unwilling to travel to MEOC	The needs and issues of each staff group will be reviewed as part of the on-going stakeholder discussions to promote the benefits of MEOC	Medium
Elective Recovery Plan targets not achieved, and income reduced	Repatriation of private sector work	Medium/High
Patients do not choose MEOC to receive their surgery	Promotion of lower waiting times, zero cancellations and a modern environment with good access together with public consultation	Medium
Travel distances cause inequality of access	Pre-assessment criteria to approve patient transport to support access to care for harder to reach patients	Low
Construction timetable slippage and supplier capacity	Modern methods of construction: modular offsite manufacture plus early engagement of main contractor with commitment to deliver	Medium
Capital cost inflation	Capped capital cost arrangement in place with main contractor to Feb 23	Medium
Clinical and operational principles challenged	Broad stakeholder engagement planned, GIRFT Team input, best practice site visits, engagement in building design	Medium

Planning permission delayed

Strong relationship with DMBC and scheme impact from a planning perspective is limited

Medium

Sensitivity analysis has been undertaken in relation to the highest areas of risk and demonstrate that the financial position remains robust against the use of locums and agency to support delays in recruitment over 12, 18 and 24 months. In the event that activity is unfunded the proposal is to use the MEOC to repatriate activity currently delivered through the independent sector.

The governance process requires sign off and letters of support as follows:

- Doncaster and Bassetlaw Teaching Hospitals NHS foundation trust
- Barnsley Hospital NHS foundation trust
- The Rotherham Hospital NHS foundation trust
- Doncaster, Rotherham and Barnsley Places
- South Yorkshire Acute Federation
- South Yorkshire ICB

Arrangements are being put in place to manage meeting dates and papers for each organisation with the aim of submitting the business case to NHSEI in early January 2023. Pre-submission review of the business case is already underway with NHSEI NEY colleagues,

The timetable for the project is as follows:

Activity	Date
<b>NHS EI approval of short form business case</b>	17/02/23
<b>Contractor instructed to commence works</b>	03/03/23
<b>Planning permission granted</b>	03/04/23
<b>Enabling works complete</b>	13/07/23
<b>Off-site manufacture of modular theatres complete</b>	13/07/23
<b>Site installation of modular theatres commences</b>	14/07/23
<b>Internal refurbishment works commence</b>	21/07/23
<b>Handover of new facilities</b>	09/10/23
<b>Final commissioning</b>	23/10/23

Current activities include the engagement of lead clinicians and operational managers in the finalisation of the building designs, room specifications and equipment requirements. During the 'fallow' construction period arrangements will be put in place for the oversight, governance and management of the facility between the trusts and the key principles agreed at business case stage will be developed to form the agreed operational, clinical, staffing and financial models together with contractual arrangements.

## RECOMMENDATIONS

The Boards of Directors is asked to approve the business case for submission to NHSEI subject to letters of support received from system stakeholders.

## Montagu Elective Orthopaedic Centre (MEOC) Short Form Business Case Template £5m - £15m Schemes

### SECTION 1: SCHEME OVERVIEW

#### SCHEME DETAILS

<b>PROJECT DESCRIPTION</b>	Region:	North East & Yorkshire
	STP / ICS Name:	South Yorkshire
	Lead Organisation for the Scheme:	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)
	Title of the Scheme:	Montagu Elective Orthopaedic Centre (MEOC)
	One Line Description of the Scheme:	A ring-fenced hub for high volume low complexity (HVLC) orthopaedic day case and inpatient activity.
	Specific Sites for Investment:	Montagu Hospital, Mexborough
	Other Organisations Impacted by this Scheme:	The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH)

#### BRIEF SCHEME OVERVIEW

Summarise the key dimensions of the scheme in terms of the outputs that will be enabled in service terms as a consequence of the investment.

MEOC is a proposed investment in a 'cold site', ring fenced, elective orthopaedic hub with dedicated beds, theatres and staffing delivering waiting list and waiting time reductions for patients in line with the Elective Recovery Plan (ERP). DBTH has developed the business case on behalf of the ICS together with its partners The Rotherham Hospital Foundation (TRH) Trust and Barnsley Hospital Foundation Trust (BH). Future developments may include capacity for Sheffield patients, potentially including paediatric activity. The partners and ICS see this Targeted Investment Fund (TIF) investment as a 'Proof of Concept' and have a broader vision for an Elective Orthopaedic Centre of Excellence in the future.

The main aims of the MEOC investment are:

- To reduce elective orthopaedic waiting lists and waiting times
- Improve productivity and efficiency
- Increase quality and effectiveness of surgical interventions
- Improve access and eliminate cancellations due to bed pressures

The facility will deliver inpatient and day case activity:

- Inpatient activity will focus on HVLC hip and knee arthroplasty targeted at increasing numbers of 0 and 1 day discharges against a current average of 2.75 day length of stay for these patients.
- Day case activity will include upper limb, shoulder, hand, wrist, foot and ankle surgery together with various other 'filler' interventions such as injections and carpal tunnels.

The breakdown of activity proposed for the first full year of operation is as follows:

Procedure	IP/DC	Activity			Total
		Barnsley	Doncaster	Rotherham	
Hand & Wrist	DC	20	252	312	584
Foot & Ankle	DC	66	104	37	207
Arm & Shoulder	DC	165	136	0	301
Carpals	DC	0	72	0	72

<b>Injections</b>	DC	0	168	0	168
<b>DC Sub Total</b>		<b>251</b>	<b>732</b>	<b>349</b>	<b>1332</b>
<b>Knee</b>	IP	116	315	132	563
<b>Hip</b>	IP	83	162	108	353
<b>Other</b>	IP	40			40
<b>IP Sub Total</b>		<b>239</b>	<b>477</b>	<b>240</b>	<b>956</b>
<b>Grand Total</b>		<b>490</b>	<b>1209</b>	<b>589</b>	<b>2288</b>
<b>Percentages</b>		<b>21%</b>	<b>53%</b>	<b>26%</b>	<b>100%</b>

The opening hours for the theatres will be:

- 48 weeks per year
- 5 days per week
- 2 (4 hour) sessions per day

Beds will be open 24 x 7 x 365.

The productivity of the unit shown above is based on agreement between lead clinicians across the three partner providers who have expressed cautious views around what is possible when the facility opens. However, GIRFT guidance recommends a 6-day week (increasing activity to 2745 cases per annum) and 2.5 sessions per day (increasing activity to 3431 cases per annum). Additionally, the basis for lower limb arthroplasty is 4 cases per 8-hour list and some of the best performing surgical hubs are delivering more than this. Our aspiration is to move to higher levels of productivity over time as the service becomes embedded.

The facility, based at Montagu Hospital, Mexborough, will include:

- two new modular lead lined and laminar flow operating theatre suites adjacent to the existing Rehabilitation Block, with dedicated access and reception.
- An improved link to the main hospital to provide direct access to the existing Rockingham Day Case Unit admission and discharge lounge facilities, incorporating a new platform lift.
- 14 existing bedspaces will be refurbished to create 12 orthopaedic inpatient beds, and further internal works will create new staff change and storage areas with remaining areas to be retained for rehabilitation services.
- The future Mexborough Development Control Plans include provision for an extension to the MEOC project, hydrotherapy pool, and Clinical Diagnostic Centre, supported by a revised site and road layout, extended car parking, and infrastructure development.

The key benefits delivered by MEOC include:

- Ring-fenced elective bed capacity on a 'cold-site' preventing cancellations due to medical outliers.
- Greater throughput for hip and knee arthroplasties through increasing the number of 0 & 1 day discharges.
- Released capacity at host sites for maintaining existing provision of orthopaedics to ensure that MEOC workload is additive.
- Implementation of best practice GIRFT care pathways with standardised peri-operative care and preassessment co-designed with clinicians to reflect management of care between hosts sites and MEOC.
- Elimination of on the day cancellations through consistent and coordinated pre-assessment processes.
- Standardisation of equipment and consumables to minimise unwarranted variation in practice and improving cost effectiveness.
- Very high levels of patient and staff satisfaction through consistent and predictable processes, excellent communications and training and specialisation opportunities.

LEAD ORGANISATION DETAILS		
<b>SENIOR RESPONSIBLE OFFICER (SRO) DETAILS</b>	Title	Deputy Chief Executive
	Name	Jon Sargeant
	Organisation	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
	Office tel.	01302644147
	Mobile tel.	07949 490162
	e-mail	jonathan.sargeant@nhs.net

APPENDICES CHECKLIST	
APPENDIX	COMPLETED / ATTACHED (Y/N)
Appendix 1 – Programme Specific monitoring and reporting	Y
Appendix 2 – Schedule of Works	Y
Appendix 3 – OB Forms	Y
Appendix 4 – Key Estates Information	Y
Appendix 5 – Equality impact assessment	Y
Appendix 6 – Letters of Support	N*
Appendix 7 – Digital capability KLOEs	Y

\*Letters of support will be procured and attached as this final draft business case is reviewed and approved through local ICS governance.

## SECTION 2: PROGRAMME SPECIFIC INFORMATION REQUESTS

**ELECTIVE RECOVERY BENEFITS** - Please provide detail of the anticipated benefit of the scheme on Elective Recovery: (Separation of activity; Demand Management; Elective 'Long Waiters', and the Cancer 62 Day Backlog)

<p><b>ELECTIVE RECOVERY BENEFITS</b></p> <p>Please provide a description of the anticipated Benefit of the Scheme on Elective Recovery, Demand Management and Elective 'Long Waiters', and the Cancer 62 Day Backlog</p>	<ol style="list-style-type: none"> <li>1. Geographical separation of the elective activity from the acute and emergency pathways through a 'cold-site' facility at Montagu Hospital Mexborough.</li> <li>2. Good accessibility for patients from host Trusts due to central location and excellent parking facilities.</li> <li>3. A ring-fenced surgical hub dedicated to the orthopaedic IP/DC elective pathway only.</li> <li>4. Co-located facilities within the hub, dedicated to orthopaedics and not shared with competing demands.</li> <li>5. Dedicated staffing for the entire pathway within MEOC but with outpatients and pre-assessment delivered at host sites for local access.</li> <li>6. Optimised peri-operative process including 'active wait' targeted support to reduce cancellations and increase timely discharge</li> <li>7. Standardised preassessment processes, carried out by the same teams delivering the surgery, to eradicate on the day cancellations.</li> <li>8. Designed for good flow, reducing delays and waste in terms of the facility layout, staffing types/levels and SOPs</li> <li>9. Best practice GIRFT pathways including an MDT approach, pre-operative planning, standardised pathways, so reducing length of stay and increasing day cases.</li> <li>10. 8-hour operating days, 5 days per week, 48 weeks per year with the aim to increase once embedded.</li> <li>11. Efficient theatre process designed to maximise knife to skin time and remove delays.</li> <li>12. Theatre equipment for the unit so that it does not have to be shared with the trauma or other elective services on another site.</li> <li>13. Standardisation of equipment and consumables to reduce training, costs and risk of error.</li> <li>14. Transport arrangements to support 'hard to access' patients.</li> <li>15. Digital solutions to support booking and sharing of patient information to include results and images across partner providers.</li> <li>16. Dedicated radiography support with back up of on-site radiology team.</li> </ol>
<p><b>TYPE OF SCHEME</b></p> <p>Please specify the intended output that this scheme intends to deliver.</p>	<p>Surgical Hubs / Theatre Block</p>
<p><b>BEDS / THEATRE CAPACITY CREATED</b></p> <p>Please set out the number of additional beds (specifying whether these are protected elective, non-elective or critical care beds) or theatre capacity created by the scheme.</p>	<p><b>Beds</b> 12 additional, dedicated orthopaedic beds co-located with theatres with dedicated staffing including physiotherapy open 24 x 7 x 365. Beds will operate at c. 90% occupancy.</p> <p><b>Theatres</b> 2 new theatres: large, modular build with laminar flow and full lead lining forming part of a theatre suite with 2 anaesthetic rooms and 4 Stage 1 recovery beds together with co-located staff change, rest room and large storage area within the 'scrub zone'.</p>

**How does the proposal address the biggest demand & capacity gaps across the wider Region and within the system (by system/trust/specialty)?**

- South Yorkshire & Bassetlaw ICS analysis has shown that the regions IP waiting list is 43% higher than in March 2020. There are 2,500 more patients waiting over 52 weeks and two thirds of them are in Orthopaedics.
- Orthopaedics also represents one of the largest gaps between planned IP/DC activity in 2022/23 and the target of 104% of 2019/20 activity, with the largest gap in patient numbers being at DBTH and Sheffield Teaching Hospitals.
- The scheme is one of two progressing in the area, which aim to significantly bridge the gap in orthopaedics inpatient and day case activity required to reduce the waiting list and meet changes in demand. (The other scheme is at Hallamshire Hospital and focusses on the Sheffield waiting list and includes HVLC orthopaedics and enhanced recovery).
- Locally, the admitted waiting list at the partner providers for the MEOC business case are as follows:

<b>Trust</b>	<b>Elective orthopaedic waiting list as at 24/11/2022</b>
Barnsley	1040
Rotherham	1200
Doncaster	3684
<b>Total</b>	<b>5924</b>

- The annual additional activity proposed in MEOC represents about 40% of the current waiting list and together with existing capacity, supports rapid reduction of longer waiters and the overall waiting list in line with Elective Recovery Plan targets. It will also support sustainable performance against expected levels of growth in the future.

## ACTIVITY PROFILE – Additional activity delivered as a result of this investment

The activity profile is based on detailed work undertaken by the three partner trusts to identify the aggregate activity which meets the criteria for the MEOC HVLC profile. The activity profile will be reviewed annually and the ambition is to increase throughput within the same resources as the service and best practice is embedded and developed. Whilst the scheme does not have a direct impact on cancer activity it is expected that over time the released capacity at the host providers can address a broader range of specialities and pathways.

EXPECTED INCREMENTAL ACTIVITY			
	Elective - Cancer activity (000s)	Elective – Non-Cancer activity (000s)	Outpatient FU activity (000s)
H1 22/23	0	0	0
H2 22/23	0	0	0
H1 23/24	0	0	0
H2 23/24	0	953	1067
H1 24/25	0	1144	1290
H2 24/25	0	1144	1290
<b>Recurrent Full Year Impact (25/26 onwards)</b>	0	<b>2288</b>	<b>2579</b>

## SECTION 3: PROJECT DELIVERY OVERVIEW

### DELIVERABILITY ASSESSMENT

<p><b>DELIVERY AND TIMETABLE</b></p> <p>Please set out the anticipated commercial and procurement route, and provide a simple timeline with key milestones for the procurement and delivery of the scheme</p>	<p><b>Commercial and procurement route – scheme delivery</b></p> <p>The project is currently being developed through the SBS Lot 3 Modular Healthcare for purchase framework directly with Module Co (SBS ref 10091) on the basis of developed relationship following a previous scheme at Doncaster Royal Infirmary and successful implementation at other surgical hubs nationally (e.g., Royal Devon and Exeter NHS Foundation Trust). Module Co are proposed to provide the full delivery route covering the Principal Contractor role for the modular and also traditional elements of construction.</p> <p>The activities planned through to commencement of construction and to final commissioning are shown in the simple timetable below. Competition is not included in the timeline as the framework being utilised has already been tendered and allows for organisations to use a call off arrangement.</p> <table border="1"> <thead> <tr> <th>Activity</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td><b>Contract agreement</b></td> <td>03/03/23</td> </tr> <tr> <td><b>Contractor instructed to commence works</b></td> <td>03/03/23</td> </tr> <tr> <td><b>Planning permission granted</b></td> <td>03/04/23</td> </tr> <tr> <td><b>Enabling works complete</b></td> <td>13/07/23</td> </tr> <tr> <td><b>Off-site manufacture of modular theatres</b></td> <td>13/07/23</td> </tr> <tr> <td><b>Site installation of modular theatres commences</b></td> <td>14/07/23</td> </tr> <tr> <td><b>Internal refurbishment works commence</b></td> <td>21/07/23</td> </tr> <tr> <td><b>Handover of new facilities</b></td> <td>09/10/23</td> </tr> <tr> <td><b>Final commissioning</b></td> <td>23/10/23</td> </tr> </tbody> </table> <p><b>Clinical, operational and staffing model</b></p> <p>Clinical and operational staff across the three partner trusts, working with local GIRFT leads for T&amp;O and anaesthetics have agreed the main principles of the clinical, operating and staffing model for MEOC:</p>	Activity	Deadline	<b>Contract agreement</b>	03/03/23	<b>Contractor instructed to commence works</b>	03/03/23	<b>Planning permission granted</b>	03/04/23	<b>Enabling works complete</b>	13/07/23	<b>Off-site manufacture of modular theatres</b>	13/07/23	<b>Site installation of modular theatres commences</b>	14/07/23	<b>Internal refurbishment works commence</b>	21/07/23	<b>Handover of new facilities</b>	09/10/23	<b>Final commissioning</b>	23/10/23
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2. Capacity would be allocated 50% to Doncaster & Bassetlaw and 25% each to Rotherham and Barnsley with annual review
3. GIRFT pathway in MEOC (and emerging best practice)
4. Post operative care provided by ACP with Anaesthetic support
5. No post operative surgical review unless by exception
6. Standardised pre-assessment and peri-operative care
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8. Surgeons follow their own patients OPD > MEOC > Follow Up
9. Profoundly ill patients transferred by ambulance to DRI
10. Data sharing (bloods, medical records, x-rays, etc) through existing ICS wide systems and access to DBTH systems as appropriate
11. Patient transport in extremis based on pre-assessment
12. Released capacity at host sites will be used to maintain current activity levels and ensure that MEOC activity is additive

Refinement of these principles and the development of the operational, clinical and staffing models ready for implementation will take place during the 'fallow' construction period post business case approval.

