Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

2 September 2025

10:00 GMT+1 Europe/London

MS Teams

Join the meeting now

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2509 - A OPENING ITEMS

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Board of Directors Public Agenda - 2 September 2025 v6.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 2 September at 10am
Via MS Teams

		Purpose	Page	Time
A	**OPENING ITEMS**			**10:00**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair of the Board* *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*			5
A2	Actions from previous meeting *Suzy Brain England OBE, Chair of the Board*	*Review*		
A3	Chair's Report including Partnership Update *Suzy Brain England OBE, Chair of the Board*	*Information*		10
A4	Chief Executive's Report including Partnership Update *Richard Parker OBE, Chief Executive*	*Information*		10
B	**PATIENTS**			**10:25**
B1	Audiology Service Update *Nick Mallaband, Acting Executive Medical Director*	*Review*		10
B2	Learning from Deaths Report *Nick Mallaband, Acting Executive Medical Director*	*Assurance*		10
B3	Winter Plan 2025/26 *Denise Smith, Chief Operating Officer*	*Decision*		10
B4	DBTH Tackling Health Inequalities Update *Zara Jones, Deputy Chief Executive*	*Decision*		10
C	**PEOPLE**			**11:05**
C1	Job Evaluation - Updated Nursing & Midwifery Profiles and Data Collection for Board Oversight Zoe Lintin, Chief People Officer	*Assurance*		5

D	**ASSURANCE & GOVERNANCE**			**11:10**
D1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
D2	Finance & Activity Report – Month 3 *Yasmin Ahmed, Deputy Director of Finance* *Denise Smith, Chief Operating Officer*	*Note*		10
BREAK 11:40 – 11:55				
D3	Board Assurance Framework including Trust Risk Register *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Approve*		10
D4	Premises Assurance Model Assessment Report 2024/25 *Kirsty Edmondson-Jones, Director of Infrastructure* *Sean Tyler, Head of Compliance*	*Approve*		10
D5	Green Plan Refresh 2025 *Kirsty Edmondson-Jones, Director of Infrastructure*	*Approve*		10
D6	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25 *Denise Smith, Chief Operating Officer*	*Assurance*		5
D7	Proposed Amendments to the Trust Constitution *Rebecca Allen, Associate Director Strategy, Partnerships & Governance*	*Decision*		10
D8	Chair's Assurance Log – Finance & Performance Committee *Mark Bailey, Non-executive Director*	*Assurance*		5
D9	Chair's Assurance Log – Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5
D10	Quality Committee Terms of Reference *Rebecca Allen, Associate Director Strategy, Partnerships & Governance*	*Approve*		5
D11	Chair's Assurance Log – Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5
E	**INFORMATION**			**13:00**
E1	2024/25 Infection, Prevention & Control Annual Report *Karen Jessop, Chief Nurse*	*Information*		-
E2	2024/25 Safeguarding Annual Report *Karen Jessop, Chief Nurse*	*Information*		-
E3	2024/25 Patient Experience Annual Report *Karen Jessop, Chief Nurse*	*Information*		-
E4	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-

F	CLOSING ITEMS			12:55
F1	Minutes of the meeting held on 1 July 2025 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
F2	Pre-submitted Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
F3	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
F4	**Date and time of next meeting:** **Date:** Tuesday 4 November 2025 **Time:** 10:30 **Venue:** Montagu Hospital	*Information*		
F5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair of the Board*	*Note*		
G	**MEETING CLOSE**			**13:20**

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 pre-submitted questions to be tabled by the Chair at an appointed time. Governors should submit their questions to the Trust Board Office in writing to dbth.trustboardoffice@nhs.net by 3pm on the day prior to the meeting.

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

- Questions at the meeting must relate to papers being presented on the day.
- If questions are not answered at the meeting the Trust Board Office will coordinate a response to all Governors, via the Governor database.
- 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

2509 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Standing item | Suzy Brain England OBE, Chair of the Board | 10:00

Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known

Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (22.8.2025).pdf

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests

Register of Interests

Suzy Brain England OBE, Chair of the Board
Chair at Keep Britain Tidy
Lead Examiner for Chartered Director by the Institute of Directors
Founder and Director of Cloud Talking, Aspirational Mentoring
Co-opted Board member Doncaster Chamber of Commerce
Advisory Committee on Clinical Impact Awards (ACCIA)
Facilitate/Chair NHS Providers training & development session as required
Supports the Board and Officers of NHS Retirement Fellowship as a consultant

Kath Smart, Non-Executive Director
Non-executive Director - InCommunities Limited (Housing Provider)
Chair – Acis Group, Gainsborough (Housing Provider)
Court Secretary – Foresters Friendly Society, Sheffield (Mutual Society)
Senior Trust Associate Manager (TAM – or 'Hospital Manager' under the Mental Health Act) – Rotherham, Doncaster & South Humber NHS FT

Mark Bailey, Non-Executive
Non-Executive Chair, Doncaster and Bassetlaw Healthcare Services Ltd
Non-Executive Director – Derbyshire Community Health Services Foundation Trust
Charity Trustee – Ashgate Hospice
Executive Coach – NHS Leadership Academy (voluntary)
Non-Executive Director for MEDQP Ltd (Voluntary)
Visiting Fellow – Cranfield University
Chair of the Board & Charity Trustee – NHS Retirement Fellowship

Jo Gander, Non-Executive Director
Membership of Advisory Committee on Clinical Impact Awards (ACCIA) Yorkshire and Humber Sub-Committee

Hazel Brand, Non-Executive Director
Councillor, Bassetlaw District Council (independent) - member of the Council's Appointments and Licencsing Committees in this role
Parish Councillor, Misterton

Lucy Nickson, Non-Executive Director
Chief Executive for Day One Trauma Support, national charity

Richard Parker OBE, Chief Executive Officer
Member of the South Yorkshire Integrated Care Board
Spouse is a senior Nurse at Sheffield Health and Social Care Trust

Dr Tim Noble, Executive Medical Director
Spouse is a Consultant Physician at DBTH

(as at 22 August 2025)

Sam Wilde, Chief Financial Officer
Director - Doncaster and Bassetlaw Healthcare Services Ltd
Member of NHS Benchmarking Network and Co-Chair of the Network's Steering Group, which oversees its operation

Zoe Lintin, Chief People Officer
Trustee on the Board of The Diocese of Sheffield Academies Trust

Denise Smith, Chief Operating Officer
Various family members work in NHS. None working in SYB network

Karen Jessop , Chief Nurse
Husband VSM at Hull University Hospital (Chief Nurse Information Officer)

Nick Mallaband, Acting Executive Medical Director
Director - Doncaster and Bassetlaw Healthcare Services Ltd

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance
Scorer - Advisory Committee on Clinical Impact Awards
Committee Member of East Midlands Branch of Chartered Governance Institute
Vice Chair, Stow Parish Council
Vice Chair of the Governing Body & Chair of Finance & Personnel Committee at Saxilby Church of England Primary School

Emma Shaheen, Director Communication & Engagement
Sister is Deputy Director of Involvement, South Yorkshire ICB

The following have no relevant interests to declare:

Emyr Jones	Non-Executive Director
Zara Jones	Deputy Chief Executive

(as at 22 August 2025)

Fit and Proper Person Declarations

The Trust can confirm that every director currently in post has declared that they:

(i) am not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(ii) am not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(iii) am not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(iv) have not made a composition or arrangement with, or granted a trust deed for, my creditors and not been discharged in respect of it;

(v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me;

(vi) am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;

(vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed;

(viii) am able by reason of my health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which I am appointed or to the work for which I am employed;

(ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(x) am not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and

(xi) am not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Directors are requested to note the above and to declare any changes to their position as appropriate in order to keep their declaration up to date.