***Workforce requirements (KLOEs)***

This business case includes the staffing required in the MEOC facility to deliver the workload identified above. The model of care principles agreed with clinicians and operational staff across the partner trusts incorporates all stages of the patient journey. Staffing for MEOC focusses on surgery and peri-operative care. The surgeons working in MEOC will rotate from their host organisations and costs will be reimbursed to allow backfill of capacity at host providers. The cost associated with anaesthetists for surgery and ward cover required is included but the decision as to whether anaesthetists will be employed by and dedicated to MEOC or rotate from their host organisations is not yet agreed. Costs do not include outpatient activity and pre-assessment taking place pre and post-surgery in the host trusts.

***Systems support for movement between organisations, recruitment, retention and rotational posts or job shares to support experience and workforce optimisation***

Trusts and partnership organisations in South Yorkshire (SY) have agreed a Workforce Sharing Agreement (WSA) to support the movement of staff across the system; this has been developed following engagement with trade unions and human resource representatives. A copy of the WSA can be provided upon request.

In addition, all acute Trusts in South Yorkshire utilise the 'C19 digital staff passport' to speed up movement of staff between Trusts whilst ensuring the relevant safety checks are completed; it supports ad hoc or regular cover, temporary staff arrangements, post grad doctor moves etc. Staff can download the app and 'own their own credentials' if they are moving between sites/organisations and HR teams at all SY Trusts facilitate the process. The C19 passport is due to be replaced with the NHS DSP (digital staff passport) and DBTH, SCFT, STH and TRFT are currently engaged in beta testing of the latter product.

GIRFT provides helpful benchmarking data with regards to service quality and performance, including pathway and workforce information. Workforce recruitment, retention and development is considered by the Orthopaedic Clinical Working Group, which reports through the Elective Collaborative Group and into the Diagnostic and Elective Oversight Group. Advice and guidance is available from the South Yorkshire Integrated Care Board (SY ICB) Workforce Hub, established in partnership with Health Education England (HEE) to support partner organisations across health and care to recruit, retain, and develop their workforce. A system-wide workforce planning exercise is underway. The SY Healthcare Science Council and SY Allied Health Professions Council meet monthly and can offer expert guidance with regards to the AHP and Healthcare Science elements of

Orthopaedic pathways; the AHP Faculty also meets monthly to consider AHP workforce supply and development.

Additional arrangements in place include:

- Collaborative staff banks in place across medics (via Holt) and non-medics (NHSP) to mitigate reliance on agency
- eRostering / eJob Planning group collaborating to enable best practice across Trusts in line with NHSE Levels of Attainment
- Multi Year Modelling delivered across trusts to identify strategic workforce planning / supply requirements over next five years (professional group level)
- Schools' engagement and careers team to encourage health and care roles across South Yorkshire Learning Environments and Placements (LEAP) programme across SY to support high quality clinical placements (non-medical) and unlock capacity barriers.
- Apprenticeship lead in role to enable update of apprentices and levy sharing where appropriate
- Employability programme underway to support widening inclusion across SY workforce
- Health and wellbeing support across all staff via ICB workforce wellbeing Hub
- Retention programme including focus on nursing and AHP preceptorships

***On-call and out of hours care***

On-call and out of hours care will be provided by nursing staff supported by Advanced Care Practitioners who will assess patients based on an agreed checklist. A duty anaesthetist will provide dedicated cover out of hours. Recruitment and training will commence as soon as the business case is approved.

***E-rostering and job planning***

E-rostering is fully in place within orthopaedics, with flexibility on shift patterns for staff. Job planning reflects the service model, and sufficient clinical sessions have been planned to cover 48 weeks of theatre lists per annum. Staffing for weekend and out of hours has been factored into the staffing model.

***Plans for more predictable working patterns***

The MEOC surgical hub is for elective orthopaedic patients only and is on a 'cold site' preventing mixing of trauma and medical patients making service delivery predictable. Theatre templates will be used for scheduling to maximise knife to skin time including the overlapping of cases and staggering of admissions. Pathways of care are defined, standardising inputs such as therapy and x-rays and adopt the latest GIRFT guidance. Pre-assessment will take place at the host trusts and will be standardised to ensure that patients are not cancelled on the day for predictable reasons. Training will be provided for staff both within MEOC and along the care pathway to ensure consistency of practice.

***Enhanced knowledge and skills development***

Plans are being put in place for visits and virtual meetings with best practice sites across the UK including SWLEOC at Epsom Hospital and SWAOC at Royal Devon and Exeter Hospitals. These engagement sessions will allow surgeons, anaesthetists, nurses, therapists and theatre staff to 'shadow' their colleagues to support knowledge and skills development.

- Standardised anaesthetics, consumables and implants will support expert knowledge and safe practice
- Pathway training for staff to deliver primary hip and knee replacement standard pathways

- Ward nurses with enhanced training so that shifts will have appropriately skilled nurses
- Flow training for admissions and theatre staff to implement fast list turnaround with overlapping of cases
- Waiting list co-ordinators trained on templates for planning staggered admission times
- Pharmacists' development of pre-pack TTOs and responsive medicines management
- Peri-operative pathways using therapists to optimise timely safe discharge
- All staff working within the unit will be trained so it becomes a staff led problem solving environment, with continuous improvement and ownership

Innovation with regard to enhance roles and accelerated training will form a core part of the further engagement and involvement of the wider clinical and operational fraternity which is planned to take place once business case approval is achieved. This work will liaise with wider system developments and ensure link across with the Sheffield orthopaedic hub at the Hallamshire.

#### **Staff well-being and morale**

MEOC is dedicated to predictable working patterns and with the best possible pathways of care and will enable orthopaedic trained staff to do their jobs well for the type of patients they are trained to care for. The service has been modelled to determine the right level of staff for each discipline to deliver the pathways, and to manage workload, enabling staff to work without stress and within their hours. There will be training opportunities and career progression into new and advanced roles. Career progression opportunities will be available to retain and ensure experience and knowledge.

The MEOC facility will have good staff facilities and be well equipped. The whole unit will be run as a single service, supporting development of a cohesive team thriving on excellent outcomes. The plans to further develop the MEOC facility beyond this proof-of-concept stage into a larger Centre of Excellence will provide staff with further opportunities and an exciting future.

#### **Staffing Plans**

The staffing required for MEOC has been developed and signed off by clinical leads in each of the respective areas across the three partner providers. Furthermore detailed discussions are planned to engage with and development staffing model plans with the workforce post approval of the business case.

The recruitment timetable is predicated on:

- The handover and opening date for the facility
- The need for senior staff to support commissioning activities
- The latest date staff must be available to:
  - Minimise costs in advance of live operation
  - Maximise the time available for recruitment
- The need for induction, orientation and training

Staff Type	Detail	WTE	Target Recruitment Date
Theatre staff	Band 6 Nurse	2.96	Aug-23
Theatre staff	Band 5 Scrub Nurse	2.96	Sep-23
Theatre staff	Band 5 ODP	2.96	Sep-23
Theatre staff	Band 2 HCA	2.96	Sep-23
Theatre staff	Band 1 / 2 Domestic	2.96	Sep-23
Theatre staff	Band 5 Recovery Nurse	2.80	Sep-23
Radiology	Band 7 Radiographer	1.20	Sep-23

<b>Anaesthetics</b>	Anaesthetist Consultant	3.00	Aug-23
<b>Surgery medics</b>	Surgical Consultant	1.67	Aug-23
<b>Surgery medics</b>	Surgical Assistant (SpR)	1.67	Aug-23
<b>Ward nursing</b>	Band 7 nurse	1.00	Aug-23
<b>Ward nursing</b>	Band 6 nurse	1.00	Sep-23
<b>Ward nursing</b>	Band 5 nurse	7.27	Sep-23
<b>Ward nursing</b>	HCA Band 2	6.79	Sep-23
<b>Ward nursing</b>	Ancillary housekeeper	0.50	Sep-23
<b>Ward nursing</b>	Ward clerk B3	1.10	Sep-23
<b>Ward therapists</b>	Band 6	2.00	Aug-23
<b>Ward therapists</b>	Band 4	3.00	Sep-23
<b>Ward therapists</b>	Band 3	1.50	Sep-23
<b>Ward ACP rota</b>	Advanced Care Practitioner B7	3.00	Aug-23
<b>Other</b>	Admin for booking B2	2.31	Oct-23
<b>Total WTEs</b>		<b>54.59</b>	

All staff currently supporting the orthopaedic elective pathways across the three trust partners will be offered the opportunity to transfer sites. This will need to be balanced with maintaining a safe services at the host sites through cross charging of costs to support backfill. All of these staff will come from within orthopaedics so there is no impact on other areas. During the 'fallow' construction period further work will be undertaken to determine the details around: movement between organisations, recruitment, retention and rotational posts or job shares to support experience and workforce optimisation.

The table above shows the staff for recruitment, and planned appointment date. Harder to fill posts such as anaesthetics, ward and theatre staff will commence recruitment (where no recruitment scheme is already in place) as soon as the scheme is approved, and contingency plans will also be implemented.

***Challenges affecting the implementation of the MEOC staffing model***

Recruitment of the workforce for the MEOC facility is the most important challenge to be overcome. The key recruitment issues are:

- Anaesthetists (Very high risk)
- Theatre staff (High risk)
- Ward nursing support staff (Moderate risk)
- Radiographers (High risk)

Anaesthetists – Partner trusts are currently recruiting to anaesthetic posts and this has proved unsuccessful over the last year. Options to mitigate this problem include: Overseas recruitment, agency locums and waiting list initiatives (WLIs). Using agency or WLIs will impact on costs and therefore is not a preferred approach. This issue has been assessed through sensitivity analysis in the finance model.

Theatre staff - Rotherham has significant issues with sickness and vacancies in theatre staff and posts have proved hard to recruit to. Long term agency posts could mitigate the need for staff but at a higher cost.

Ward nursing support staff – Low pay associated with these roles make them unattractive. Potentially offering a strong route to Nursing Associate (B4) roles will help retain staff and for them to see a longer career trajectory, but it won't be easy to get stability and consistency in this area of the MEOC workforce

Recruitment programmes are in place locally and at ICS level to address these areas. The Sheffield surgical hub has identified the same issues and recognises the inability to recruit will have an impact on throughput. This will also be the case for MEOC.

<p><b>RISKS TO DELIVERY</b></p> <p>Please set out the potential risks to delivery and mitigating actions to address these.</p>	The following table sets out the key risks and mitigations for MEOC:	
	Risk	Mitigation
	<b>Local and national shortage of certain professional groups for which recruitment is required to create a dedicated staffing model for MEOC.</b>	Workforce action plan in development including: <ul style="list-style-type: none"> <li>• Ambitious recruitment drive</li> <li>• Potential overseas recruitment</li> <li>• Promotion of the unit as a great place to work.</li> <li>• Alternatives where possible</li> <li>• Different models of care</li> <li>• Temporary use of agency and locums</li> </ul>
	<b>If the MEOC staff are used to support the orthopaedic trauma service or wider Trust emergency pathway, the planned theatre throughput (activity) cannot be fully delivered</b>	The Trusts including wider MSK to commit to ring fencing resources (beds, theatres and staffing). Location of MEOC on a 'cold site' away from emergency pathways will mitigate this issue.
	<b>Existing staffing may find it difficult and therefore be unwilling to move to the MEOC away from their existing base of work</b>	The needs and issues of each staff group will be understood, and concerns addressed. This issue will be restricted to surgical (and potentially anaesthetic) staff as they will be the only peripatetic staff within MEOC.
	<b>The business case assumes that all activity in MEOC is additional and will be funded by the Elective Recovery Plan at 75% of tariff. This assumes that the underlying activity is delivering 104% of 2019/20 levels. This is currently not the case and there is a risk that by the time the unit opens revenue funding will not be available.</b>	The partner organisations are undertaking a review of private work which could be repatriated to MEOC. Depending on the outcome of this review this work could offset or in the best case fully fund the workload in MEOC.
	<b>The business case assumes that patients will travel to MEOC for their surgery. There is a risk that a proportion choose to receive their surgery at their local hospital site.</b>	The initial view is that the attractiveness of the MEOC facility with lower waiting times and a modern environment with good parking will result in patients choosing MEOC. It is envisaged that a public consultation may be required if patients are to be directed to MEOC. There is evidence that patients will travel to take advantage of shorter waiting times.
	<b>The location of the new facility results in harder to reach patients being excluded from the service and has consequent health inequality impacts.</b>	It has been agreed that patients will be assessed for access to patient transport where this is a barrier to receiving care. This will be carried out at pre-assessment using criteria and the costs for patient transport are included in the financial costs for MEOC.
<b>Slippage due to delays with construction and availability of materials</b>	The contractual arrangements in place will ensure that provided approval for the business case is	



		<p>received during February 2023 the timelines to deliver the new building will achieve this by late October 2023. The approach to construction is off-site, modular build which offsets the timeline risk associated with traditional on-site build. There is a residual risk associated with the ground works which will be managed through the contract.</p>
	<p><b>Risk of inflation impacting on the capital costs taking them above the £15 million allocated to the scheme.</b></p>	<p>The arrangements with the main contractor include a cap on inflation through to the proposed business case approval in February 2023. Provided this timeline is met, the main capital costs associated with the modular build element, the largest proportion of the scheme, will not increase. There is a residual risk associated with inflation in relation to the non-modular works and also associated with delayed approval of the business case. Appropriate contingencies have been put within the financial numbers to offset this.</p>
	<p><b>Agreement has been reached in principle with clinical colleagues from across the three partner organisations with regard to the clinical, operating and staffing model. Due to time constraints, it is recognised that further, more detailed work will be undertaken to refine the assumptions which sit behind these principles. There is a risk that known challenges associated with the model of care are not agreed in a timely manner and in readiness for opening of MEOC.</b></p>	<p>A programme of meetings is currently underway with clinical colleagues to review the design of the MEOC building and further meetings have been discussed with regard to visits to best practice sites to align views on key operating arrangements. Further meetings will be put in place during the fallow, construction phase to engage with clinical colleagues more broadly and translate the principles agreed into the detail required for operational readiness.</p>
	<p><b>Planning permission has not yet been granted and resource constraints at Doncaster Metropolitan Borough Council (DMBC) have delayed progress. There is a risk that planning permission will not be granted or more likely that conditions will be placed on permission which may or may not add cost to the scheme.</b></p>	<p>DBTH has a very strong relationship with DMBC and as set out in the "Planning Assumptions" section the scheme impact from a planning perspective is limited. A timetable has been agreed for the delivery of permission and dialogue is ongoing with planners to ensure that this risk does not accrue.</p>
<p><b>PLANNING ASSUMPTIONS</b></p> <p>Please set out the current planning position, and the steps that will be taken to ensure appropriate planning permission is in place.</p>	<p><b>Approach</b> The Development Control Plan and proposals for MEOC have been submitted to the local authority for pre-application advice.</p> <p>An initial submission was made on 31/08/2022, followed by a second submission with additional/revised information on 18/10/2022</p> <p><b>Feedback</b> Due to current workload pressures at the local authority, we are yet to receive formal feedback on the proposals. The Trust maintains a good working relationship</p>	