(as at 22 August 2025)

2509 - A2 ACTIONS FROM PREVIOUS MEETING

Standing item | Suzy Brain England OBE, Chair of the Board | 10:00

5 minutes

REFERENCES

Only PDFs are attached

A2 - BoD Action Log - 1 July 2025.pdf

Action notes prepared by: Angela O'Mara
Updated: 21 August 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	1 July 2025

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P25/03/D2**	**Trust Strategy** To be received for approval by the Board.	**ZJ**	~~**May**~~ **July 2025**	Deferred to July 2025's Board of Directors meeting **Update** – included on the agenda @ D2 **Update 1/7/2025** – approved – **action closed**
2.	**P25/03/F3**	**2025/2026 Success Measures** To be received by the Board.	**ZJ**	~~**May**~~ **July 2025**	Deferred to July 2025's Board of Directors meeting **Update** – included on the agenda @ D2 **Update 1/7/2025** – approved – **action closed**
3.	**P25/05/E2**	**Review of Strategic Risk Two Target Risk Rating** Chief People Officer to consider target risk, Board Assurance Framework to be considered at June's People Committee, ahead of July's Board of Directors meeting.	**ZL**	**July 2025**	**Update 17/06/2025 –** discussion and agreement reached at June's People Committee to retain the target risk rating of 12. The Board Assurance Framework is included on the agenda @ F2 for review and approval by the Board. **Update 1/7/2025** – reviewed and approved by the Board – **action closed**

Action notes prepared by: Angela O'Mara
Updated: 21 August 2025

No.	Minute No.	Action	Responsibility	Target Date	Update
4.	**P25/07/B1**	**<u>Audiology Reporting</u>** Performance against agreed trajectories, including clinical priorities, to be incorporated into future Audiology Service updates.	**ZJ**	**September 2025**	**Update 21/8/2025** – capacity and demand work in progress with the Elective Care Improvement Support Team to support/inform trajectories.
5.	**P25/07/D1**	**<u>Doncaster & Bassetlaw Healthcare Services</u>** To establish a set of metrics against which performance could be reported.	**SW**	**November 2025**	

2509 - A3 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Suzy Brain England OBE, Chair of the Board | 10:05

10 minutes

REFERENCES

Only PDFs are attached

A3 - Chair's Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Chair's Report including Partnership Update**			
Executive Sponsor:	Suzy Brain England OBE, Chair of the Board			
Authors:	Adam Tingle, Deputy Director of Communications & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)				

Executive Summary – Key messages and Issues
The report provides an insight into the Chair's activities since the last Board report in July 2025, including visits, duties and areas of interest as Chair of the Board and Council of Governors.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	This report highlights the commitment to support patients in a setting to best suit their healthcare needs.
People	This report highlights the Trust's commitment to support its people.
Partnerships	This report identifies how the Trust interacts with its partners at a Place, system and national level.
Pounds	We are efficient and spend money wisely.
Health Inequalities	This report does not have any impact on health inequalities.
Legal/ Regulation:	This report does not identify any legal or regulatory impact.
Partner ICB strategies	This report does not impact on the strategies of our partner ICBs.

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Chair's Report

Suzy Brain England
Chair of the Board

August 2025

Since our Board meeting in Bassetlaw on 1 July, I would like to provide colleagues with an overview of recent activities and engagement undertaken on behalf of DBH.

I was pleased to attend a national NHS England meeting launching the ten-year plan for a Neighbourhood Health Service. The ambitions set out at this event - more integrated care - closely mirror the direction of travel described in the various developments within the Chief Executive's Report, particularly in how our sites are evolving to deliver safe, person-centred services.

I was also pleased to see how our own recently published Trust Strategy, Healthier Together – Delivering Exceptional Care for All, echoes these sentiments and aligns with this overall direction of travel not just locally, but nationally.

At Bassetlaw Hospital, I joined colleagues to thank the Rapid Relief charity team who provided free lunches in recognition of the NHS's birthday. This complemented the wider celebration on site where 500 meals were shared with colleagues, an uplifting community moment also highlighted in the Chief Executive's Report.

During the period, I also welcomed Daniel Elkeles, Chief Executive of NHS Providers, to Bassetlaw Hospital. This provided an opportunity to show him some of the exciting developments now under way, as well as to discuss both the challenges we face and the successes we are achieving across the organisation.

Along with colleagues from the Board of Directors, we completed recruitment for new Non-Executive Directors in July.

Following a strong field of applicants, Jo Gander has been reappointed for a further three years, and she will be joined by Stephen Radford, a financially qualified turnaround professional who currently serves on the Board of Barnsley Hospital.

I know I speak for our Chief Executive, as well as the rest of the Board, when I say that we look forward to continuing our working relationship with Jo and to working closely with Stephen in the coming months.

Beyond this, I chaired the Acute Federation in South Yorkshire, where we considered our future role ahead of forthcoming changes to the performance management and regulatory framework, including a reduction in the size of the Integrated Care Board (ICB).

I continue to meet regularly with the Chairs of our two ICBs, with provider Chairs across Nottinghamshire and South Yorkshire, and with our own Chief Executive and the NHS England Regional Director.

It has also been encouraging to see the progress being made on our sites with various capital projects. As reflected in the Chief Executive's report, the new Discharge Lounge and Surgical SDEC move at DRI, the groundbreaking for the new Critical Care Department, and the opening of the Minors Unit at Bassetlaw are all important steps forward.

At Montagu, the Phoenix Therapy Suite represents an equally exciting development, made possible through both capital investment and the enduring generosity of our Charity and supporters such as Fred and Ann Green.

Together, these projects represent tangible improvements in the way we deliver care and serve our communities.

I would also like to recognise the outstanding achievement of our colleagues in securing the Green Flag Award across all three of our hospital sites. This national recognition for quality green spaces is a credit to all involved and, as the Chief Executive noted this month, reflects our commitment to wellbeing, biodiversity and creating environments that support recovery.

It is also encouraging to see how colleagues are contributing ideas through our Bright Ideas Clinic, with more than 190 suggestions submitted so far. As the Chief Executive sets out in his own report, these range from small practical changes to larger projects with significant impact. On behalf of the Board, I want to thank everyone who has taken the time to share their ideas — they show the creativity and commitment of colleagues across DBH.

Looking ahead, I will be speaking at the forthcoming Team Doncaster Summit in October, which this year is focused on "Health and the Economy", with particular attention to workforce and innovation. This will be an important opportunity to reflect on DBH's role as a major employer, our work in creating opportunities for young people, and the way we contribute to Doncaster's wider economic resilience.

We also look forward to welcoming members to our next Annual Members Meeting - our first in-person event since 2019 - on 30 September at 5pm. Details are available on our website for those wishing to attend.

Away from DBTH, I continue to be active as Chair of the charity Keep Britain Tidy, as the national Lead Examiner for the Chartered Director Accreditation, as a Co-opted Director on the Doncaster Chamber of Commerce, and as an assessor for the national Clinical Impact Awards.

Finally, I want to give special thanks to Hazel Brand, who has now come to the end of her term as a Non-Executive Director. Mirroring the thanks of our Chief Executive, Hazel has made an enormous contribution to the Trust over many years: First as a long-standing Head of Communications and Engagement, then as a Lead Governor, and most recently as a valued member of the Board. Her insight, commitment and counsel have been greatly appreciated, and she leaves with our warmest thanks and best wishes.