	<p>with the planners and is in frequent dialogue to discuss the long-term implementation of the site development plan at Mexborough Hospital.</p> <p><b>Scheme impact</b> In planning terms, the scheme will have minimal impact on the hospital site:</p> <ul style="list-style-type: none"> <li>• No net loss of parking on site</li> <li>• Building height is comparable with adjacent buildings</li> <li>• No visual or acoustic impact on adjacent residential property</li> </ul> <p><b>Resolutions</b> The design team will continue constructive discussions with the local authority to assist the timely completion of the application process. Full planning approval is anticipated in Spring 2023.</p>
<p><b>PROVIDER CAPACITY AND CAPABILITY</b></p> <p>Please provide a brief overview of the experience of the SRO and Exec Team accountable for the project.</p>	<p>The SRO and executive team have delivered previous schemes of a similar scale in recent years. There is an existing governance structure, supported by Trust executives who also have an history of successfully delivering schemes. The scheme has full backing and engagement of the clinical teams who are committed to the solution for orthopaedic patients.</p> <p>A dedicated programme manager is leading on this project and clinical leadership resources time is also built into the delivery.</p> <p>SY ICS has resources and programmes of activity in place to support the development of the orthopaedic hubs proposed and will continue to be closely engaged with the project through development and delivery strengthening provider leadership.</p>

## SECTION 4: FINANCIAL OVERVIEW

These Tables can be provided in Excel Form. If a proposal involves multiple Providers, these Tables will need to be completed for each individual Provider.

### FUNDING SOURCES

PLEASE SET OUT ALL FUNDING SOURCES FOR THE PROJECT	DHSC PDC £	14,921,104
	Other (please specify) £	0
	<b>Total £</b>	<b>14,921,104</b>

### CAPITAL EXPENDITURE PROFILE

FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
DHSC PDC funded capital expenditure			420	1,348	1,767	13,153	0	<b>14,921</b>
Other (specify)	0	0	0	0	0	0	0	<b>0</b>
<b>Total</b>			<b>420</b>	<b>1,348</b>	<b>1,767</b>	<b>13,153</b>	<b>0</b>	<b>14,921</b>


### BREAKDOWN OF SCHEME CAPITAL COST (using OB Form headings)

FUNDING SOURCE	2022/23 Q1 £'000	2022/23 Q2 £'000	2022/23 Q3 £'000	2022/23 Q4 £'000	2022/23 Total £'000	2023/24 Total £'000	2024/25 Total £'000	TOTAL £'000
Works Costs	0.0	0.0	179.1	716.3	895.4	6,490.1	0.0	7,385.5
Fees	0.0	0.0	71.6	60.8	132.4	101.4	0.0	233.8
Non-Works Costs	0.0	0.0	0.0	0.0	0.0	121.4	0.0	121.4
Equipment Costs	0.0	0.0	0.0	0.0	0.0	786.8	0.0	786.8
Optimism bias	0.0	0.0	23.9	74.1	98.0	715.3	0.0	813.3
Planning contingency	0.0	0.0	22.5	69.8	92.3	673.2	0.0	765.5
Inflation Adjustment	0.0	0.0	70.1	217.4	287.5	2,097.6	0.0	2,385.1
VAT	0.0	0.0	52.5	209.8	262.3	2,167.5	0.0	2,429.8
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>419.7</b>	<b>1,348.2</b>	<b>1,767.9</b>	<b>13,153.3</b>	<b>0.0</b>	<b>14,921.1</b>

Please provide a narrative on the basis of the costs e.g., tendered costs, PUBSEC indices, cost advisor reports. Please **STATE** the following:

1) PUBSEC Indices used:	Extension of PUBSEC Tender Price Index of Public Sector Building Non-Housing
2) Basis of the costs: HPCG / benchmark rates from cost advisor / tendered costs / schedules of rates / previously tendered rates.	Costs are based on the P+HS drawing DBHOH-PHS-XX-XX-DR-A-020_P02 Internal Works, dated 19.10.2022. The Modular Theatres cost is based on a fixed price quotation provided by ModuleCo Ltd, which is inclusive of a design and build risk, that ModuleCo have offered to fix the price



	of the two modular theatres until February 2023 when it is expected an order can be placed for construction.
3) Cost advisor Review of the vfm / procurement process.	<p>The fixed price offer has been reviewed by WT and is considered to offer value for money for the scope and specification proposed in the current market and that they represent value for money. The following embedded document is the cost advisor report:</p> <p style="text-align: center;">   MEOC Modular  Theatres VFM Statem </p>

**STATEMENT OF COMPREHENSIVE NET INCOME**  
**Incremental Impact of Scheme on the I&E of Lead Organisation**

	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 – 2031/32 £'000	Total £'000
Operating income from patient care activities	0	3,089	7,500	71,505	82,094
Other operating income	0	752	871	0	1,622
(Employee expenses)	0	(1,424)	(2,908)	(22,140)	(26,472)
(Operating expenses excluding employee expenses)	0	(8,850)	(5,089)	(38,113)	(52,052)
<b>Less Cash Releasing Benefits</b>	0	0	0	0	0
<b>Operating surplus / (deficit)</b>	<b>0</b>	<b>(6,433)</b>	<b>374</b>	<b>11,252</b>	<b>5,192</b>
Finance Income	0	0	0	0	0
(Finance Expense)	0	0	0	0	0
(PDC Dividends Payable)	0	(180)	(300)	(3,225)	(3,705)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
<b>Retained surplus / (deficit)</b>	<b>0</b>	<b>(6,613)</b>	<b>74</b>	<b>8,027</b>	<b>1,487</b>
Adjustments (including PPA, IFRIC 12 adjustment, and impairments)	0	6,814	0	0	6,814
<b>Adjusted financial performance retained surplus / (deficit)</b>	<b>0</b>	<b>201</b>	<b>74</b>	<b>8,027</b>	<b>8,301</b>

**STATEMENT OF COMPREHENSIVE NET INCOME**  
**Whole Trust Position including the Investment over the Appraisal Period**

	<b>2022/23 £m</b>	<b>2023/24 £m</b>	<b>2024/25 £m</b>	<b>2025/26 – 2031/32 £m</b>	<b>Total £m</b>
Operating income from patient care activities	451.2	439.3	437.0	3,837.4	5,164.8
Other operating income	50.9	55.9	56.2	459.6	622.5
(Employee expenses)	(327.0)	(317.3)	(337.4)	(3,056.8)	(4,038.6)
(Operating expenses excluding employee expenses)	(185.0)	(180.2)	(181.8)	(1,197.4)	(1,744.4)
<b>Less Cash Releasing Benefits</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Operating surplus / (deficit)</b>	<b>(9.9)</b>	<b>(2.3)</b>	<b>(26.0)</b>	<b>42.8</b>	<b>4.3</b>
Finance Income	0	0	0	(0.1)	0
(Finance Expense)	(0.3)	(0.3)	(0.2)	(1.3)	(2.1)
(PDC Dividends Payable)	(6.0)	(7.3)	(7.4)	(75.6)	(96.3)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
<b>Retained surplus / (deficit)</b>	<b>(16.2)</b>	<b>(9.9)</b>	<b>(33.6)</b>	<b>(34.2)</b>	<b>(94.1)</b>
Adjustments (including PPA, IFRIC 12 adjustment and impairments)	30.2	15.1	20.0	111.2	176.4
<b>Adjusted financial performance retained surplus / (deficit)</b>	<b>14.0</b>	<b>5.2</b>	<b>(13.6)</b>	<b>77.0</b>	<b>82.3</b>

## SECTION 5: FIVE CASE MODEL PROJECT DETAIL

### STRATEGIC CASE

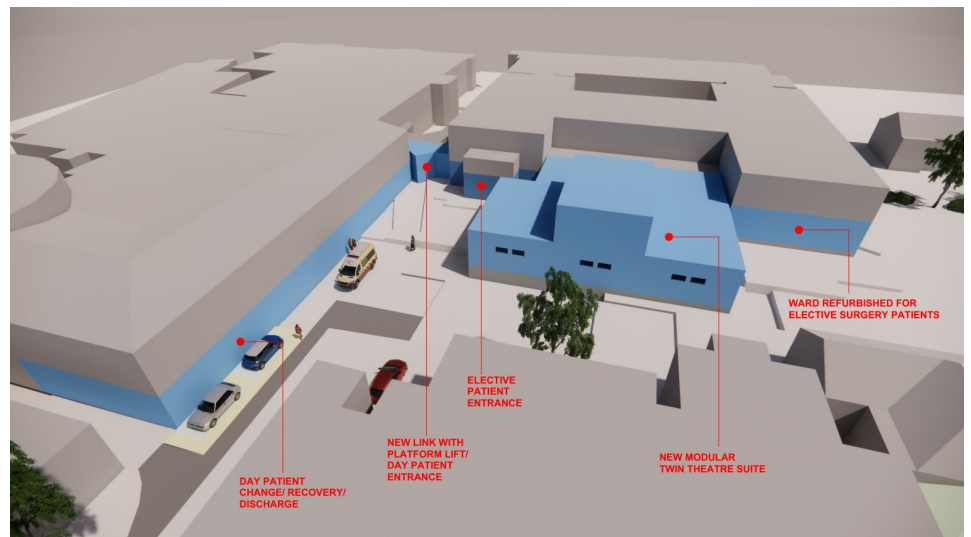
<p>a) Please set out the strategic rationale and case for change.</p>	<p><b>Strategic Rationale</b> The ‘Elective recovery planning supporting guidance’, April 2022, sets out a clear strategic context for the NHS.</p> <p><i>“The pandemic has placed considerable strain on planned service delivery, which was already under pressure before the pandemic. Consequently, there are now significant waiting lists across the country and potentially more patients still to come forward. Our plans will need us to do things differently, creating additional capacity and changing for the better the way services are delivered, while giving patients more control over their experience in the NHS.”</i></p> <p>It describes a delivery plan and the key ambition, to which MEOC responds, relating to the reduction of waiting lists: “Eliminating the longest waits of over two years, except when it is the patient’s choice, by July 2022. Following this, the ambition is to eliminate waits of over 18 months by April 2023 and waits of over one year by March 2025, except where patients choose to wait longer or in specific specialties”.</p> <p>Orthopaedics is the largest component of the waiting list for South Yorkshire ICS making up approximately 60% of the total. MEOC will play a key role in the South Yorkshire ICS in delivering required improvements by March 2025, specifically in relation to orthopaedic waiting lists. To achieve the required waiting list reductions the volume of activity required at a national level is an increase of 30% over 2019/20 levels.</p> <p>GIRFT provides guidance on best practice pathways and expected standards of performance. Developing local approaches to address shortfalls against GIRFT standards is an important strategic driver for this project.</p> <p><b>The case for change</b> The South Yorkshire ICS will not be able to achieve the future plans for elective recovery without intervention. There is insufficient inpatient capacity for the volume of orthopaedic patients needing treatment. Trusts have made very limited progress in ring fencing orthopaedic infrastructure on their acute sites and cannot guarantee patients uninterrupted admission to elective surgery. Orthopaedic staffed beds often underpin medical capacity to the detriment of elective patients. Additionally, there is insufficient theatre capacity to meet the required demand. Rises in trauma workload often result in cancelled lists and de-prioritisation of elective cases. The lack of dedicated elective orthopaedic facilities inhibits the development of best practice pathways and frustrate productivity and efficiency initiatives. There are gaps in the staffing required to deliver the intensity of workload required and disruption to the consistent running of elective orthopaedic services adds pressure and impacts detrimentally on staff and patient experience. Acute site provision of elective orthopaedics often results in sharing arrangements for equipment again prevents smooth running of the service.</p>
<p>b) Please explain how this scheme will contribute to the delivery of the programme aims.</p>	<p>MEOC will contribute to the broader programme aims through:</p> <ol style="list-style-type: none"> <li>1. Creating an environment which delivers increased activity at greater levels of productivity and efficiency</li> <li>2. Enabling an orthopaedic elective model and pathways delivered to the patient using best practice methods</li> <li>3. Providing a facility that is specifically designed and fit for purpose, maximising access and flow, reducing waste and delays on a ‘cold site’:</li> </ol>

	<ol style="list-style-type: none"> <li>a. All facilities are co-located together – admission, discharge, theatres, recovery, theatre support and staff amenity space, and beds</li> <li>b. Enabling full MDT working to support the entire pathway</li> <li>c. Efficiently and effectively linking together pre-admission and post discharge services across the partner trusts</li> <li>d. Exploiting systemwide digital functionality to ensure patient information is available where it is needed</li> </ol> <ol style="list-style-type: none"> <li>4. It will remove the service from the disruptions of the emergency pathways at the acute sites</li> <li>5. It will allow greater management control of the service because the resources are dedicated, and ring fenced for orthopaedics</li> <li>6. It will improve the patient experience and outcome with a predictable/controlled environment</li> <li>7. It will be a better place for staff to work, where they can do their jobs well</li> <li>8. Provides greater assurance that waiting times can be reduced and the national targets will be met</li> </ol> <p>Specifically, MEOC will deliver additional activity over and above existing volumes to support elective recovery programme aims. Orthopaedic elective provider spells across BH, TRH and DBTH were 11,881 in 2019/20 (Source: HED). MEOC will deliver 2,288 spells initially, making a 20% contribution to increases in volumes of activity over 2019/20 with ambitions to improve throughput by increasing day case rates and theatre productivity in future years.</p> <p>MEOC is not designed to specifically impact on cancer pathways. However, it will release capacity at host organisations and discussions have been held with regard to the potential to re-purpose this for cancer work, increasing capacity in this area.</p>
<p>c) Provide confirmation of stakeholders e.g. support from clinicians, commissioners, cancer alliances and STP / ICS accountable officers (formal letters of support to be appended to this business case template).</p>	<p>The MEOC business case is fully supported by representatives from across the three provider trusts: Barnsley Hospital, The Rotherham Hospital, and Doncaster &amp; Bassetlaw Teaching Hospitals. The following groups have been engaged in the detail development of the business case:</p> <ul style="list-style-type: none"> <li>• Executive directors</li> <li>• Clinical stakeholders</li> <li>• Operational stakeholders</li> </ul> <p>In particular, clinical stakeholders from each of the trusts have recently attended three business case development meetings focusing on clinical, operational and staffing model development. Through these meetings the leads for Trauma &amp; Orthopaedics confirmed their support for the project.</p> <p>All the meetings have been attended by South Yorkshire ICS representatives of the Elective Recovery Programme and who are strongly supportive of the scheme.</p> <p>As the host trust, DBTH has provided regular reports to its Trust Executive Group and Finance and Performance Committee.</p> <p>Formal letters of support are included in Appendix 6.</p>
<p>d) Please outline the investment objectives for the project.</p>	<p>The investment objectives for the MEOC project are as follows:</p> <ol style="list-style-type: none"> <li>1. To develop a high-volume, low complexity elective orthopaedic service on a non-acute site</li> <li>2. To create sufficient capacity to deliver material improvements to the orthopaedic waiting list</li> <li>3. To configure the solution to support dedicated staffing, beds and theatres free from interruption due to medical and trauma outlier patients and the demands of broader emergency services</li> </ol>

4. To ensure that the location of the facility supports equitable access for patients across the catchments for the three partner trusts
5. To provide an environment which supports high quality care and a positive patient and staff experience
6. To deliver improved productivity through better theatre utilisation and increased delivery of day case lower limb arthroplasty
7. To design a clinical and operational model which is consistent with GIRFT and emerging best practice achieving high levels of performance safely
8. To create opportunities for career progression through innovative new roles supported by training and education
9. To adopt and develop digital and IT solutions to support service delivery and ensure information is provided seamlessly between provider organisations to support safe and effective care
10. To work in partnership with local providers and across the South Yorkshire ICS to develop a new collaborative model which will act as a proof of concept for future initiatives
11. To ensure that the solution delivered is sustainably affordable and value for money

#### Fit with Estates Strategy

The new MEOC facility, highlighted in blue in the diagram below, forms part of the development control plan for the Montagu Hospital Mexborough.



e) Please confirm fit with estate strategy.