2509 - A4 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Richard Parker OBE, Chief Executive | 10:15

10 minutes

REFERENCES

Only PDFs are attached

A4 - Chief Executive's Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Chief Executive's Report including Partnership Update**			
Executive Sponsor:	Richard Parker OBE, Chief Executive			
Authors:	Adam Tingle, Deputy Director of Communication & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1 - 7			

Executive Summary – Key messages and Issues
The report provides an overview of areas of interest and focus at a local, system and national level connected to the work of the Trust and aligned to its four strategic priorities.

Recommendations
The Board of Directors is asked to note the content of the report.

Healthier together – delivering exceptional care for all	
Patients	This report highlights the actions taken by the Trust to ensure patient experience is assessed and refreshed to ensure the delivery of safe, exceptional person-centred care.
People	A positive, engaged and supported workforce contributes to the delivery of good patient care.
Partnerships	The Trust works with partners and local community groups to support improvements in service delivery.
Pounds	To ensure efficient use of resources, spending public money wisely, whilst safe care remains a priority.
Health Inequalities	The Trust considers its activities, including clinical research, through the health inequalities lens and engages with patient and community groups to ensure mitigating actions limit variation in access.
Legal/ Regulation:	This report does not identify any legal or regulatory impact.
Partner ICB strategies	The Trust continues to work closely with partner Integrated Care Board in respect of financial management and service provision.

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **YES/NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Chief Executive's Report

Richard Parker OBE
Chief Executive

August 2025

Our Strategy, **Healthier Together – Delivering Exceptional Care for All**, sets out four Strategic Priorities which guide the way we work and the decisions we make.

This report is structured around four Strategic Priorities outlined within the document, providing an update on key developments and activities in recent weeks:

- **Patients**: We deliver safe, exceptional, person-centred care
- **People**: We are supportive, positive, and welcoming
- **Partnerships**: We work together to enhance our services with clear goals for our communities
- **Pounds**: We are efficient and spend public money wisely

Patients

We deliver safe, exceptional, person-centred care.

Temporary Minors Unit opens at Bassetlaw Hospital

The temporary Minors Unit at Bassetlaw Hospital opened on **20 August 2025**, marking the first phase of the new Same Day Emergency Care (SDEC) and Minors development on site. The interim facility includes a waiting area, treatment and assessment rooms, ECG and blood-work bays, and new staff workstations, all designed to improve patient flow ahead of the full redevelopment scheduled for autumn.

Groundbreaking ceremony for new Critical Care Department at DRI

On the same day, the Trust celebrated the groundbreaking for a **£19.8 million** Department of Critical Care at Doncaster Royal Infirmary (DRI). When complete in autumn 2026, the new 22-bed unit will feature advanced monitoring technology, specialist staffing, and a palliative garden to provide high-quality care in a modern, purpose-built environment. As the Chair has highlighted in her own report, this is a fantastic development - real, tangible progress in our long-term refurbishment plans, and a testament to the hard work of colleagues in making it happen.

Surgical SDEC Unit relocates to refurbished home at DRI

Earlier in the month, the Surgical Same Day Emergency Care (SDEC) unit relocated to a newly refurbished ground-floor space at DRI. Closer to the main entrance and outpatients, the unit now offers a more accessible, welcoming setting for patients while also making way for the forthcoming Critical Care Department.

New Discharge Lounge now open at DRI

The new Discharge Lounge at DRI opened on **28 July 2025**, located in the West Ward Block (formerly the hydrotherapy pool). It features comfortable seating, a TV, a five-bedded trolley bay, accessible facilities, a refreshments area, and calming murals designed to support patients, particularly those with cognitive needs.

Phoenix Therapy Suite opens at Montagu Hospital

In June, the Trust opened the **Phoenix Therapy Suite** at Montagu Hospital - a pioneering NHS space for stroke rehabilitation. Equipped with seven robotic therapy systems, including gait trainers, upper-limb and balance devices with interactive gaming, the facility supports intensive recovery. It is expected to be fully operational in autumn 2025.

Compassionate care recognised with Chief Nursing Officer Award

Lauren Lawton, Child Death Review Key Worker, received the **Chief Nursing Officer Award** in June for her exceptional compassion in supporting families bereaved by child loss. Since initiating the role, she has gone above and beyond to provide tailored support and drive service improvement, reflecting the Trust's commitment to dignified and empathetic care.

Endoscopy service at DRI awarded JAG accreditation

Doncaster Royal Infirmary's endoscopy service has been awarded full JAG accreditation for five years, following reassessment in June 2025. This national recognition confirms that the service meets the highest standards of safety, quality, workforce, leadership, and patient experience. The accreditation reflects the dedication and hard work of colleagues who have made significant improvements in areas such as governance, clinical practice, dignity, and patient information, ensuring the service continues to provide exceptional care.

Flu vaccination campaign begins in September

Our annual flu vaccination campaign will launch in September, offering free flu jabs to all colleagues across DBTH. Vaccination remains the best way to protect ourselves, our patients, and our loved ones from flu during the winter months. Colleagues will be able to access the vaccine through drop-in clinics and roving peer vaccinators, with full details to be shared in the coming weeks. We

strongly encourage everyone to take up the offer this year, helping us to stay healthy, reduce sickness absence, and continue delivering safe, high-quality care for our patients.

People

We are supportive, positive, and welcoming.

Midwives recognised for professional support and mentorship

On 19 August 2025, two of our midwifery colleagues, Lizzie Ivill and Lee Gigg, were nominated for the Sheffield Hallam Outstanding Midwifery Awards (SHOMA). These nominations, initiated by students, celebrated their professionalism, kindness, and the confidence they inspire during placements at DBTH, reflecting the supportive culture within our maternity services.

DBTH awarded the National Preceptorship Quality Mark

We are delighted that on 15 August 2025, DBTH was awarded the prestigious National Preceptorship Quality Mark by NHS England - recognising our multi-professional preceptorship programme as exemplary. As one of just 12 trusts nationally to receive this honour, our programme meets rigorous standards of governance, leadership, supervision, and educational support, enhancing early career experience and ultimately underpinning safe, high-quality care for patients.

DBTH Way into Action

On 29 July 2025, we launched the “DBTH Way into Action” initiative in partnership with independent consultants from thevaluecircle. Hundreds of colleagues have already taken part in this anonymous workplace experience survey, providing invaluable feedback. We’ll be reviewing the findings over the coming weeks to shape a practical action plan that strengthens our culture and working environment. Alongside this work, the national NHS Staff Survey will soon be underway, giving colleagues another important opportunity to share their views and help shape improvements at DBTH. I know I speak for the Chair and the Board when I encourage everyone to take part in these surveys - your feedback is essential in helping us understand where we can improve and in making DBTH an even more supportive, positive and welcoming place to work.

Appraisal season success with over 93 % achieved

We are delighted to report that over 93% of all colleagues received their performance appraisal during this year’s summer Appraisal Season (spanning three months). This milestone underlines the importance we place on continuous performance dialogue, professional development, and supporting our people to grow in their roles.

Appointments

As the Chair reflects in her report, this period has also seen important changes to the Board. We are pleased to confirm the reappointment of Joanne Gander and to welcome Stephen Radford as a new Non-Executive Director, while offering our thanks to Hazel Brand as she reaches the end of her term. In addition, we welcome Sabrina Jones and Jim Eustace, who have joined the Trust as Divisional General Managers for our Women's and Children's, and Surgery Divisions respectively. These appointments, alongside the continued dedication of colleagues across the organisation, ensure we remain a supportive, positive and welcoming place to work.