#### Development Control Plan

The embedded document below provides a diagram of the Mexborough Hospital. It identifies the MEOC project together with the other initiatives which are planned for the site.



MEOC-PHS-XX-XX-D  
R-A-002\_Site Develop

The Development Control Plan (DCP) for Montagu Hospital incorporates a number of schemes to be developed, including MEOC, MEOC expansion, Hydrotherapy, Diagnostics (CDC), and new electrical infrastructure.

The DCP has been developed over several iterations as site analysis has informed the design process and individual elements of the scheme were explored in detail with clinical stakeholders.

The premise of the DCP is to co-locate key functions in the centre of the hospital site, improving internal staff/patient links and allowing efficient distribution of

services. The initial phases of development are positioned to utilise immediately available areas of the hospital site. Later phases will then reconfigure the internal access roads around the new buildings, freeing up space for expansion of the new facilities.

Within the DCP, this project focuses on the modular MEOC Theatres, plus refurbishment of existing bedrooms.

***Explanation of location selected (key criteria)***

The DPC submitted for approval provides key benefits for the hospital, including:

- Consolidation of all new development in one central location, providing opportunities for reduced infrastructure costs
- Re-use of existing, underutilised site (e.g. Mortuary)
- Development is in a strategic position, with close proximity to all existing buildings, entrances / exits and car parking areas
- MEOC can be delivered immediately utilising off-site construction solutions developed to date
- Future expansion of Theatres and Beds is possible within the masterplan
- Hydrotherapy can be independently procured and delivered without affecting existing road infrastructure / MEOC / Diagnostics building
- Expansion to MEOC can be delivered in phases (if required) with potential to collocate additional Beds and Theatres
- Location of proposed new buildings limits the potential conflict with existing road infrastructure whilst retaining daylight to all building elevations
- New road layout allows for a more compact arrangement of buildings with greater space for MEOC expansion

***Dependencies and Constraints***

The Development Control Plan seeks to minimise interdependencies, and as a result there is no direct connection between and any of Hydrotherapy, Diagnostics or Electrical Infrastructure.

Some dependencies to still remain:

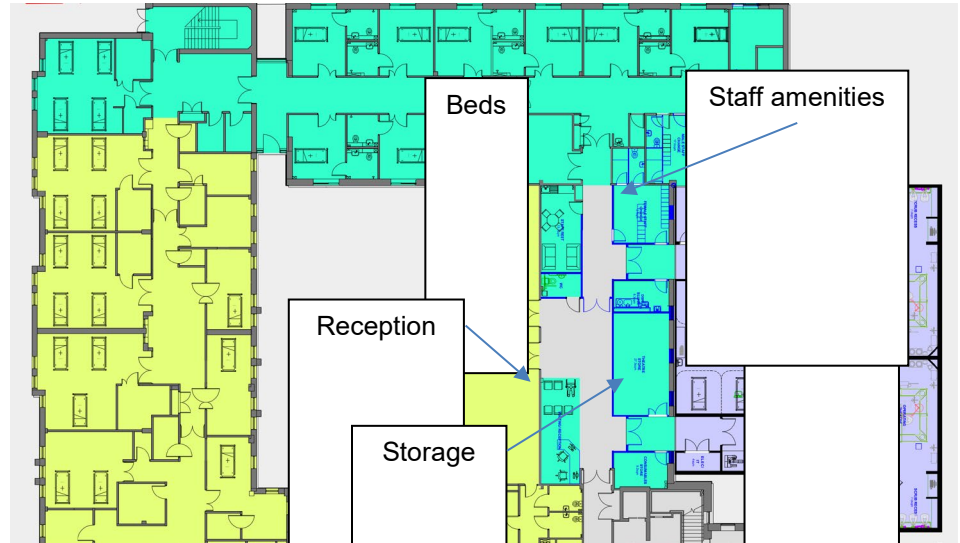
- Expansion of MEOC (potentially a third operating theatre and additional beds) connects into the current proposed scheme, and is thus dependent on its completion
- Hydrotherapy is dependent on completion of electrical infrastructure works in order to support the therapy pool

***Power***

The current sites facilities and activities are nearing the site's agreed electrical allowance with the National Power Grid. The additional theatres and ancillary rooms will add further demand on the current electrical infrastructure.

Discussions with the National Power Grid has identified that the sites current HV transformer settings can be increased to its maximum capacity 800KvA, this will allow sufficient power to power the new facility. To enable the increase in power, the sites LV infrastructure will need to be reconfigured by introducing a new LV distribution panel. This design is nearing completion ready for an order to be placed and the works to commence.

## Design of Preferred Option



The following embedded document provides a detailed drawing of the proposed MEOC facility:



Montagu Hospital  
MEOC 161122 (1).pdf

### Description of key features

MEOC involves the provision of two new modular operating theatre suites adjacent to the existing Rehab block, sharing access but with dedicated reception. The link to the main hospital will be improved to provide a more direct route, incorporating a new platform lift to deal with the level change.

### MEOC Theatre Suite

The Theatre Suite consists of two main elements – a new modular building containing two operating theatres and supporting facilities, and conversion of existing space in the Rehab building to provide reception, staff facilities, and storage.

The modular section is designed to be mainly constructed and fitted out in the factory, to the highest standards, based on hundreds of previous successful projects. This achieves the highest quality in the shortest time, with minimum disturbance and pollution. Theatres are lead lined and laminar flow.

The room sizes generally conform to the recommendations of HBN26, and provide spacious, carefully planned spaces, based on previous solutions which have been highly recommended by users.

Access is via an improved internal route using a new platform lift to the main hospital, or directly into the adjacent dedicated 12 bed inpatient ward. This provides safe internal progressive horizontal escape solutions, with an external access providing fire brigade access and a last resort escape option. Each Theatre has its dedicated anaesthetic room, sterile pack prep, and scrub recess, with a shared dirty utility. A four bay 1st Stage Recovery room is adjacent.

The converted area includes staff change facilities with through access directly into the theatre corridor, a staff rest room, cleaners room, reception/ waiting area, and storage areas totalling 45sqm.

14 existing bedspaces will be refurbished and reassigned to create 12 beds dedicated for orthopaedic elective patients, and further internal works will create new staff change and storage areas. Release of the existing 14 beds is required by July 2023 to allow works to commence. Service leads have agreed the release of these beds which are largely used for escalation and winter pressures.



The remaining areas are retained for Rehab use.

Future phases could include an extension to the MEOC project, hydrotherapy pool, and diagnostic unit, supported by a revised layout, extended car parking, and infrastructure development.

The final result will create a coordinated and efficient centralised facility.

### Functional content

The proposal is designed to create effective elective surgery facilities to meet the urgent demand.

The new operating theatres are designed to the latest standards, and built and fitted to the highest quality using factory-based Modern Methods of Construction.

The supporting wards will include 8 single rooms and one 4 bed ward with ensuite facilities, ideal for the varying requirements.

### Schedules of Accommodation

The following embedded document sets out the schedule of accommodation for MEOC.



3587-PHS-XX-XX-L-A  
-0001 P02 Schedule o

### Compliance with HTM / HBN

Generally, the scheme will be designed, installed and commissioning in accordance with the relevant HTMs and HBNs. Due to the site location, available footprint and part refurbishment on the scheme there will be minor derogations which will be reviewed as part of the design development process and either addressed and designed out as necessary or accepted and included in the final derogation schedule.

Refurbished areas utilise existing room sizes and bed spacing. These existing areas are below the recommended areas in HBN 00-03 but review of the activity zones confirms that the proposed room layouts are functional and meet IPC requirements for patient spacing.

### 2D Layouts

The following embedded document sets out the two-dimensional layout for the scheme:



Montagu Hospital  
MEOC 161122 (1).pdf

### 3D Massing

The following embedded document illustrates the three-dimensional massing of the MEOC scheme:



Montagu Hospital  
View 1 111122 (1).pdf



Montagu Hospital  
View 2 111122.pdf

### Equipment

All required fixed equipment will be provided by the modular supplier. The capital costs include a budget for moveable equipment and clinical meetings are being held to finalise the specific list in December 2022 and January 2023. The main items of equipment assumed for each theatre include:

- |                     |                    |
|---------------------|--------------------|
| • Operating table   | • Patient Trolleys |
| • Imaging equipment | • Stack system     |
| • Infusion pumps    | • Defibrillator    |



- |                                |                     |
|--------------------------------|---------------------|
| • Patient monitoring equipment | • Suction carousel  |
| • Mindray monitors             | • Diathermy machine |
| • Instrument trolleys          | • IT equipment      |
| • PACS Screen                  | • JAX's trolley     |
| • PC's                         | • Mobile trolleys   |
| • Telephones                   |                     |

### **Net Zero Carbon**

The overarching design approach to the new Elective Orthopaedic Centre (OEC) building at Mexborough Montagu Hospital will be in line with the guidance principles set out by the NHS England Guidance Document "Delivering a Net Zero National Health Service". This will ensure the OEC building will have reduced energy and reduce carbon. The building will be designed with enhanced levels of insulation and high efficiency heating, ventilation and air conditioning plant. There is likely potential for the use of electrically driven high efficiency air sourced heat pumps that would provide the heating and hot water to the new OEC building. It would not be the intent to connect the building into the existing gas fired heating network. The scheme will also have high efficiency LED lighting within every space. A review of on-site renewable technologies will be carried out a detailed design stage consider technologies such as Photovoltaic panels to generate on site electricity that would feed back into the building.

Module Co as proposed provider have completed an in-depth carbon reduction plan written in accordance with ISO14064 and verified by BSI. As standard, MMC offers a more sustainable solution by reducing construction waste (ModuleCo recycle 90+% of all site waste produced) and providing a relocatable building with a 60-year structural design life. The facilities themselves are built from steel with at least 25% recycled content and that is completely recyclable at the end of use. The facility will be built to the latest Part L guidelines with Net Zero technologies incorporated, including Air Source Heat Pumps, to ensure the best operational sustainability. The above measures ensure a facility with low embodied carbon (compared to traditional construction) and high operational efficiency with efficient heating generation supporting the Trust Green Plan and the NHS with Net Zero 2030 goals.

### **Modern Methods of Construction**

The new build element of the project will utilise in its entirety MMC, in particular Category 1 MMC, which will be pre-manufactured 3D primary structural systems with volumetric modules being 90% completed off-site and delivered to site onto pre-prepared foundations.

This approach maximises the use of MMC to the very full potential and this element will have a pre-manufactured value (PMV) in excess of 90%.

There will be limited opportunity to use MMC in the refurbishment element of the project as the scope is relatively minor in terms of extend of work and mainly focuses on forming a few new internal rooms, decorations and amendments to the existing M&E services.

### **Access and parking**

Access into the proposed area is typically through the existing hospital. The existing level differences within the hospital ground floor are currently addressed via a ramp; this scheme proposes a new lift to bridge the level difference and provide a more direct route to MEOC.

The proposed location for the theatre extension covers a number of existing parking spaces. This provision will be re-provided immediately adjacent to the Theatres to ensure there is no net loss of parking.

### **Patient and staff flow in building**

	<p>Movement within the department has been considered as part of the overall layout. As noted above, a new lift provides a direct and accessible route for patients arriving from the main hospital into Block 15.</p> <p>Patients arriving from the site car parks can utilise the existing entrance ramp and doors, which arrive at the same point, overseen by the Block 15 reception area.</p> <p>From here, patients can enter the Theatre block, the circulation is designed to provide a separate entrance/exit for patients pre-/post-surgery.</p> <p>The staff change is also designed as a pass-through area with an access either side of the clean corridor extent.</p> <p><b>Digital capabilities</b> The MEOC costs include provision for the peripheral devices required in the facility. DBTH is procuring and implementing a new cloud based EPR system which will support controlled access to digital capabilities required to enable the MEOC model of care across partner organisations. SY ICS has in place and is developing further initiatives to provide connectivity between system organisations, for example: ICE Open Net already provides blood results from all SY Trusts to other SY Trusts. Appendix 7 sets out our response to the Digital Capability KLOEs.</p> <p><b>Flexibility and expansion options</b> Designs have been mindful of the potential need to expand theatre and bed capacity for MEOC if the ambition to pursue a larger Centre of Excellence is pursued. Various drawings have been prepared which identify alternative locations for additional theatres and beds colocated with the proposed scheme.</p>
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## ECONOMIC CASE

<p>a) Please submit a VFM template with this business case template.</p>	<p>The net present value of costs and benefits assessed demonstrate a value for money ratio of 1.3. This indicates that the scheme is value for money over the 10 year assessment period included in the VFM model.</p> <table border="1" data-bbox="547 1176 1380 1971"> <thead> <tr> <th>Incremental costs and benefits</th> <th>10 year VFM: Present Value of Cashflows</th> </tr> </thead> <tbody> <tr> <td colspan="2"><b>COSTS</b></td> </tr> <tr> <td>Capital Costs (including optimism bias)</td> <td>11,547,049</td> </tr> <tr> <td>Revenue Costs</td> <td>41,341,845</td> </tr> <tr> <td>Transitional &amp; non-recurrent revenue costs</td> <td>-</td> </tr> <tr> <td><b>INCREMENTAL COSTS TOTAL</b></td> <td><b>52,888,894</b></td> </tr> <tr> <td colspan="2"><b>BENEFITS</b></td> </tr> <tr> <td>Capital Costs (including optimism bias)</td> <td>3,502,097</td> </tr> <tr> <td>Revenue Costs</td> <td>-</td> </tr> <tr> <td>Transitional &amp; non-recurrent revenue costs</td> <td>-</td> </tr> <tr> <td>Cash Releasing Benefits</td> <td>64,558,438</td> </tr> <tr> <td>Non-cash Releasing Benefits</td> <td>-</td> </tr> <tr> <td><b>INCREMENTAL BENEFITS TOTAL</b></td> <td><b>68,060,536</b></td> </tr> <tr> <td><b>Value for Money Ratio</b></td> <td><b>1.3</b></td> </tr> </tbody> </table>	Incremental costs and benefits	10 year VFM: Present Value of Cashflows	<b>COSTS</b>		Capital Costs (including optimism bias)	11,547,049	Revenue Costs	41,341,845	Transitional & non-recurrent revenue costs	-	<b>INCREMENTAL COSTS TOTAL</b>	<b>52,888,894</b>	<b>BENEFITS</b>		Capital Costs (including optimism bias)	3,502,097	Revenue Costs	-	Transitional & non-recurrent revenue costs	-	Cash Releasing Benefits	64,558,438	Non-cash Releasing Benefits	-	<b>INCREMENTAL BENEFITS TOTAL</b>	<b>68,060,536</b>	<b>Value for Money Ratio</b>	<b>1.3</b>
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VFM template MEOC  
V4 11-12-22.xlsx

The VFM template is embedded here:

b) Please provide an incremental VFM analysis that shows the VFM ratio (Net Present Social Value) for Business as Usual and the preferred option and provide an explanatory narrative on the VFM analysis.