Partnerships

We work together to enhance our services with clear goals for our communities.

Federated Data Platform pilot to launch soon

On 19 August 2025, we introduced NHS England's Federated Data Platform (FDP) at DBTH. This innovative digital solution aggregates operational data into a secure, near real-time platform to support smarter elective care planning, theatre scheduling, and waiting list management. Initial pilot deployments include inpatient and Referral to Treatment (RTT) modules, with rollout to teams in theatres, ENT, trauma and orthopaedics, and other validation teams - backed by targeted training.

Brand-new Pleural Clinic launches thanks to charity support

A new pleural clinic formally launched at Doncaster Royal Infirmary in July 2025, enabled by a generous donation of an ultrasound machine from Doncaster Cancer Detection Trust. Operated by our Respiratory team, this "one-stop shop" outpatient service streamlines diagnosis and treatment of pleural effusions, reducing emergency admissions and offering quicker, more comfortable care for cancer patients.

Record-breaking attendance at school healthcare careers events

On 22 July 2025, nearly 2,000 Year 8 students attended our "We Care into the Future" events at The Dome in Doncaster and Worksop College - the highest turnout to date. Featuring DBTH staff alongside partners from universities, colleges, councils, and local organisations, the events offered hands-on activities like CPR practice and physiotherapy equipment demos. Feedback was overwhelmingly positive, inspiring many to consider NHS careers beyond just doctors and nurses.

Green Flag Award across all hospital sites

We're proud that Montagu Hospital has joined Doncaster Royal Infirmary and Bassetlaw Hospital in achieving the prestigious Green Flag Award - the international benchmark for quality green spaces. Recognition is now across all three sites, thanks to work on areas like the Rainbow Gardens,

Butterfly Garden, and Fred and Ann Green Memorial Garden, which foster wellbeing, remembrance, and biodiversity. As the Chair also highlights in her report, this is a credit to all involved and a strong signal of the pride we take in our sites and environments.

500 free meals for Bassetlaw colleagues on NHS birthday

On 11 July 2025, in celebration of the NHS's 77th birthday, Bassetlaw Hospital staff—including radiologists, paramedics, and midwives - received 500 free BBQ meals from the Rapid Relief Team. The event, hosted in the sunshine by the Rainbow Garden, was an uplifting community moment recognising staff commitment across departments. The Chair joined this celebration in person, personally thanking the team - a reminder of how much these partnerships mean to colleagues on the ground.

Immersive hospital escape room brings NHS careers to life

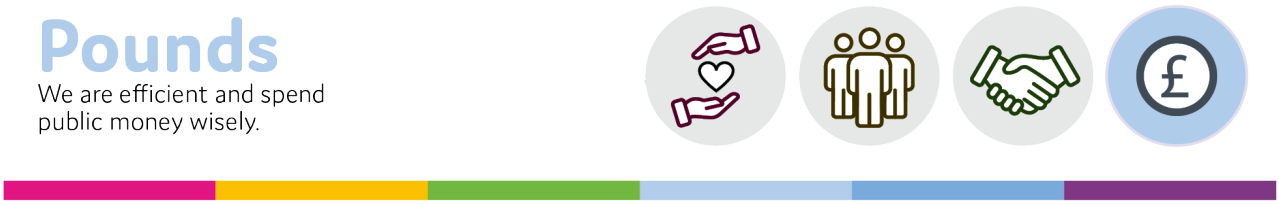
As part of the 2025 Doncaster Remake Learning Festival, we hosted "Operation: Patient Discharge" at DRI—an escape room-style experience designed to introduce young people to NHS roles through interactive, team-based challenges across pharmacy, radiology, healthcare assistant, and porter stations. This innovative format encouraged career curiosity in a fun, hands-on way.

Doncaster Deaf School students help improve paediatric care

On 7 July 2025, four pupils from Doncaster Deaf School visited DRI's Children's Observation Unit and Ward, evaluating inclusivity, safety, and communication from a deaf child's perspective. Their feedback will directly influence service improvements, with plans to invite older students next to review young adult services. This initiative supports our commitment to tackling health inequalities and ensuring every child feels seen and heard.

Doncaster Anti-racism Partnership shortlisted for national award

As highlighted in my previous report, Doncaster Anti-racism Partnership, which brings together DBTH, RDaSH, City of Doncaster Council, the South Yorkshire ICB and wider partners, has been shortlisted for the Excellence in Community Partnership Award at the National BAME Health and Care Awards 2025. The collaboration is focused on tackling racism in the workplace through fair recruitment, shared training opportunities and unified messaging, with colleagues, staff networks and leaders all actively involved.



Financial position update

We continue to make good progress with our financial position, but there is still more work to do. Our target is to deliver a £31.4 million Cost Improvement Plan (CIP) this year. To date, around £9

million has already been achieved, thanks to the commitment and effort of teams across the organisation. This is an encouraging start, but continued focus and collective effort will be essential in the months ahead.

Reducing Did Not Attend (DNA) rates in young adult diabetic patients

A new WhatsApp reminder system, trialled by our Diabetes team, has significantly reduced DNA rates among young adult patients. With around 200 young adult diabetic patients in the system—many juggling complex lives and challenges—attendance has historically been low, with DNA rates reaching as high as 40%.

Introduced in July 2025 by Hannah Burns, Diabetes Medical Secretary, the initiative uses WhatsApp to send secure reminders one to two days before appointments. Patients, or their parents, can also cancel or rearrange easily, freeing up slots for others. Early results are extremely positive: one recent clinic recorded zero DNAs. This simple but effective change is already improving clinic efficiency and supporting better patient engagement.

Bright Ideas Clinic success

Our Bright Ideas Clinic has quickly become an important part of how we improve and innovate. The initiative invites colleagues to share practical suggestions that could enhance services, save money, or make everyday tasks easier. To date, more than 190 ideas have been submitted, with around 40 identified to progress following initial review. These range from straightforward changes that make daily work more efficient to larger-scale projects with the potential for significant impact. We encourage colleagues to keep coming forward with their ideas, as their insight is helping us build a more sustainable future.

As the Chair and I - and indeed the Board - have often said, we are always pleased to hear about practical innovation from colleagues. Small ideas can make a big difference, improving services and ensuring we spend public money wisely.

2509 - B PATIENTS

10:25

2509 - B1 AUDIOLOGY SERVICE UPDATE

Discussion Item | Nick Mallaband, Acting Executive Medical Director | 10:25

10 minutes

REFERENCES

Only PDFs are attached

B1 - Audiology Service Update.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Audiology Service Update**			
Executive Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director			
Authors:	Claire Jones Audiology Recovery Programme Lead			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	~~Information~~	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	BAF 1, 2, 3, 4 & 6			

Executive Summary – Key messages and Issues

The Board of Directors last received a report in July 2025 providing an update on the position regarding our audiology service following the limiting of service activity from September 2024.

The reasons for this included specific challenges relating to the paediatric service, linked to an NHS England established programme, alongside more local issues across the entire service associated with IT, physical estate, equipment and compliance with expected standards following some clinical observations.

The recovery and improvement process is well underway with both the digital and estates work now being fully completed. The remaining improvement actions are still on going, with positive progress being made in all areas to ensure that we can safely provide an effective audiology service in the future.

This paper provides a brief update on the position regarding the remaining work streams that underpin the Audiology Recovery Programme in place across the audiology service within the Trust.