There is no Business as Usual option. This is consistent with other schemes where new investment is made to deliver new activity. As a consequence, there are no comparative benefits, risks and costs analysis for this scheme and no VFM ratio.

c) Provide a narrative on:

- The options considered to achieve the scheme's objectives, including business as usual.
- The process through which the long-list of options was narrowed down to the preferred option.
- The main costs, benefits and risks for the Business as Usual and preferred option.
- The appraisal period for the scheme.

The options appraisal for identification of MEOC as the preferred way forward was undertaken at regional, system and local levels in response to the strategic imperative to reduce elective waiting times. Initial work was undertaken to identify the focus for investment at a South Yorkshire system level. This identified the key specialties and other enabling areas which would benefit through investment. Analysis by Newton as part of the national programme of developing the elective recovery plan confirm that Orthopaedics presented the best opportunity for delivery of improved waiting times. Agreement was reached that the system will be best served through the development of two hubs, one serving Sheffield and the other supporting Barnsley, Rotherham and Doncaster & Bassetlaw patient populations. MEOC is a response for Barnsley, Rotherham and Doncaster & Bassetlaw and was identified as Mexborough Hospital represents the only potential cold site solution, an essential criterion for separation of elective pathways from acute and emergency pathways. South Yorkshire ICS included the MEOC proposal in its consolidated long list of options for consideration by NHS EI North East & Yorkshire and the NHS EI central team. As a result of this exercise both MEOC at Mexborough Hospital and the surgical hub at the Hallamshire Hospital were allocated funding subject to a business case process.

Options were then considered for the potential to deliver a solution at Mexborough Hospital:

Option Name	Option Description
<b>Long-List</b>	
<b>Option 2 (BAU)</b>	10 Bed Refub + 1 x Existing Theatre Refurb
<b>Option 3</b>	2 Theatres + Refurb of Ground Floor Wards for surgical beds
<b>Option 4</b>	2 Theatres + 12 new Beds + Refurb of First Floor Wards for surgical beds
<b>Option 5</b>	2 Theatres + 24 new Beds
<b>Option 6</b>	2 Theatres + Refurb of Ground Floor Wards for surgical beds + Alterations to Rockingham admissions / discharge
<b>Option 7</b>	2 Theatres + 12 New Beds + Alterations to Rockingham admissions / discharge
<b>Option 8</b>	2 Theatres + 24 New Beds at Ground Floor + Alterations to Rockingham admissions / discharge
<b>Short-List</b>	
<b>Option 3A</b>	2 Theatres + Refurb of Ground Floor Wards for surgical beds + lift
<b>Option 4A</b>	1 Theatre + 10 new beds + Refurb of Ground Floor Wards for surgical beds + lift
<b>Option 5A</b>	2 Theatres + 26 new Beds

Each of the options was costed and reviewed from an affordability and estates feasibility perspective together with the potential impact on other existing services. Option 3A was the only option that could be afforded within the budget of £15 million and deliverable without significant disruption to existing services.

There is no Business as Usual option. This is consistent with other schemes where new investment is made to deliver new activity. As a consequence, there is no comparative benefits, risks and costs analysis for this scheme.

d) Confirm inflation, VAT, depreciation, PDC are excluded from the economic analysis.

Inflation, VAT, depreciation, PDC have been excluded from the economic analysis.

## COMMERCIAL CASE

a) Please set out the commercial and procurement route, e.g., P22.	The project is currently being developed through the SBS Lot 3 Modular Healthcare for purchase framework directly with Module Co (SBS ref 10091) on the basis of developed relationship following a previous scheme at Doncaster Royal Infirmary. Module Co are proposed to provide the full delivery route covering the Principle Contractor role for the modular and also traditional elements.
b) Set out the basis of the negotiated position, including the final price for the works.	The modular element will be priced on the basis of a fixed fee using the NEC4 contract and GMP (as per P23) with risk managed through a 50/50 gain share but providing surety to the Trust in terms of maximum price.
c) Confirm status of any legal documentation or processes required for the scheme to be delivered in full and what (if anything) remains to be agreed.	The scheme as noted above will be delivered through Trust terms and conditions but also controlled by the NEC4 Contract signed by both parties and monitored by the Trust appointed Project QS (PQS)
d) We assume that Modern Methods of Construction (MMC) will be used for new builds. Please provide details of how MMC will be utilised.	The main element of the project (Theatres and recovery) is proposed to be delivered using an offsite modular construction approach which will initially provide a much shorter delivery timeframe on site compared to traditional methods, potentially shortening the time period to delivery and enabling earlier clinical activity. An offsite approach also minimises disruption by limiting time on site ensuring continued access for patients and healthcare professionals. The modules will be designed in close collaboration with the Trust, considering day-to-day challenges to create a space that would respond to prevailing challenges.
e) Confirm contribution to carbon reduction plan (if applicable).	Module Co have completed an in-depth carbon reduction plan written in accordance with ISO14064 and verified by BSI. As standard, MMC offers a more sustainable solution by reducing construction waste (ModuleCo recycle 90+% of all site waste produced) and providing a relocatable building with a 60-year structural design life. The facilities themselves are built from steel with at least 25% recycled content and that is completely recyclable at the end of use. The facility will be built to the latest Part L guidelines with Net Zero technologies incorporated, including Air Source Heat Pumps, to ensure the best operational sustainability. The above measures ensure a facility with low embodied carbon (compared to traditional construction) and high operational efficiency with efficient heating generation supporting the Trust Green Plan and the NHS with Net Zero 2030 goals.

## FINANCIAL CASE

a) Please provide narrative to support the detail provided in Section 4 (above).	<p><b>Capital Costing</b></p> <p><b>Methodology</b> The preferred option has been computed using advice from a modular contractor incorporated into an elemental cost plan.</p> <p><b>Basis of costs</b> Costs are based on the P+HS drawing DBHOH-PHS-XX-XX-DR-A-020_P02 Internal Works, dated 19.10.2022. The Modular Theatres cost is based on a fixed price quotation provided by ModuleCo Ltd, which is inclusive of a design and build risk. ModuleCo have fixed the price of the two modular theatres until February 2023 when it is expected an order can be placed for construction.</p> <p><b>Cost plan</b> A RIBA Stage 1 cost plan has been produced by WT Partnership, dated 01.11.2022. The cost plan totals £14,921,104, and includes: building works, associated main contractor design &amp; build costs/fees, trust costs for equipment, fees, contingency/risk, and non-works costs, and VAT @ 20%.</p>
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**OB forms**

The cost plan that has been factored into OB forms for reporting purposes. Inflation has been calculated to mid point and all figures within the OB forms are directly taken from the elemental cost plan and adjusted for price level

**Contingency and risk implications**

Within the cost plan for the preferred option, planning contingency and optimism bias have been included as prescribed by NHS EI at 10% and 20% respectively of the build cost for the non-modular enabling/refurbishment works.

Due to the fixed price offer provided by ModuleCo Ltd, a combined percentage of 5% has been allowed for the Modular element of works only, as this is deemed a lower risk than the non-modular portion of works.

The percentages included in the OB forms are compounded percentages using the total risk allocations across the whole project (i.e., the figure is as the cost plan – the percentages are worked back from those actual allowances).

**Cashflows**

The cashflow has been produced including the necessary spend for the modular contractor to maintain a March project mobilisation and a May commencement of construction with all works (modular and refurbishment) will be completed within 2023/24 fiscal year.

**Revenue Assumptions**

The key revenue assumptions used in the financial model are as follows:


1. Income has been calculated on the basis of November 2022 HRG prices for the specific HRG's included within the inpatient work. Day case prices have been calculated based on the average price for the relevant HRG's relating to lower complexity upper limb, shoulders, hands, wrists, feet and ankles. HRG prices have been inflated for the Market Forces Factor for DBTH. For the period associated with the Elective Recovery Programme, through to March 2025, HRG prices are at 75% of tariff. Beyond this point, full tariff is assumed.
2. Capital charge funding has been assumed on the basis of the allocations provided for the period through to March 2025. After this point, the cost of capital is funded through the full tariff price (as described above).
3. Staff costs have been calculated based on the midpoint of scale. For anaesthetist and surgeon costs an hourly rate has been calculated and the total costs are based on the total hours agreed to meet the service requirements multiplied by the hourly rate.
4. Theatre consumables, prostheses, drugs and blood have been calculated using the latest, 2022/23, PLICS data for DBTH and are based on a combination of the number of spells and the number of lists per annum.
5. Overhead costs have been calculated using the latest, 2022/23, PLICS data based on an initial overhead absorption approach followed by a line by line review to ensure that all overhead costs allocated are relevant and appropriate. Overheads equate to 15% of total costs.
6. Capital charges have been calculated based on the total cost of capital included in the OB forms after an impairment of 50% to reflect the impact of inflation and other factors which affect the accounting valuation.
7. PDC dividend has been calculated at 3.5% on the average net relevant assets for each year based on the incremental impact of the MEOC project on the trust's balance sheet.
8. Depreciation has been calculated based on the manufacturers estimate of the life associated with the modular buildings at 60 years and equipment has been depreciated over 10 years.

	<p>9. Revenue life-cycle costs are included within the overhead costs described above. Capital life-cycle costs are minimal during the first 10 years and will be picked up by the trust's capital programme.</p> <p>10. The financial model does not include any productivity gains or cost improvements. It is likely that once the service in beds a higher throughput of day case work will be achievable with low variable costs.</p> <p>11. Costs and income included in 2023/24 have been prorated for the five months of operating. However, staff costs have been assumed to commence earlier in order to support the commissioning of the new facility.</p>																																																																																																																														
<p>b) Please explain any incremental revenue consequences of the investment and how they can be mitigated.</p>	<p>The financial model indicates incremental surpluses in all year 2024/25. Sensitivity analysis has been undertaken as follows:</p> <p><b>Income sensitivity (Switching values):</b> A 10% drop in income results in the I&amp;E position after 10 years reducing to £0 (breakeven) assuming activity and costs remain the same. All other things being equal the MEOC model is highly sensitive to revenue funding for the planned activity and costs.</p> <p>If no new activity were funded in MEOC it could be used for repatriation of private work. In 2021/22 Private patient income was £3,705m across the three trusts for relevant orthopaedic work. If this private patient work were repatriated and undertaken in MEOC this would equate to 40% of planned income. Variable costs would reduce, and the deficit would be circa £1.81m over 10 years. Other private work is commissioned directly, and this information is being requested and will improve the position.</p> <p><b>Recruitment supplemented with locum and agency sensitivity</b> Three profiles have been examined examining the impact of staffing in MEOC supplemented with locum and agency staff at a premium rate of 130% (DBTH 2022/23 average) for different profiles of recruitment and pace:</p> <ul style="list-style-type: none"> <li>• 12 months</li> <li>• 18 months and</li> <li>• 2 years</li> </ul> <table border="1" data-bbox="549 1301 1513 1626"> <thead> <tr> <th>Case</th> <th>Year</th> <th>2023/24</th> <th>2024/25</th> <th>2025/26</th> <th>2026/27</th> <th>2027/28</th> <th>2028/29</th> <th>2029/30</th> <th>2030/31</th> <th>2031/32</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td rowspan="3">12 months to recruit</td> <td>Staff at agency rate (%)</td> <td>100%</td> <td>50%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td></td> </tr> <tr> <td>Months of year at agency rate</td> <td>5</td> <td>7</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>12</td> </tr> <tr> <td>I&amp;E Surplus/(Deficit) £'000s</td> <td>(226)</td> <td>(181)</td> <td>1,396</td> <td>1,311</td> <td>1,227</td> <td>1,144</td> <td>1,063</td> <td>983</td> <td>903</td> <td>7,619</td> </tr> <tr> <td rowspan="3">18 months to recruit</td> <td>Staff at agency rate (%)</td> <td>100%</td> <td>50%</td> <td>25%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td></td> </tr> <tr> <td>Months of year at agency rate</td> <td>5</td> <td>12</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>18</td> </tr> <tr> <td>I&amp;E Surplus/(Deficit) £'000s</td> <td>(226)</td> <td>(363)</td> <td>1,377</td> <td>1,311</td> <td>1,227</td> <td>1,144</td> <td>1,063</td> <td>983</td> <td>903</td> <td>7,419</td> </tr> <tr> <td rowspan="3">2 years to recruit</td> <td>Staff at agency rate (%)</td> <td>100%</td> <td>75%</td> <td>50%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td>0%</td> <td></td> </tr> <tr> <td>Months of year at agency rate</td> <td>5</td> <td>12</td> <td>7</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>24</td> </tr> <tr> <td>I&amp;E Surplus/(Deficit) £'000s</td> <td>(226)</td> <td>(581)</td> <td>1,136</td> <td>1,311</td> <td>1,227</td> <td>1,144</td> <td>1,063</td> <td>983</td> <td>903</td> <td>6,959</td> </tr> <tr> <td>All recruited from start</td> <td>I&amp;E Surplus/(Deficit) £'000s</td> <td>201</td> <td>73</td> <td>1,396</td> <td>1,311</td> <td>1,227</td> <td>1,144</td> <td>1,063</td> <td>983</td> <td>903</td> <td>8,301</td> </tr> </tbody> </table> <p>While this analysis indicates that failure to recruit and the use of supplementary agency and locum staff would result in deficits in the early years the overall ability for the model to sustain an aggregate surplus after 10 years is comfortably achieved.</p>	Case	Year	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Total	12 months to recruit	Staff at agency rate (%)	100%	50%	0%	0%	0%	0%	0%	0%	0%		Months of year at agency rate	5	7	0	0	0	0	0	0	0	12	I&E Surplus/(Deficit) £'000s	(226)	(181)	1,396	1,311	1,227	1,144	1,063	983	903	7,619	18 months to recruit	Staff at agency rate (%)	100%	50%	25%	0%	0%	0%	0%	0%	0%		Months of year at agency rate	5	12	1	0	0	0	0	0	0	18	I&E Surplus/(Deficit) £'000s	(226)	(363)	1,377	1,311	1,227	1,144	1,063	983	903	7,419	2 years to recruit	Staff at agency rate (%)	100%	75%	50%	0%	0%	0%	0%	0%	0%		Months of year at agency rate	5	12	7	0	0	0	0	0	0	24	I&E Surplus/(Deficit) £'000s	(226)	(581)	1,136	1,311	1,227	1,144	1,063	983	903	6,959	All recruited from start	I&E Surplus/(Deficit) £'000s	201	73	1,396	1,311	1,227	1,144	1,063	983	903	8,301
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<p>c) Are there any cash flow issues, such as fees, enabling works, that require early funding?</p>	<p>Early funding of £383k has been issued in 2022/23 to support design team fees.</p>																																																																																																																														
<p>d) Confirm that the project can be managed within existing funding envelopes.</p>	<p>The MEOC initiative delivers additional activity. Discussions have been held with commissioners to confirm that this additional activity will be funded.</p>																																																																																																																														



e) Confirm and demonstrate that the recurrent revenue cost of the scheme is affordable.	The financial model sets out the recurrent revenue position through to 2031/32. It demonstrates that after 2024/25 the recurrent revenue cost is affordable based on the assumptions set out above. Sensitivity is currently being undertaken in order to get assurance around the impact of changes to key variables with regard to income and delayed recruitment of staff. Mitigations are being investigated to manage any affordability issues such as repatriation of independent sector work.
f) Confirm the trust has assessed and is able to fund lifecycle costs to keep the facility at condition B.	The trust's cost advisers, WT Partnership, have prepared life-cycle costs associated with maintaining the new facility at Condition B. These costs will be managed through the partner trusts annual capital programmes on an equitable basis and revenue consequences of life-cycle costs are included in the overhead calculation described above.