The outstanding improvement actions are key to being able to run a safe and effective service in the future. To seek assurance on the improvements and mitigations that have been made since the external review in January 2024, an assurance visit will take place towards the end of September with colleagues from NHSE and the ICB.

The paediatric harm review process continues with no further cases of harm identified since the last Board of Directors update in July 2025. Progress in this area is closely monitored by NHSE and the ICB at a bi-weekly meeting.

The Trust remains committed to addressing the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically and are sorry for the impact this has caused individuals.

Updates will continue to be provided to the Board of Directors as our recovery work continues.

Recommendations

The Trust Board is asked to review and discuss the content of the report.

Healthier together – delivering exceptional care for all

Patients	This report highlights the actions taken by the Trust to recover and improve its audiology provision to be in a position to reinstate a safe service.

<table>
<tr><td>People</td><td>This report highlights the Trust's commitment to support its people through training and development and investment in equipment and infrastructure.</td></tr>
<tr><td>Partnerships</td><td>This report identifies how the Trust is working in partnership to support the recovery and delivery of the audiology service through the provision of mutual aid, use of insourcing, outsourcing and with the support of subject matter experts.</td></tr>
<tr><td>Pounds</td><td>To ensure the Trust works efficiently and spends public money wisely.</td></tr>
<tr><td>Health Inequalities</td><td>To mitigate the impact due to service limitations.</td></tr>
<tr><td>Legal/ Regulation:</td><td>This report does not identify any legal or regulatory impact.</td></tr>
<tr><td>Partner ICB strategies</td><td>There remains a system and national focus on audiology services and partner ICBs are aware of the work of the Trust.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Executive Team, Trust Leadership Team, Quality Committee & Finance and Performance Committee. Various dates in 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>• Deliver the improvement plan
• Ongoing communications with patients and stakeholders
• Prioritising urgent patients for mutual aid
• Stand service back up when safe to do so</td></tr>
<tr><td>Is this in line with Current risk appetite

YES/NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
</table>

Context

As previously reported to the Board of Directors in July 2025, the audiology service across DBTH has offered a limited provision to our patients since September 2024, as we undertake a process of improvement. Since the last update it is positive to report that a number of elements of the audiology service recovery plan are now delivering and we can report an improvement in the number of patients that we are seeing across many parts of the audiology pathway. Whilst we are not currently able to offer the complete end to end paediatric audiology pathway, it is felt that the service we are now offering shows a marked improvement for our community and stakeholders.

This board paper serves to update on the activities and decisions taken across the audiology service since the last update to the Board of Directors in July 2025.

The Audiology Recovery Programme

To enable the audiology service to recommence, there have been a number of areas of the service that required specific focus [Estates, Digital, workforce etc.]. Each area has been allocated to a work stream and each week separate workstream meetings are held, where all of the related issues are identified, discussed and resolved. The work streams form the core of the audiology recovery programme, which is striving to deliver a safe and effective audiology service for patients and families to access. The Board of Directors is asked to note that the digital and estates and infrastructure work streams have now been completed, as every element of the planned work has now been successfully delivered.

It is important to note that whilst the service is working through the improvement and redesign work, patients are still being seen and the number of patients being seen is increasing week on week as the elements of the improvement work come to fruition.

Our own audiologists who have successfully completed their competency assessments are continuing to see patients across both the adults and paediatric waiting lists. In July 2025, 1253 patients were seen across both the adults and paediatric service, this compares to 1112 seen in June 2025. The adult insourcing was not operational in July, this has now recommenced and an additional 341 patients were seen for diagnostic assessments over the weekends in August.

The audiology recovery programme now consists of four key work streams, see below. Each workstream has both an operational lead and an executive lead and progress in each of the workstreams are reported into the bi-weekly audiology recovery group meeting, chaired by the audiology programme recovery lead. Executive oversight is maintained via regular meetings between the programme recovery lead and deputy chief executive and acting executive medical director. Progress is reported to external stakeholders into the bi-weekly Paediatric Audiology Integrated Care Board [ICB] meeting, and the Adults audiology ICB meeting chaired by the ICB Deputy Director of Nursing.

Engagement with our patient stakeholder groups continues. On 7th July 2025 a meeting was convened at the Civic Centre in Doncaster between the Doncaster audiology action group, Doncaster ICB, Doncaster Public Health, Health Watch and representatives from DBTH. The focus of the meeting was twofold; firstly the improvement work that is being undertaken across the audiology service at DBTH, the updates on progress were very well received. Secondly, the audiology action group wanted to explore opportunities for development of the *Health on the High street* agenda with specific reference to audiology with the ICB. A further meeting is planned for November 2025.

On the 15th September 2025 we have a further audiology stakeholder meeting that will be hosted at DRI and the Doncaster Deaf Society, the Doncaster Audiology Action Group and the Doncaster Deaf Trust will be invited for them to gain further assurance in relation to the improvement work that is taking place at DBTH.

Harm reviews update – paediatric audiology

There has been minimal activity in relation to the paediatric harm review position since the last report to the Board of Directors in July 2025.

There remains thirty four children who are yet to be reviewed due to pathways of care yet to be completed. Every child in this cohort now has a management plan and the last child is scheduled to be seen in January 2026.

To date sixty two cases have been reviewed by NHS England Subject Matter Experts (SMEs) and levels of harm allocated out of a total of one hundred and twenty five previously reported.

Of the sixty two children reviewed for harm the outcomes to date are:

Forty one - no harm

Ten – low harm

Ten – moderate harm

One – severe harm

Duty of Candour part two (second contact with families following harm review outcomes) has been commenced in all cases and followed up formally in writing.

The themes of harm identified are delays to treatment, inappropriate or incorrect treatment or testing not completed to the national expected standards as determined by the British Association of Audiologists. All the themes have an improvement plan that is covered in the overarching audiology action plan.

Severe harm has sadly been identified in one child as a result of a lack of appropriate hearing testing. The child is profoundly deaf in one ear and has mild loss in the other ear. Due to the delay in diagnosis, the child has poor access to sounds and speech and now has a speech delay. As a result of this the child was fitted with bilateral hearing aids. The child is under the care of the Speech and Language Therapy Department at DBTH and is receiving support and Duty of Candour has been undertaken with the family.

The learning from this case has been incorporated in to the Patient Safety Incident Response Framework (PSIRF) principles that focus on investigating less and learning more. We are able to provide assurance that the legal and regulatory elements of this have been incorporated in to the Duty of Candour process, and the contributory factors relating to this case are being addressed in the safety improvement plan that is monitored via the Audiology Governance function. This approach has been endorsed by the South Yorkshire and Bassetlaw ICB at the most recent Paediatric Audiology Incident Management Group meeting on the 14th August 2025.

A separate learning forum has been established with the paediatric audiologists and the Head of Service, specifically to review all of the cases of harm identified through this recall process, with a view to understanding the various factors contributing to each incident of harm and fostering a culture of learning and improvement within the team.

We are sincerely sorry for the harm that has been confirmed for the children reported here and the impact that this will have on both the children and their families. Lessons learned will be shared and applied across the service for the future.

Mutual aid update

The provision of mutual aid [support from other hospitals to see our patients] continues to be supported by the South Yorkshire and Bassetlaw Acute Federation, and we have agreed pathways for the most urgent activity to be seen at other Trusts.

The Rotherham Foundation Trust are continuing to undertake specialist activity in the assessment of patients who require Bone Anchored Hearing Aids at a rate of two patients per month and have accepted urgent adult referrals for patients requiring immediate care.