## MANAGEMENT CASE

a) Confirm the arrangements for the management and delivery of the scheme.	<p><b>Management of the scheme</b></p> <p>DBTH will take formal responsibility for the management and delivery of the scheme both during the construction phase and into operation. Jon Sargeant, Deputy Chief Executive at DBTH will remain as Senior Responsible Officer for the project. The governance structure which has been put in place for development of the business case will be enhanced with a joint steering group including senior membership from each of the partner organisations. This steering group will report and make recommendations to the trust boards for each of the partner organisations through the appropriate committees. A memorandum of understanding has been developed and this will be turned into a formal contract between the three partner organisations setting out the roles and responsibilities of each and the delegated powers to DBTH for day-to-day operational and management responsibility. The memorandum of understanding and contract will also set out the financial arrangements between the organisations. The steering group will be supported by a clinical advisory group which will provide input into the detailed conversations for implementation of MEOC and subsequently provide guidance and oversight of the future development of the clinical model. The steering group will also have a reporting line through to the Acute Federation and South Yorkshire Integrated Care Board to ensure oversight of the impact of MEOC from a systems perspective. Project management responsibility will fall under the Senior Responsible Officer. The project team will be enhanced to include further representation from each of the partner organisations in order to share the workload associated with preparation for implementation and to ensure engagement and involvement in all the key details as they develop. The project management team will include representation from the elective recovery team within South Yorkshire ICS and also relevant Commissioner and Doncaster, Barnsley and Rotherham Places.</p> <p><b>Delivery of the scheme</b></p> <p>The following embedded document sets out the programme of activities to deliver the MEOC infrastructure solution.</p> <p> Montagu Hospital - Theatres, Recovery ar</p> <p>The following activities will be undertaken in order to prepare MEOC for operation:</p> <ol style="list-style-type: none"> <li>1. Clinical review of detailed facility designs working with architects to sign off the room datasheets (January 2023)</li> <li>2. Clinical stakeholder engagement with best practice sites nationally three site visits and Microsoft Teams meetings (February/March 2023)</li> <li>3. Recruitment activities commence (January 2023)</li> <li>4. Deep dives on clinical, operating and staffing model based on areas of discussion identified during October and November 2022 clinical meetings (March/April 2023)</li> <li>5. Deep dive on health equality impact of the service and design of further initiative to improve access to disadvantaged or minority groups.</li> </ol>
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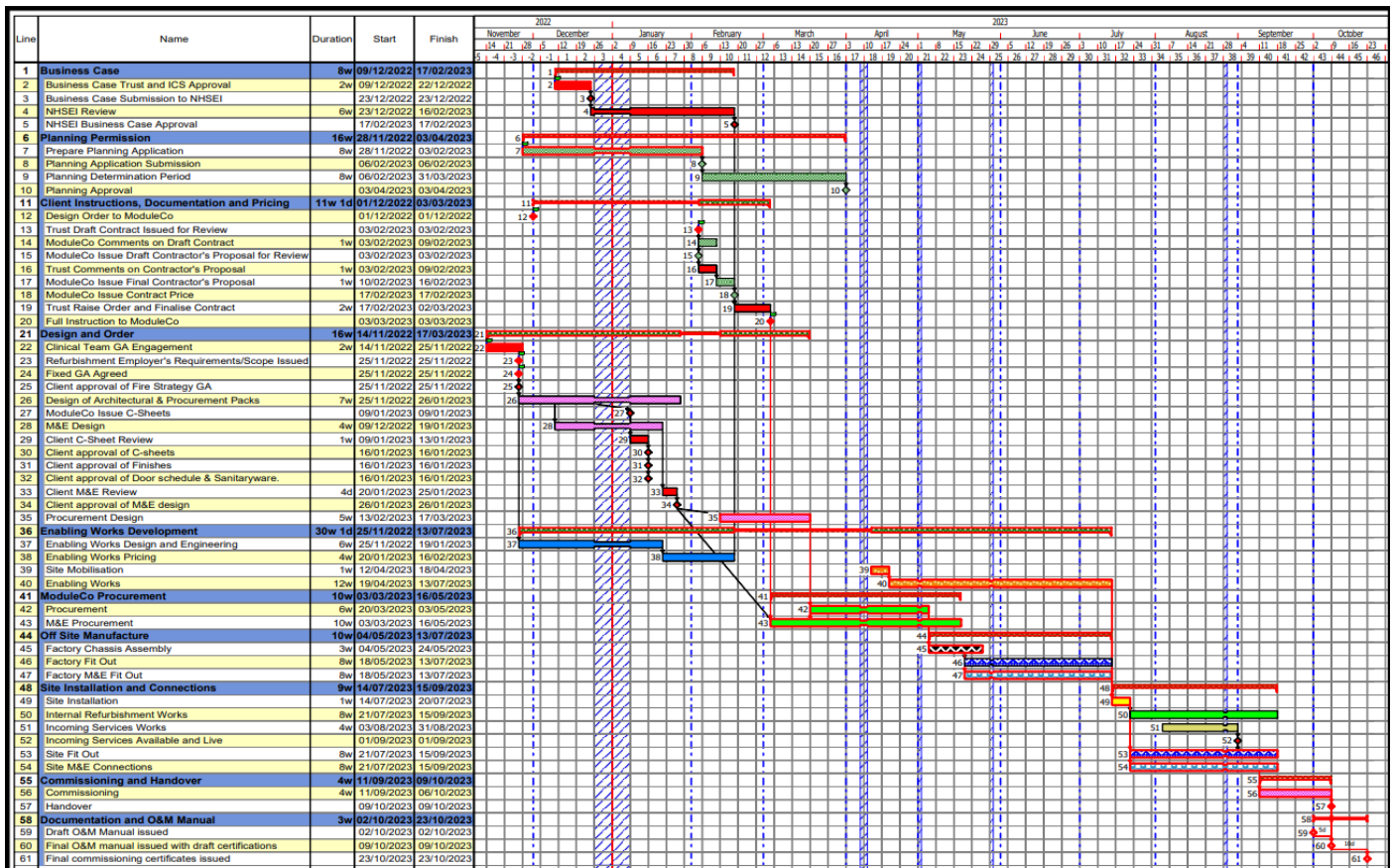
	<p>6. Development of the draft memorandum of understanding into a contractual arrangement between the three organisations (April/May 2023)</p> <p>7. Development of the requirement and approach to public consultation (April/May 2023)</p> <p>8. Finalisation of planning permission (March 2023)</p>
b) Confirm the key risks to delivery and measures to mitigate and manage these risks.	The key risks to delivery and measures to mitigate and manage these risks are set out in Section 3 above. The project management team will be responsible for day-to-day management of the project risk register together with escalation of key issues to the steering group.
c) Set out the benefits realisation strategy and how the Trust intend to monitor and report on benefits.	<p>Benefits realisation will form a key part of the responsibilities of the project team and the steering group post implementation of MEOC. The key benefits will be set out as a series of measures for regular monthly reporting and will include:</p> <ul style="list-style-type: none"> <li>• Waiting list impact</li> <li>• Activity volumes</li> <li>• Theatre utilisation</li> <li>• Day case rates</li> <li>• Staffing metrics</li> <li>• Financial performance</li> <li>• Patient &amp; Staff experience feedback</li> </ul> <p>These measures will be reported through the governance structure described above. The project team will hand over responsibility for benefits realisation to the operational management for MEOC once the process is embedded. It is anticipated that benefits will be included formally as part of the annual process of reviewing the contractual arrangements, aims and objectives for MEOC between the partner trusts and the ICS at the end of each operating year.</p>
d) Set out the expectations for Post-Project Evaluation, and the expected timescales for the review of delivery.	Post project evaluation will follow standard DBTH approaches. However, given that the MEOC is a system resource the evaluation process will involve partner trusts, the ICS and wider GIRFT and national stakeholders. It is intended that a formal post project evaluation report will be prepared after one full year of operation.



**Appendix 1 – [Programme Team to evaluate what data is required for collection, both for reporting and monitoring purposes, and to build necessary evidence for future SRs]**

<b>Anticipated Benefit</b>	<b><i>Improved metrics/KPIs</i></b>
<b>A reduction in the size of the waiting list as a proxy to access</b>	Pre-pandemic levels
<b>A good, and much improved, patient experience</b>	No cancellations due to lack of infrastructure Patient satisfaction survey
<b>Provide orthopaedic surgery at the right time to achieve the best clinical outcome</b>	90% of patients operated on within 12 weeks of being added to the waiting list
<b>No constraints due to lack of theatre equipment</b>	No cancellations or theatre delays recorded
<b>High job satisfaction, being a part of and being proud of the service staff are delivering to the orthopaedic patients</b>	Recruitment and retention Staff sickness Staff satisfaction
<b>Attractive work for theatre staff: day working, no on-call night theatre provision</b>	Recruitment and retention Staff sickness Staff satisfaction
<b>Delivery of government waiting list targets</b>	March 2024 No one will wait longer than 65 weeks March 2025 No one waiting longer than 52 weeks
<b>Release infrastructure at BH, THT and DBTH</b>	960 lists per annum
<b>Improved use of trust theatres</b>	48 weeks per year 8 hours per day 2 theatres
<b>Greater standardisation of theatre consumables</b>	Cost efficiency and safety metrics
<b>Standardisation of anaesthesia</b>	Cost efficiency and safety metrics
<b>A robust and sustainable activity plan</b>	Delivery of BC activity plan
<b>Increased theatre throughput</b>	4 IP cases and 4-12 DC per 8 hour list
<b>Day case pathway for primary joint replacements</b>	Increased lower limb arthroplasty as day cases
<b>Overall reduction in LOS</b>	LOS for primary joints 2.75 days and reducing
<b>Staggered admissions for patient's 3<sup>rd</sup> plus on the theatre list</b>	Patients admitted through day with an acceptable wait prior to surgery
<b>Good flow, impacting on theatre throughput</b>	Lists start on time
<b>Shortest possible gap between cases in theatre</b>	Gap between cases
<b>Theatre time used</b>	Knife to skin time
<b>Patient experience</b>	Patient feedback/PROMs

## Appendix 2 – Schedule of Works (to be attached by Trust)



### Montagu Theatres and Recovery



Client: Sales

Prepared by: Sam Hanks

Date: 01/11/2022

Revision No. Rev E


### Appendix 3 – OB Forms (to be attached by Trust)



Microsoft Excel  
97-2003 Worksheet

A small, low-resolution thumbnail of an Excel spreadsheet. It shows a grid of cells with some text and numbers, but the details are too small to read. The spreadsheet appears to be a multi-column table with several rows of data.

**Appendix 4 – Key Estates Information [to be evaluated and adjusted for each individual programme]**

KEY ESTATE METRICS	
Total Area of Building m <sup>2</sup>	1,607.3m <sup>2</sup>
New build clinical GIA m <sup>2</sup> and % of total GIA	408.8m <sup>2</sup> and 25%
New build non-clinical GIA m <sup>2</sup> and % of total GIA	161.5m <sup>2</sup> and 10%
Refurbishment clinical GIA m <sup>2</sup> and % of total GIA	1,023.9m <sup>2</sup> and 64%
Refurbishment non-clinical GIA m <sup>2</sup> and % of total GIA	13.1m <sup>2</sup> and 1%
No. of beds and type	12 no Surgical
PFI Estate Implications <ul style="list-style-type: none"> <li>- Is the build on an existing PFI Estate?</li> <li>- Does the build interface with any PFI Estate?</li> <li>- Are there any other implications with the PFI Contract that need to be considered?</li> </ul>	No
MMC (Modern Methods of Construction) Status. Percentage to be achieved and brief overview	35% of the scheme will be delivered through MMC. Details with regard to MMC are included in Section 5.
Summary of any significant derogations and assurance (derogations template is available)	There are a few minor derogations within the scheme which will be reviewed during the detailed design process and either addressed or accepted as part of the scheme.
£ Reduction in BLM	£26,880
Any temporary accommodation required – provide details	Not applicable – Rehab beds used for surgical will be managed
Is a land purchase required – provide details	Not applicable
Is this an owned or leased facility – provide details if leased	Not applicable
Stage of design development and trust approval (please attach design drawings)	Stage 2 Concept Design.  MEOC-PHS-XX-XX-D R-A-002_Site Developo
Estimated average lifecycle costs £/m <sup>2</sup> over asset life	

## Appendix 5 – Equality Impact Assessment

<b>Business area:</b>	Musculoskeletal Services
<b>Team/Department:</b>	Orthopaedics
<b>Date completed:</b>	November 2022
<b>Name(s) of author(s):</b>	James Nicholls

<b>Name of policy / guidance / strategy / proposal / operational activity etc. – Highlight here if this is related to COVID-19</b>
Montagu Orthopaedic Elective Surgical Hub

<b>What are the aims, objectives and projected outcomes?</b>
<ul style="list-style-type: none"> <li>• Reduction in the length of time patients are waiting for elective surgery to at least the national recovery targets</li> <li>• Implementation of the best orthopaedic pathways of care including more day case pathways and an overall reduced length of stay for IP's. These pathways have been co-designed (and tested) with staff and service users based on national guidelines</li> <li>• Increased elective operating above baseline activity levels</li> <li>• Removal of historical constraints and dependencies in running the elective service on the acute site</li> <li>• Stop the cancellation of patients due to lack of infrastructure</li> <li>• The establishment of a centre of excellence for orthopaedic surgery in which staff aspire to work within and do the job they have chosen to do. Employing sufficient, happy and cared for staff.</li> <li>• Creation of an integrated MDT working environment which facilitates improved collective care and decision making with the right physical infrastructure within the unit</li> <li>• A new service delivery model with innovative, effective and efficient patient pathways to maximise value and remove delays and waste which are aligned to GIRFT</li> <li>• High levels of patient satisfaction gained through a reduced wait for surgery, a better predictable environment, MDT working and reduced length of stay</li> </ul>

### Section 1: EQUALITY INFORMATION

<b>1.1 What relevant quantitative and qualitative information (data) do you have? This may include national or local research, surveys, reports or research; workforce / patient data; complaints and patient experience data, etc.</b>						
	<b>Positive Impact</b> This will actively promote or improve equality of opportunity or address unfairness or tackle discrimination	<b>Negative Impact</b> This will have a negative or adverse impact which will cause disadvantage or exclusion	<b>Neutral Impact</b> There is no likely impact on any of the protected groups	<b>Does it advance equality of opportunity? (Y/N)</b>	<b>Does it eliminate unlawful discrimination? (Y/N)</b>	<b>Does it foster good relations between people? (Y/N)</b>
Race (including nationality)	<b>The scheme will deliver waiting list reductions for all members of the relevant populations irrespective of race</b>			Y	n/a	n/a
Religion/belief and non-belief			<b>The scheme will treat patients already on the waiting</b>	n/a	n/a	n/a

			list. There is no bias here			
Disability	More patients with disability will be treated due to the volume of activity delivered by MEOC and the release of capacity at host sites.			Y	n/a	n/a
Sex			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a
Gender Reassignment			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a
Sexual Orientation			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a
Age			The criteria for admission will allow access to patients of all ages who are suitable for MEOC pathways.			
Pregnancy and Maternity			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a
Marriage and Civil Partnership			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a
Human Rights (FREDA principles)			The scheme will treat patients already on the waiting list. There is no bias here	n/a	n/a	n/a

Carers	In treating patients, to help them cope better. Also, we are moving away from an environment where short notice cancellations are common which can cause extreme difficulties for carers due to the planning required.			Y	n/a	n/a
Other groups e.g. Gypsy, Roma, Travellers, vulnerable adults or children (e.g. homeless, care leavers, asylum seekers or refugees)	Again, these people tend to be in IMD 1 & 2 which is over represented on the current waiting list and will be treated faster.					

**1.2 List any specific equality issues and information gaps that may need to be addressed through engagement and/or further research**

The location of MEOC in the Mexborough Hospital allows equitable access to patients from Doncaster, Rotherham and Barnsley. There is excellent parking and good public transport. Patient transport will be laid on where travel is a barrier to care which will be agreed at pre-assessment.

**Section 2: ANALYSING THE EQUALITY INFORMATION**

In this section record your assessment and analysis of the evidence. This is a key element of the EIA process as it explains how you reached your conclusions, decided on priorities, identified actions and any necessary mitigation.

**2.1 Analysis of the effects and outcomes**

Through delivery of high volumes of surgery with excellent outcomes in a modern facility with good transport links and excellent parking the MEOC facility will improve access to all patients on its waiting list therefore reducing inequalities.

**Section 3: OUTCOME(S) OF EQUALITY IMPACT ASSESSMENT**

No major change needed X	Adjust the policy/proposal	Adverse impact but continue	Stop and remove the policy/proposal
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## **Appendix 6 – Letters of support**

Letters of support will be agreed and appended here as the business case passes through the governance process.



Appendix 6 – Digital capability KLOEs

Digital Capability KLOE's	Yes/No	Narrative
<b>Must Haves</b>		
<p><b>Transformation</b></p> <p>There are policies in place and the transformation is embedded for:</p> <ul style="list-style-type: none"> <li>• Digital preoperative assessment</li> <li>• Digital prehabilitation tools</li> <li>• Digital consent</li> <li>• Keeping in touch with patients while they wait</li> <li>• Alternatives to digital contact where required</li> </ul> <p>Note: Transformation is not embedded for preoperative assessment. DBTH are currently working on a business case for an interim solution until the new EPR is deployed.</p>	Yes	<p>DBTH is progressing through a business case process to procure and implement a new EPR. The key business needs which this will address reflect the Digital Capability KLOE's and include:</p> <ul style="list-style-type: none"> <li>• Digitise patient interactions: Patients will be able to interact and provide updates to teams in ways more efficient than the existing physical appointment process. Through a single patient portal, they will be able to see when their next appointment is due (helping to reduce the likelihood of missed appointments), access results and information related to their own healthcare needs.</li> <li>• Improve user experience: This will be achieved by using fewer systems and adopting more streamlined access methods whilst retaining high levels of security.</li> <li>• Deliver enabling technology: The Trust will implement systems that improve technology that supports the ability of teams to care for patients rather than be viewed as an administrative barrier.</li> <li>• Provide relevant tools for the role: The Trust will implement digital technology that allows carers to remain at the patient's side when updating or viewing information with devices which are relevant to the environments in which they are operating. Tools such as tablet computers, smart phones, and wearable devices will all have a place as part of digitally connected ways of working.</li> <li>• Ensure accurate and timely data at the point of care: This will improve the speed at which analysis can be made and improve the accuracy of decisions. The data acquired through daily activity will be proactively placed back into the hands of clinicians, managers, leaders and decision-makers through compelling self-serve reports and dashboards.</li> <li>• Implement a fully digitised end to end process: This will have administrative and clinical benefits by removing the need to manually collate and process paper charts across every bed. Instead, activity can be easily prioritised based upon recorded observational feedback. Digitising core activities, such as observations, will lead to improved patient care, safety, and reduced costs. Safety will be further improved as the reliance on interpreting handwritten notes will be removed with the introduction of clinical noting.</li> <li>• Data sharing and interoperability: At an organisational level, the success of the strategy will be proven when digital is regarded by patients, staff, and health economy partners as a key enhancement to every clinical pathway and embedded as a way of working.</li> </ul>

<p><b>Systems</b></p> <p>We will have established systems for:</p> <ul style="list-style-type: none"> <li>• Electronic appointment management</li> <li>• Clinic scheduling/worklists</li> <li>• Theatre allocation</li> <li>• The use of digital triage</li> </ul>	<p>Yes</p>	<p>Existing digital provision is largely in place for these areas but the advent of a new EPR at DBTH will enhance current capabilities and ensure that digital requirements for the MEOC are comprehensive.</p>
<p><b>Accessibility</b></p> <ul style="list-style-type: none"> <li>• Integrated Care Records and Interoperability to existing ICS systems to support the data flows</li> <li>• Shared diagnostic imaging from all organisations to prevent the duplication of testing</li> <li>• Access to patient records within ICS as a minimum - a shared care record that allows information to follow the patient and flow across the ICS. Links to external ICS partners: private, dentistry, community, social care and ambulance</li> <li>• One time login for clinical and operational staff - providing access to all clinical information around the surgical hub</li> </ul>	<p>Yes</p>	<p>DBTH will act as host for the digital requirements of the business case and provide access as required to partner providers to support processes such as booking for MEOC.</p> <p>ICE Open Net already provides blood results from all SY Trusts to other SY Trusts</p> <p>All patient facing systems will be compliant with nationally recognised accessibility standards (e.g. WCAG 2)</p>
<p><b>Should Haves</b></p>		
<p><b>Connectivity</b></p> <ul style="list-style-type: none"> <li>• Adoption of cloud-based services where feasible</li> <li>• Use of virtual consultations and integration with wearable devices where appropriate</li> <li>• Connectivity requirements: wifi, 5G ...</li> </ul>	<p>Yes</p>	<p>DBTH anticipates moving its EPR to a cloud based system and adopting best practice connectivity across and within its sites.</p> <p>Suitable digital innovations will be adopted and adapted to support the MEOC model of care and will be developed alongside existing initiatives.</p>
<p><b>Innovation</b></p> <p>There will be aspirations to:</p> <ul style="list-style-type: none"> <li>• Share continuous improvement and innovation of digital solutions to surgical care</li> <li>• Using Artificial Intelligence within the surgical hub</li> <li>• The use of Robotic Process Automation to improve processes. E.g. <ul style="list-style-type: none"> <li>- Automated patient feedback - RPA, output of dashboard.</li> </ul> </li> </ul>	<p>Yes</p>	<p>SY ICS and the partner trusts are ambitious with regard to the development of digital and IT enablers to support pathways of care. The programme of activities through to implementation of the new MEOC will ensure that existing technology is adopted and ongoing development of the service will seek to exploit digital innovation appropriately, working with clinical and operational staff.</p>

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on  
Tuesday 29 September 2022 at 09:30  
via MS Teams

- Present:** Mark Bailey - Non-executive Director  
Suzy Brain England OBE - Chair of the Board (Chair)  
Hazel Brand - Non-executive Director  
George Briggs - Interim Chief Operating Officer  
Mark Day - Non-executive Director  
Jo Gander - 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
- In attendance:** Marie Hardacre, Head of Nursing for Corporate Services (agenda item B1)  
Fiona Dunn - Director of Corporate Affairs / Company Secretary  
Angela O'Mara - Deputy Company Secretary (Minutes)  
Jenny Marsh – Interim Deputy Director of Finance  
Lois Mellor - Director of Midwifery  
Adam Tingle - Acting Director of Communications & Engagement
- Public in attendance:** Peter Abell - Public Governor Bassetlaw  
Henry Anderson – Member of the Public  
Laura Brookshaw - 360 Assurance  
Rob Allen - Staff Side  
Lynne Logan - Public Governor Doncaster  
Andrew Middleton - Public Governor Bassetlaw  
Pauline Riley - Public Governor Doncaster  
Alison Ryan – Member of the Public  
Lynne Schuller - Public Governor Bassetlaw  
Kevin Turner – Member of the Public  
Karen Jessop – Observer  
Sheila Walsh - Public Governor Bassetlaw
- Apologies:** Alex Crickmar, Acting Director of Finance
- P22/11/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 members of public in attendance. The above apology for absence was noted and no declarations were made.

**P22/11/A2 Actions from Previous Meetings (Enclosure A2)**

**Action 1 – Risk Management**

The timeline was provided as part of the Executive Medical Director's Update. Action to be closed.

**Action 2 - Medical Advisory Committee and Risk Management Board**

The structure was included within the Executive Medical Director's Update. Action to be closed.

**Action 3 – Corporate Director Objectives**

The meetings for the non-executives/executive director were in the diary, with the exception of the Chief Operating Officer and Chief Nurse which would take place by the end of Q4 2022/2023, following their substantive appointments in January 2023. Action to be closed.

***The Board:***

- ***Noted the update to the action log.***

**P22/11/B1 Tendable (Enclosure B1)**

The Chair of the Board welcomed the Head of Nursing for Corporate Services to the meeting. As a quality inspection tool, the introduction of Tendable supported the monitoring of internal and regulatory requirements relating to the provision of patient care. Prior to its implementation careful consideration had been given to its scope, the learning from other organisations, alignment to the Care Quality Commission's domains and the Trust's specific needs.

The tool, an easy-to-use mobile application, had been well received with good levels of engagement across all three sites. Availability of audits would be expanded over time to ensure a managed introduction. The functionality of action planning would be a key aspect, in order to progress the outcomes of the audit and drive quality improvements.

The data would be available via Monday.com, monitored by the Tendable Steering and reported to the Quality Steering Group.

The next stage of the roll out would be to extend the use to non ward areas, including outpatients and theatres, and a series of audit questions were being developed for this purpose. The Chief Executive recognised colleague buy in would be linked to the added value and looked forward to the data being incorporated within the Quality Dashboard, currently under development.

160 audits had been completed during November 2022 and where an area of improvement had been identified, a supporting action plan developed. The Head of Nursing for Corporate Services confirmed the need for further education in developing appropriate action plans.

Kath Smart welcomed the introduction of Tendable as a clinical audit tool and shared colleagues' positive reactions as part of a recent board visit. It was a great example of workforce led improvement.

The Chair of the Board thanked the Head of Nursing for Corporate Services and the wider team for their work in implementing Tendable.

***The Board***

- ***Noted the Tendable presentation***

**P22/11/C1 Board Assurance Framework – SA1 (Enclosure C1)**

The Board received an updated Board Assurance Framework (BAF) in respect of risks to the achievement of the Trust's strategic aim 1 – to provide outstanding care and improve patient experience; changes were highlighted for ease of reference.

The Executive Medical Director confirmed the opportunities being explored to deliver the strategic objective. The external peer review of patient safety and governance had now been received and recommendations aligned with the project plan for the implementation of the Patient Safety Incident Response Framework (PSIRF). A business case was being developed to support its implementation.

In response to a question from Jo Gander, it was agreed that CQC preparedness would be added as a measure to the framework. The Interim Deputy Chief Nurse confirmed his involvement in CQC network and engagement meetings and noted the expected introduction of quality statements to replace the existing key lines of enquiry (KLOEs).

Mark Bailey recognised the significant change required to implement PSIRF and sought clarity on the approach, the Executive Medical Director confirmed the Trust would explore learning from early adopters.

The Chief Executive acknowledged the journey to deliver outstanding care would be an iterative approach, a clear view of the end goal was required, as was clarity of the governance arrangements. The changing position would be accurately reflected in the BAF.

***The Board:***

- ***Noted and took assurance from the Board Assurance Framework***

**P22/11/C2 Chief Nurse Update (Enclosure C2)**

The Chief Nurse Update provided information, outcomes, and assurance on the key deliverables for patient safety and experience and safe staffing numbers. The Interim Deputy Chief Nurse confirmed that the revised Infection Prevention and Control Board Assurance Framework had now been received and would be presented to next month's Quality & Effectiveness Committee, ahead of its submission to Board in January 2023.

A total of 63 newly qualified nurses had been recruited, a small number had experienced a slight delay to their start date, due to the impact of the pandemic on the required number of placement hours for registration.

International recruitment continued to progress well, with a further cohort of 12 recruits expected to arrive in the UK in January and February 2023. A recent celebratory event to recognise completion of the international recruits' Objective Structured Clinical Examinations had been hosted by the Trust. The event was a great opportunity to

celebrate individual successes and observe the development of international recruitment. The Chair of the Board, the Chief People Officer and Non-executive Director, Jo Gander had supported the event and extended their appreciation of the planning, recognition and support offered by the Stay & Thrive Matron and pastoral support from the international recruitment team. The support extended beyond the workplace and ensured colleagues were embedded into the local community and had an appropriate support network, including signposting for specialist advice, when required.

The Royal College of Nursing's leadership programme had been extended to provide additional places for staff nurse development, and to support delivery of the Professional Nurse Advocate (PNA) national strategy, a total of 21 colleagues were now qualified PNAs, with a further 11 expected to complete their training by March 2023. As part of their preceptorship the newly qualified PNAs would join an aptly named "flying squad".

In view of the national pay structure, the Chief Executive acknowledged the added value to staff was linked to training, education and career development opportunities. To enhance staff retention there was a need to understand the reason colleagues leave, and alongside the exit interview the Interim Deputy Chief Nurse advised of newly introduced retention clinics.

In response to a question from Kath Smart with regards to the level of resource required to implement PSIRF, the Interim Deputy Chief Nurse confirmed that a gap analysis would be completed as part of the business case preparation, there was an expectation that the resource was available but there would be a need to work differently to deliver the project plan.

Kath Smart queried the relatively low Friends and Family Test (FFT) response rate of 7.2% reported for September, in order to move this closer to the target of 9.5% the Interim Deputy Chief Nurse confirmed opportunities to utilise digital solutions, such as the QR code, were being explored. An improved range of accessible options were to be pursued with the Communications & Engagement Team.

***The Board:***

- ***Noted and took assurance from the Chief Nurse Update.***

**P22/11/C3 Maternity Update (Enclosure C3)**

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.

The first face to face meeting of the Maternity Voices Partnership had taken place and feedback had been received in relation to professional's use of language when explaining care and associated risks, the triage service and availability of information. In response to a question from Kath Smart, the Director of Midwifery confirmed the feedback was not unexpected and would form part of an action plan to be progressed by the newly appointed Lead Midwife for Equity & Equality.

The Board noted the ongoing work in respect of the Clinical Negligence Scheme for Trusts (CNST) and the actions that remained at risk. The Chief Executive reminded colleagues of

the extensive work in year two and three to declare compliance and the volume of evidence submitted. The Trust's internal auditors had carried out an audit of the CNST year 4 standards and the Ockenden recommendations and in due course the report would be presented to the Audit & Risk Committee.

In response to a question from Kath Smart, the Director of Midwifery confirmed that the data within the North East & Yorkshire perinatal oversight report provided a more up to date regional comparison than the MBRRACE-UK data. The Chief Executive acknowledged that a significantly higher level of deprivation in Doncaster and Bassetlaw resulted in an added complexity to both antenatal and post-natal care.

In respect of training compliance and in response to a question from Hazel Brand, the Director of Midwifery confirmed that all colleagues had received training within the previous 18 months, training dates were allocated and included in rosters. The position was closely monitored by the education team and opportunities for completion explored to mitigate the risk.

***The Board:***

- ***Noted and took assurance from the Maternity Update***

**P22/11/C4**

**Executive Medical Director Update, including Q1 2022/2023 Learning from Deaths Report (Enclosure C4)**

The Executive Medical Director's report provided an overview of the current programmes of work within his portfolio. In order to address actions arising from previous meetings appendices to clarify the reporting structure of the Medical Advisory Committee and the risk management timeline were included.

Following scrutiny at the Quality & Effectiveness Committee in October 2022 the Board received the Q1 2022-2023 Learning from Deaths Report. The Executive Medical Director confirmed plans to review the format of the report, with a view to producing an annual report supported by quarterly data analysis updates and a peer group comparison of Hospital Standardised Mortality Ratio (HSMR).

In response to a question from Jo Gander with regards to the escalation of risks the Company secretary clarified the governance route. Kath Smart sought confirmation from the Executive Medical Director that the timeline for review of those risks rated 15+ was achievable, good progress was reported and the rate of completion would be subject to continued monitoring.

In response to a question from Kath Smart, the Executive Medical Director confirmed the rate of completion of medical appraisals during Q1/2 was not a cause for concern and mirrored the picture seen in previous years, unlike the non-clinical appraisal process completion was across the year rather than within a specific window.

Mark Bailey welcomed the expansion of the foundation programme and supported the Executive Medical Director's view that the importance of a high quality training resource was crucial to success, recognising the clear link between a positive training experience and the ability to attract and retain colleagues.

The impact of the Getting It Right First Time programme in terms of improved productivity and supporting elective recovery was recognised and the Board had a keen interest in its development.

The Chair of the Board thanked the Executive Medical Director for the comprehensive report.