Nottingham University Hospital Trust have agreed to take seventy five P4 Children [these are children who have been assessed as having the lowest level of clinical need but represent the biggest cohort of children on the paediatric waiting list - 870]. The children will be seen in cohorts of 25 over the months of September, October and November.

In order to gain a greater level of mutual aid around the P4 cohort of children, DBTH have reached out to the South Yorkshire and Bassetlaw Acute Federation for their assistance in helping to broker further help from acute providers across the system. This piece of work is currently on going and progress will be reported in future updates to the board of directors.

We are utilising specialist paediatric insourcing at weekends and occasional weekdays, from subject matter experts identified and approved by NHSE to assess and treat the children from the waiting list who are of the highest clinical priority [P1 and P2 patients]. This arrangement started at the beginning of July and to date

sixty nine patients have been seen. This is an open ended agreement that is funded via NHSE as part of the national review of paediatric audiology services.

We have recommenced insourcing from *Your Medical Services* [YMS] for our adult patients at weekends, from the beginning of August 2025 for a three month period. They are seeing adults who are on the waiting list for diagnostic assessments in the first month, in the second month; adults requiring fittings and in the third month they will be seeing a combination of both. To date they have seen 341 patients for diagnostic assessments in the month of August.

Clinical Workforce update

The paediatric audiologists will be receiving further training and competency assessments on site in DRI starting from the end of September. This arrangement is felt to be preferable by the team as it minimises their travel to other centres and allows them to utilise their own equipment in their own clinical environment. They will receive training and assessment of their competencies from a senior audiologist SME from Sheffield Children's Hospital who has been fully endorsed by NHSE to undertake this piece of work.

To train and assess the adult audiologists, we have reached an agreement with Nottingham University Hospital Trust who are providing a senior adult audiologist SME, to work alongside our adult audiologists on site in Sandringham Road. This arrangement commences on the 1st September 2025 and eleven days have been allocated in the initial instance across the team for this piece of work to be delivered.

Satisfactory completion of the above requirements will provide confidence that all audiologists are delivering practice that meets the National British Association of Audiology standards.

A number of training opportunities have been made available to the audiology team in the last month and it is pleasing to note that these have been very well received. A number of the audiologists are going to be undertaking masters level modules across a number of areas that are pertinent to their practice, these opportunities are funded by NHSE.

Data update

The audiology service has been working closely with the Elective Care Improvement Support Team [IST] to undertake demand and capacity modelling for paediatric audiology to understand the capacity required to meet diagnostic waiting time standard (DM01) and to develop an improvement trajectory to show when this will be achieved.

Work on the demand and capacity modelling for adult audiology is in progress and due for completion by the end of August 2025. The Elective IST has also supported the Trust to develop a Patient Tracking List (PTL) for paediatric and adult audiology; PTL meetings are due to commence in early September 2025 and will be supported by the Elective IST to ensure these are established in line with best practice.

NHSE and ICB assurance visit to Audiology Services at DBTH

Following the review of the paediatric audiology service in January 2024 and the associated feedback, the ICB and NHSE are undertaking a focussed visit to the paediatric audiology service. This was scheduled to take place at a point over the summer, however due to sickness and annual leave the visit has now been scheduled for the end of September 2025.The purpose of the visit is to focus on the immediate mitigations identified during the enhanced improvement phase to ensure a safe and quality led service.

The scope of the visit will include a review of the recovery improvement areas covered above in this report.

The audiology service team are continuing to work hard to ensure that full-service provision is restored for the populations of Doncaster and Bassetlaw as soon as possible. We remain deeply sorry for the impact on patients and families of the disruption to our service and apologise for the long waiting times that so many of our patients continue to endure.

2509 - B2 LEARNING FROM DEATHS REPORT

Discussion Item | Nick Mallaband, Acting Executive Medical Director | 10:35

10 minutes

REFERENCES

Only PDFs are attached

- B2 - Learning from Deaths Report.pdf
- B2 - Appendix 1 - Q4 2024-25 LfD.pdf
- B2 - Appendix 2 2024-25 LfD Annual Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Learning from Deaths Report**			
Executive Sponsor:	Nick Mallaband, Acting Executive Medical Director			
Authors:	Mandy Dalton, Interim Mortality Manager			
Appendices:	Appendix 1 – Q4 2024/25 Learning from Deaths Report Appendix 2 - 2024/25 Learning from Deaths Annual Report			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1			

Executive Summary – Key messages and Issues

Two reports are presented here:

1. The Quarter 4 Learning from Deaths Report: This report is in line with the National Quality Board's guidance on Learning from deaths.

   Of particular note is that 9% of deaths are reviewed using Structured Judgement methodology and particular learning themes as well as areas of good practice are identified. The Trust aspires to review circa 15% of all deaths. Additional medical staff reviewers will be required to achieve this but the current figure is a good improvement on the position from 12 months ago.

2. The Annual Learning from Deaths Report (LFD) draws together the learning which has been identified within each of the quarterly LFD reports. It concludes that:

   - The Trust is compliant with the National Learning from Deaths process.
   - The medical examiner role is well established with good working processes and governance, linking in with all other patient safety and patient experience processes.
   - The Trust is compliant with the 'Learning from Lives and Deaths – people with a learning disability and autistic people' (LeDeR) process, ensuring all deaths were the patient had a learning disability, significant mental health issue and/or autism are reported to LeDeR and reviewed via the Structured Judgement Review (SJR) process.

Consideration is now being given to how the learning identified can be linked into Divisional priorities.

Work is also ongoing to develop a bespoke report drawn from the data within the SJR Plus application and will be presented at Mortality Governance.

Recommendations

The Board is asked to :

- note the two reports and take assurance of the ongoing mortality improvement work

<table>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>We deliver safe, exceptional, person-centred care by reducing risk to patient safety through improved systems and processes, as well as learning from deaths, in line with national recommendations and regulations</td></tr>
<tr><td>People</td><td></td></tr>
<tr><td>Partnerships</td><td>Delivering seamless care that meets the diverse needs of our population, in the right place</td></tr>
<tr><td>Pounds</td><td></td></tr>
<tr><td>Health Inequalities</td><td></td></tr>
<tr><td>Legal/ Regulation:</td><td>The Trust’s mortality processes comply with legislation in:
– Health and Social Care Act 2008
– Health and Care Act 2022</td></tr>
<tr><td>Partner ICB strategies</td><td>Aligns with partner ICB strategies:
– South Yorkshire ICS
NHS Nottingham & Nottinghamshire ICS</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Effective Committee, 2 July 2025.
Quality Committww, 7 August 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

YES/NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

LEARNING FROM DEATHS QUARTERLY REPORT 2024/25 - Quarter 4

1. Introduction

This is the quarterly learning from deaths report to be received by the Mortality Governance Group and the Effectiveness Committee. It reports on the deaths of patients under the care of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as required by the National Guidance on Learning from Deaths. (National Quality Board, March 2017).

It covers Q4 (1st January – 31st March 2025) and includes the most recent data on crude mortality, SHMI metrics and presents key metrics on the mortality case review process, namely Structured Judgement Reviews (SJRs) and provides insight into the learning from SJRs.