***The Board:***

- ***Noted and took assurance from the Executive Medical Director Update.***

**P22/11/D1 Board Assurance Framework – SA2 & 3 (Enclosure D1)**

The Board received an updated Board Assurance Framework, which included risks to the achievement of the Trust’s strategic aim 2 – everybody knows their role in achieving the vision and strategic aim 3 - feedback from staff and learning in top 10% in UK.

The Chief People Officer confirmed all actions and risks had been reviewed and where appropriate discussions from this month’s People Committee reflected in the narrative. An additional action relating to succession planning had been added.

Recent discussions at the Trust Executive Group with regards to internal audit feedback identified an element of crossover between the two frameworks and this would be subject to review.

***The Board:***

- ***Noted and took assurance from the Board Assurance Framework***

**P22/11/D2 People Update (Enclosure D2)**

The People Update provided an overview of developments in relation to activities to support staff engagement and experience, and the development of the new People Strategy.

The Board’s attention was drawn to the closing position of the 2022 national staff survey, a completion rate of c. 65% was noted as at 25 November, an increase from the previous year and one of the leading acute trusts in the country.

In addition, a completion rate of 83.43% was reported for non-clinical appraisals; although higher than previous year the ambition was to continue to increase completion, but with a clear focus on the quality of the conversation.

In response to a question from Mark Bailey, the Chief People Officer confirmed that the current People Strategy was coming to an end, the refresh would reflect the NHS People Plan and NHSE’s report “The future of NHS human resources and organisational development”, issued in November 2021. Education and research would be an integral part of the strategy.

As the former Chair of the People Committee, Mark Day shared his appreciation of the energy and enthusiasm of the Chief People Officer and her team and welcomed the Equality, Diversity & Inclusion action plan which addressed diversity in its widest sense.



In response to a question from the Chair of the Board, the Chief People Officer confirmed that the refreshed strategy would include a comprehensive delivery plan to be supported by a workforce plan, developed in collaboration with medical and clinical colleagues and linked to business planning.

In closing, the Chief Executive highlighted the anticipated national workforce strategy and emphasised the key to success was to work collaboratively at place and system level, whilst maximising opportunities to explore the use of technological and artificial intelligence solutions.

***The Board:***

- ***Noted and took assurance from the People Update.***

**P22/11/D3 Guardian of Safe Working Quarterly Report (Enclosure D3)**

In the absence of the Guardian of Safe Working the Chief People Officer presented the quarterly report, feedback would be provided to Dr Pryce post meeting.

The Board's attention was drawn to a higher level of exception reporting during the period August to October 2022; no specific areas of concern had been highlighted with regards to work schedules but an increased workload for junior doctors was noted. This was anticipated to increase into the winter months. There was no alignment of reporting to rota gaps.

Kath Smart welcomed the feedback from the most recent junior doctor forum which noted improved staff morale and enquired of the support available to the trainees, noting the reference to staying beyond the end of their shift to complete clinical work. The Executive Medical Director confirmed that staff welfare was a high priority and a handover process at the end of the shift was a supportive measure. The commitment of the trainees was recognised in completing work post shift. Board members were reminded of previous work to improve doctor's mess facilities and the provision of sleep pods. The accessibility and availability of refreshments, particularly out of hours, had been considered by the Medical Advisory Committee and the Executive Medical Director was working with the Director of Finance to consider options to address this.

***The Board:***

- ***Noted and took assurance from the Guardian of Safe Working Quarterly Report***

**P22/11/E1 Board Assurance Framework – SA4 (Enclosure E1)**

The Board received an updated Board Assurance Framework (BAF) which identified risks to the achievement of the Trust's strategic aim 4 – in recurrent surplus to invest in improving patient care.

The Acting Deputy Director of Finance summarised the changes to the BAF, which had been subject to a substantial review and were highlighted for ease of reference. Supporting detail was contained with the month 7 finance report and no change to the risk rating was reported.

***The Board:***

- ***Noted and took assurance from the Board Assurance Framework***

**P22/11/E2 Finance Update (Enclosure E2)**

The Acting Deputy Director of Finance provided a high-level overview of the month seven position. The Board was asked to note an in-month deficit of £0.9m, which was a £19k favourable variance to plan. The year-to-date financial position was a deficit £10.1m, £1m adverse to plan. The position was largely driven by a pay overspend, due to the continued high usage of temporary staffing, these pressures were offset by non-pay spend on elective recovery. National guidance on the clawback of elective funding for Q3/4 had not yet been received. In view of the challenging financial position a review of the year end forecast was in train.

The capital position was currently underspent but delivery of the plan by the year end was expected.

The Trust's underlying cash position had decreased in month and was expected to continue to fall throughout the remainder of the year, this was due to the income and expenditure position and the back loaded capital plan. In view of this, the Board were informed that the year end audit opinion may include an emphasis of matter section relating to going concern.

The Chair of the Finance & Performance Committee welcomed the comprehensive update and confirmed an additional meeting of the Committee had been called to consider the revised financial forecast in early December. The Board Assurance Framework focused attention on the controls, mitigations and actions in place and a debate on the Trust's funding position would be welcomed. The aged infrastructure at Doncaster Royal Infirmary continued to be challenging and there remained a strong case to be made for a new hospital.

The Chief Executive acknowledged the variance in activity and the presence of covid as compared to the planning assumptions and with three waves throughout the year there had been significant additionality, which had impacted upon usage of temporary staffing. In view of this the elective and diagnostic recovery was not where the Trust had hoped, and the challenges of winter had already been seen with the earlier than planned opening of winter beds.

The Trust would continue to work collaboratively with its partners towards achieving the system balance, and the directors of finance and chief executives were actively involved in place, system and Integrated Care Board discussions.

***The Board:***

- ***Noted the Finance Update.***

**P22/11/E3 Board Assurance Framework – SA1 & 4 (Enclosure E3)**

The Interim Chief Operating Officer confirmed the relocation of services to support the urgent and emergency care programme had now been completed and the update reflected on the Board Assurance Framework.

**Operational Performance Update including Ambulance Handover Delays (Enclosure E4)**

The Interim Chief Operating Officer provided an insight into the current operational performance.

Emergency Department attendances remained high, often at record levels, although there had been minimal impact on hospital admissions, the volume of activity and increased staff absence in October had proved challenging.

Ambulance handover delays remained under close scrutiny despite improvements over the last six weeks. Additional ambulance spaces had been created at Doncaster Royal Infirmary and the impact of the Early Assessment Unit and introduction of the Acute Physician at the front door had been positively received and feedback would be sourced to ensure an understanding of what had worked well and what required further improvement. A quality improvement project had been commissioned with NHSE's Emergency Care Improvement Support Team (ECIST) to commence in December.

The number of medically fit patients awaiting discharge continued to create a significant pressure on beds. The Trust was focused on reducing length of stays and timely discharges but due to a lack of available care packages in the community a system wide solution was required, and the Trust continued to work closely with its partners at Place to source appropriate care tailored to the patient's needs.

The Interim Chief Operating Officer confirmed the range of meetings which focused on delivery of the Place Plan, which included partners from the Council, Acute, Mental Health and Community Trusts, these were supported by Acute Federation and Integrated Care Board meetings involving Chief Executive colleagues.

The focus on quality improvement initiatives had been seen as part of a recent board visit by the Chief People Officer and Jo Gander to Doncaster Royal Infirmary's Emergency Department.

Kath Smart welcomed the support of ECIST to complement internal improvements, including the red to green initiative and the discharge hub and enquired of access to the recently announced government discharge funding of £500m. The Trust would work closely with the Council on this matter but the workforce challenges in respect of care home recruitment were noted and guidance on how this money would be spent had not yet been received.

The Chief Executive noted the challenging position and the required improvement in standards of delivery, which would be realised through iterative improvements. Focused work on falls and mental health conveyance to hospital and the provision of virtual wards were part of a wider plan, which required collaborative working at place and system level. As the NHS continued to face these challenges the support of the public was required in reducing the potential for demand of the services, through active support of the vaccination programmes, and adherence to hands, space, face and ventilation.

Whilst the Chief Executive acknowledged the need to recover both elective and diagnostic activity, post pandemic it seemed appropriate to consider workforce requirements for delivery within core hours and considering the benchmarking of the Getting It Right First Time Programme.

***The Board:***

- ***Noted and took assurance from the Operational Performance Update***

**P22/11/E5 Directorate of Recovery, Innovation & Transformation Update (Enclosure E5)**

The Interim Director of Recovery, Innovation & Transformation introduced the report which provided an insight into the directorate's work. Since the paper had been written news had been received that the Electronic Patient Record Outline Business Case had been approved. This was a significant achievement for the Trust and work to complete the Full Business Case would now be progressed ahead of the financial year end.

The service strategy work had now been completed and a final service line report would be presented to a future Finance & Performance Committee and Board to feed into the planning process.

Work to progress a site-based strategy continued with input from the Chief Operating Officer, Executive Medical Director and Chief Nurse teams. A workshop to receive board members input would be arranged for January and both integrated care systems would be actively engaged.

Good progress was reported on the Mexborough Elective Orthopaedic Centre business case which was expected to be presented to the next Board meeting. In response to a question from Jo Gander, the Interim Director of Recovery, Innovation & Transformation confirmed that the case had been developed taking into account recommendation of the GIRFT Programme, a requirement of the Target Investment Funding.

***The Board:***

- ***Noted and took assurance from the Directorate of Recovery, Innovation & Transformation Update.***

**P22/11/F1 Community Diagnostic Centre Imaging Suite Business Case (Enclosure F1)**

The Interim Director of Recovery, Innovation and Transformation confirmed the case presented was to provide a static CT and MRI scanner, a condition of approval of the Year 2 business case. Board members were informed that as the case progressed through the approval process there may be a change to the phasing of the work.

Claire Ainsley, Strategic Programmes Manager, summarised the detail of the business case, which in addition to the introduction of the static scanners would see the ultrasound provision co-located in the Community Diagnostic Centre and the purchase of software to support cardiac MRIs, a welcomed addition which would avoid the need for patients to travel to the Northern General Hospital in Sheffield. The enhanced patient pathway would offer an improved experience by supporting access to a single location for a range of diagnostic testing, increasing capacity and supporting the reduction of backlogs. Supporting upgrades to the electrical infrastructure were included in the case.

The X-ray facility at Retford Hospital would be utilised initially as a training facility for 11 radiographers and subsequently had the potential to be used as a spoke facility, again improving accessibility across South Yorkshire and Bassetlaw.

In response to a question from Hazel Brand, it was confirmed that consideration had been given to the infrastructure and services to support the development. The development of the site also had the potential to impact positively on local businesses.

In view of the benefit to the residents of the town and the development of the Montagu site, the Chair of the Charitable Funds Committee and the Interim Director of Recovery, Innovation & Transformation had discussed the potential to utilise the Fred and Anne Green legacy with the executors.

The Chair of the Finance & Performance Committee confirmed the case had been considered by the Committee, who had sought assurance that the workforce plan was being developed but were supportive of the plans and supporting business case.

The Board supported the case and gave its approval for submission.

***The Board:***

- ***Approved the Community Diagnostic Centre Imaging Suite Business Case***

**P22/11/G1 Corporate Risk Register (Enclosure G1)**

The Board received the Corporate Risk Register and supporting paper. No new corporate risks, rated 15+ had been added to the register. There was a total of 99 risks rated 15+, 11 of which were monitored via the Corporate Risk Register.

Additional commentary had been added to the Corporate Risk Register to provide an update on the controls in place. Kath Smart shared her appreciation of the update and enquired if risk ID 1519 (Q&E9) in respect of availability and supplies of medicines was worthy of review. The Executive Medical Director confirmed the matter would be considered at the next meeting with the Chief Pharmacist to reconsider the position for reporting via the appropriate governance route, an update would also be included within the Executive Medical Director's board report.

TN

To aid clarity, the Chair of the Audit Committee shared the auditor's recommendation to separate the controls and mitigating actions.

The expectation of the Risk Management Board would be to establish that the risk and its score remained relevant and that mitigating actions were effective, or if improved mitigation was required.

***The Board:***

- ***Noted the Corporate Risk Register.***

**P22/11/G2 Use of the Trust Seal (Enclosure G2)**

The Board noted and approved the use of the Trust Seal in relation to the lease extension of 28-50 Ryton Street, Worksop. The document had been signed and dated by Richard Parker, Chief Executive and Alex Crickmar, Acting Director of Finance on 26 October 2022.

***The Board***

- ***Approved the Use of the Trust Seal***

**P22/11/G3 NHSE Consultations (Enclosure G3)**

The Company Secretary's report highlighted the current NHSE consultations in respect of the NHS provider licence and NHS enforcement guidance, open until 9 December 2022.

An individual response would not be submitted by the Trust as Company Secretaries had provided feedback on the proposed changes to the provider license at a session facilitated by NHS Providers on 24 November 2022.

***The Board***

- ***Noted the NHSE Consultation Update***

**P22/11/H1 Information Items (Enclosure H1 – H9)**

***The Board noted:***

- H1 Chair and NEDs Report
- H2 Chief Executives Report
- H3 Performance Update Appendices
- H4 Minutes of the Finance and Performance Committee 21 July, 12 August & 26 September 2022
- H5 Minutes of the People Committee 5 July & 6 September 2022
- H6 Minutes of the Quality & Effectiveness Committee 5 September 2022
- H7 Minutes of the Audit & Risk Committee 14 July 2022
- H8 – Minutes of the Charitable Funds Committee 20 June 2022
- H9 Minutes of the Trust Executive Group 12 September 2022

**P22/11/I1 Minutes of the meeting held on 25 October 2022 (Enclosure I1)**

***The Board:***

- ***Approved the minutes of the meeting held on 25 October 2022.***

**P22/11/I2 Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were raised.

**P22/11/I3 Governor Questions regarding the business of the meeting (10 minutes) \***

The following questions were raised by the Deputy Lead Governor, on behalf of the governors:

**"A constant challenge for providers is maintaining or improving productivity, including through process control and pathway re-design. The productivity challenge is frequently mentioned in the Finance & Performance Committee which is consistent**

**with the third strategic aim for ICSs of improving productivity and VFM. What steps has the trust taken to identify where productivity gains can be made, what actions have been taken, and what gains have been achieved or planned so far?"**

The Interim Director of Recovery, Innovation & Transformation confirmed the Trust was able to utilise a range of productivity tools, such as Model Hospital and the Getting It Right First Time Programme. The Trust's internal cost improvement programme had been successful in delivering multiple value for money efficiency schemes, feedback on which was provided to the Finance & Performance Committee.

**"In relation to the serious incidents and patient safety is there a link to the freedom to speak up workstream? Ensuring staff are able to actively raise concerns re patient safety, whilst feeling supported could potentially lead to reduction of serious incidents. If the links already exist, do we have a reporting mechanism highlighting near misses"?**

The Executive Medical Director confirmed the reporting of risks, incidents and near misses was actively encouraged and supported as part of everyday practice, submissions were via Datix, which provided a rich source of information. There was also extensive communication to encourage and support speaking up.

**"Staff values and behaviours (Pg 28) links with previous reports of staff attitude. This has remained as a cause for complaint for some time. Has any work been undertaken to understand the details behind this theme and share with patients / visitors any rationale sitting behind the "values and behaviours" or to address if an issue is identified"?**

In respect of complaints, it was recognised that staff attitude was nearly always the number one cause of concern. Communication was a critical skill, keeping patients and families well informed with regards to decision making and next steps. Where patterns emerged within department/ward targeted support and education would be provided.

The Chief People Officer confirmed a leadership behaviour framework would be launched shortly, to focus on values and behaviours for a broad range of colleagues.

The Chair of the Board thanked those in attendance for their contribution and the governors for their continued support and engagement.

***The Board:***

- ***Noted the governor questions.***

**P22/11/I4**

**Date and time of next meeting (Verbal)**

**Date:** Tuesday 20 December 2022

**Time:** 09:30am

**Venue:** MS Teams

**P22/11/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.***

**P22/11/J**      **Close of meeting (Verbal)**

The meeting closed at 13.10