2. Key Points.

- There have been 498 in patient deaths at the Trust during the quarter and 64 in the Emergency Department. A total of 562.
- One death following an elective admission and six deaths of patients with a learning disability.
- 171 deaths were reported to HMCoroner
- 49 inquests were opened during the quarter and 33 were concluded
- 14 Structured Judgement Reviews (SJRs) were requested by the Medical Examiner Office and a further 37 SJRs were requested for patients who died in the Emergency Department. Total = 51
- 15 cases were referred by the ME team as potential patient safety incident investigations (PSII)'s.
- Of the deaths subject to SJR, no death was judged more likely than not to be due to problems in care.
- There have been two deaths investigated by HMC which have resulted in the Trust receiving two regulation 28 reports.
- The Summary Hospital Level Mortality Indicator (SHMI) rolling 12 month figure is 106.60. With the most current figure (accurate as of 13th May 2025) is 104.00

Learning points from the completed SJRs are:

- Swift management of low BP is crucial.
- The use of the tracker in ED is essential to ensure patients are assessed as soon as possible, referrals are timely and medication prescribed and administered on time.
- Ensure ward staff are aware of who is responsible for complex wound management.

3. Deaths by month- Crude Mortality January 2025 – March 2025

3.1 There were a total of 562 deaths in Doncaster & Bassetlaw Teaching Hospital Foundation Trust (DBHFT) in the 3 months between January and March 2025. This is a decrease of 27 deaths on the last quarter.

3.2 Figure 1 shows inpatient deaths per month split by hospital site, figure 2 shows deaths in the Emergency Department split by site and figure 3 shows the inpatient deaths split by treatment function code.

Figure 1

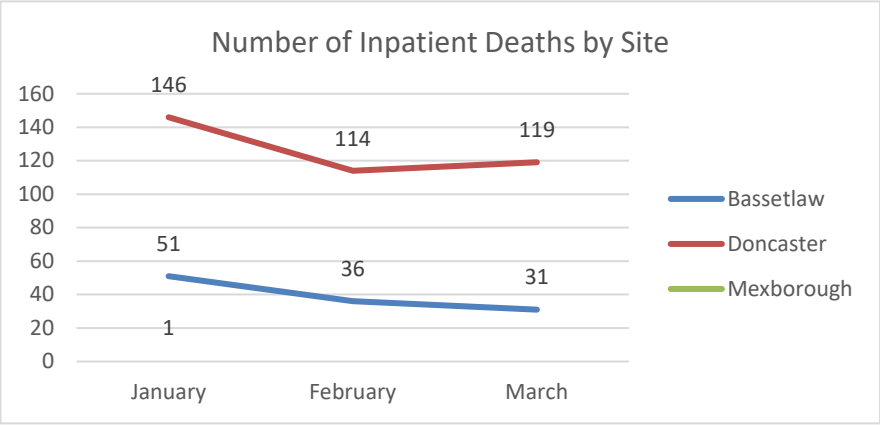


Figure 2

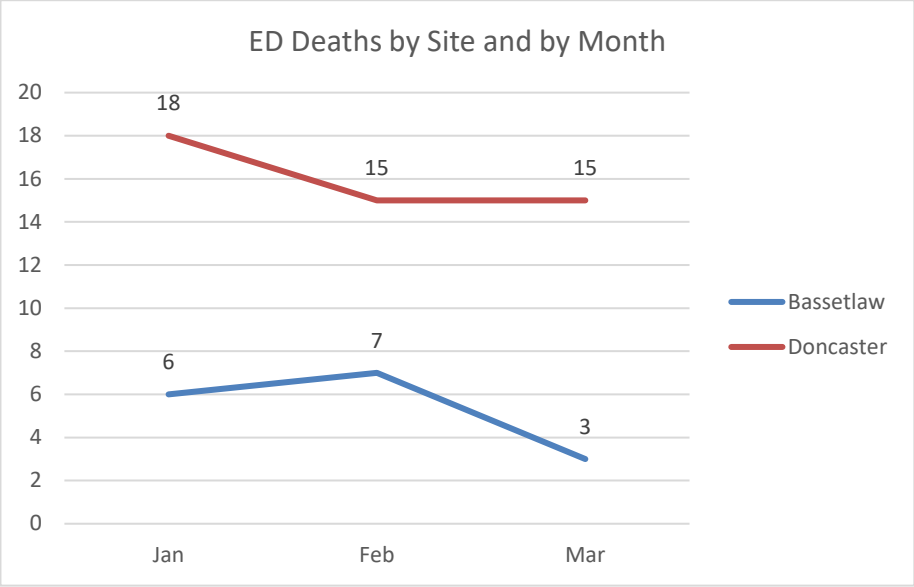
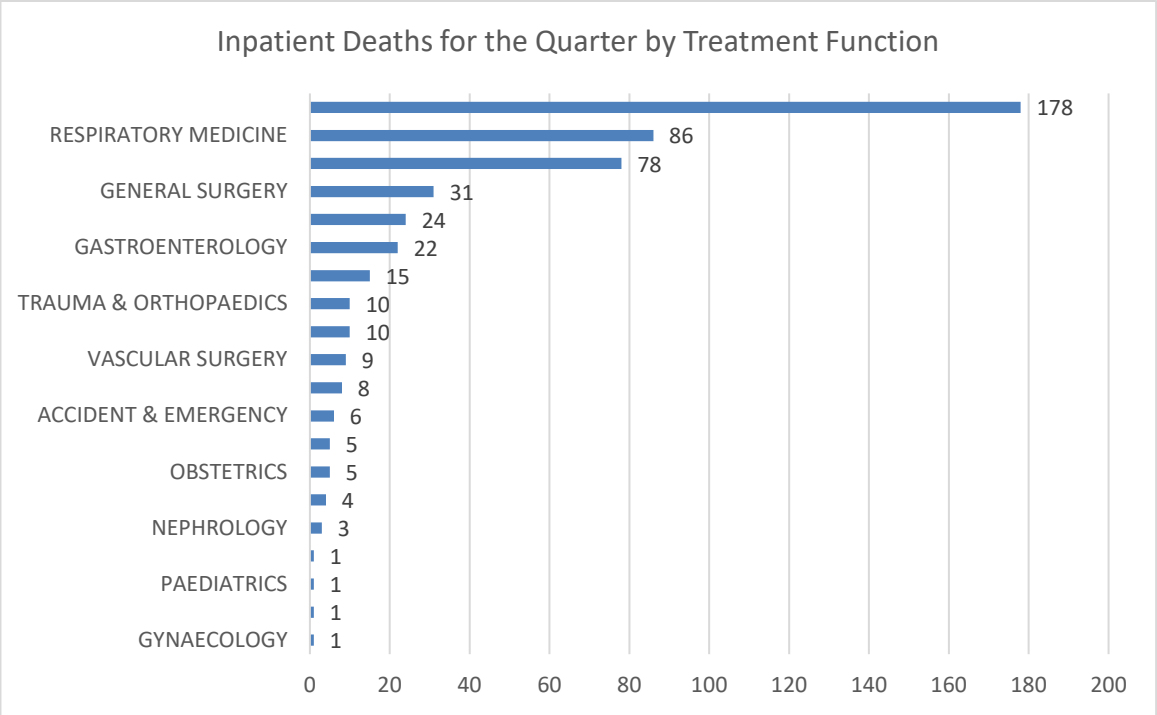


Figure 3



3.3. Deaths of patients with a Learning Disability (LD).

There were six patients recorded as having either a Learning Disability or significant mental health issue and/or Autism this quarter. All of these cases are reported to the LeDeR programme and also have had an SJR undertaken with input from a learning disability nurse. All patients were concluded to have received good, appropriate, multi disciplinary care.

4. Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

Many discussions have been held over several months on these two different metrics being used to compare mortality outcomes across Trusts. Neither of these metrics are a measure of actual quality of care or avoidability of deaths. Both metrics cause concern when figures in one Trust are much higher (or lower) than in another.

The chart below indicates the key differences between SHMI and HSMR.

Attribute	SHMI	HSMR	Rationale for Change
Deaths Included	All Deaths	83% Deaths	Gives a more complete picture of mortality associated with hospitalisation
Deaths 30 days post discharge	Included	Not Included	Gives a more complete picture of mortality associated with hospitalisation & reduces the effects of differences in discharge processes and palliative care provision (hospice) in the community
Palliative Care Coding	no adjustment	adjusts	Variation in coding practice & over-adjustment concerns
Diagnosis Group, Accumulate Risk Monitoring & Banding	10 Diagnosis Groups	56 Diagnosis Groups	Groups with high numbers of deaths and statistical models that are considered to have sufficiently explained the expected variation in outcomes due to the case-mix adjustment.

Following much debate at both regional and national forums it has been decided that the Trust will now report on SHMI only.

The latest SHMI figure and accurate as of 13th May 2025 is 104.00 with a rolling 12 month average (Feb 24-Jan 25) of 106.60. This is significantly lower than the last quarter's figure of 113.37.

Work is ongoing with regards identifying those cases that fall in to an "outlier" category and as such, negatively affect the Trust's overall SHMI figure. These cases will be reviewed as part of the ongoing SJR work.

5. Mortality Case Review Process- Structured Judgement Review (SJR)

5.1 A Structured judgement review (SJR) blends traditional, clinical-judgement based review methods with a standardised format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments and to score each phase of care. The result is a relatively short but rich set of information in a form that can be aggregated to produce knowledge about clinical services and systems of care. The crucial aspect of this whole process is the identification of themes for learning and also to recognise good care. It is the responsibility of clinical teams, via their various governance teams to ensure the learning is translated into actions, audit topics and quality improvement.

5.2 Currently there are 16 SJR trained reviewers who are consistently completing reviews. However, challenges continue with regards to some consultants not having protected time agreed within their job planning. As a result, more senior nurses are completing the SJRs. This is being addressed by the Medical Director as it is important that the process is primarily consultant led.

5.3 During this quarter 14 have been undertaken on those deaths referred by the Medical Examiner (ME) team and in addition to these, a further 37 cases, where the patient has died in ED have been completed. This is a total of 51 reviews (9% of all deaths) and 57% of the cases where the patient died in ED. The decision to review the ED deaths was due to the fact that there had been a growing number of deaths in ED and the Trust wanted to be assured that these patients still received good care. As part of the review process the reviewers explored the environmental factors in particular looking at the length of time they spent in ED and whether transfer out to a more appropriate place to die had been delayed.

5.4 Learning from SJR.

Of the 51 SJRs completed this quarter, the breakdown of the overall assessment scores can be seen in the following chart:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1.Very Poor	0	0	0	0
2.Poor	0	3	3	1
3.Adequate	3	4	5	4
4.Good	7	18	35	36
5.Excellent	1	8	7	10
Total SJRs	11	34	50	51

One SJR this quarter judged that the patient had received poor overall care. As per the escalation process, this will be discussed at the next multidisciplinary SJR team meeting in May. Feedback will be given to the clinical team and governance group. It is very reassuring to see that the vast majority of cases reviewed are judged to have had "Good" and "Excellent" care.

Of the 37 ED deaths reviewed, 35 were judged to have received overall good care with only two cases judged to have received "adequate" care for the following reasons:

- "some slight delay in initial clerking resulting in a delay in the referral to medical team"
- "due to increased activity in the department a dose of antibiotics was considerably delayed"

An important aspect of the SJR process is that it highlights good care as well as poor care. As can be seen in the chart above, the majority of cases reviewed have recorded "4" (good care). Frequently seen examples of "good care" include:

- There was evidence of timely escalation by the nursing team to the medical staff where needed with timely review.
- Was escalated to a physician very promptly
- Sepsis bundle completed within one hour of admission
- Clearly documented management plan.
- Very good and clear documentation of communication with the family around ceiling of care.
- Prompt investigations and treatment.

Learning points from the completed SJRs where overall care was judged to be "poor" are:

- Swift management of low BP is crucial.
- The use of the tracker in ED is essential to ensure patients are assessed as soon as possible, referrals are timely and medication prescribed and administered on time.
- Ensure ward staff are aware of who is responsible for complex wound management.

The learning must happen at ward and department level. It is the responsibility of specialty and Divisional Governance leads to ensure this report is shared widely. Linking with the education department and the quality improvement team is crucial for the wider organisational learning.

7. SJR PLUS

This application is now in use and the majority of reviewers are completing SJRs using the app. This provides the Trust with the immediate availability of completed SJRs and will enable it to be able to capture the SJR compliance rates and themes more readily. However, the production of a fit for purpose dashboard will require the assistance of the information department with the initial set up. This has been requested and is actively being chased.

8. Referral to His Majesty's Coroner (HMC)

8.1 This quarter there have been **171** referrals to the coroner.

Referral to the Coroner does not necessarily mean the case will go to Inquest. In many cases, the Coroners will review the referral and the Medical Examiner Scrutiny and proposed cause of death as documented on the MCCD. Following communication and agreement with the family, if the proposed cause of death is accepted a form CN1A is issued. This is commonly known as an 'APASS'. An interim death certificate can be issued by the coroner, this could be due to the post mortem result being inconclusive, an investigation is ongoing by the coroner or there is to be an inquest. The interim certificate replaces a certified copy of the death certificate until the inquest or investigation is concluded. This enables the death to be registered and therefore families can move forwards with their plans. Similarly, if no medical

practitioner can state the cause of death to the best of their knowledge and belief, the coroner will have to be notified. It would then be for the coroner to determine the cause of death.

49 inquests have been opened this quarter and 33 concluded. The details of these are reported to the Patient Safety Review Group on a quarterly basis and to the Patent Safety Committee 6 monthly.

9.2 Regulation 28 Prevention of Future deaths reports.

Two Regulation 28: Prevention of future deaths reports were issued to the Trust this quarter. The matters of concern raised by HM Coroner were as follows:

- The lack of a system for prioritisation of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital
- The lack of a system for monitoring clinical parameters of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital.
- Protocol for producing and disseminating radiology reports produced by a third party was both out of date and unclear.

Each of these reports are presented to the Effective Committee. Once the response has been completed, the recommendations will be noted at Mortality Governance and the Effective Committee will monitor the action plans.

10. Patient Safety Incident Response Framework (PSIRF) investigations

10 15 cases were referred by the ME team as potential patient safety incident investigations. (PSII's). All have been reviewed and discussed at either divisional level or the Trust's Learning from Patient Safety Event's (LFPSE) panel. Of these cases, four resulted in open discussions with the family, two were declared as PSII's and two after action reviews (AAR's).

The two declared PSSI's were both thought to be more likely than not due to problems in care and are currently under investigation.

11. Conclusion

The Mortality Governance Group and Effective Committee are asked to note the content of the report.

12. Recommendations

- This report to be shared with all Divisional governance leads and tabled at all clinical governance group meetings and more widely with the ward and department staff. Clinical Governance groups to consider the learning points and suggest, design and implement change to ensure improvements are made.
- The Mortality Governance group to consider the trajectory for the numbers of SJRs to be completed each month.
- The Mortality Governance group to decide on the cohort of deaths to be reviewed each quarter for 2025/26 based on intelligence from the internal DERRICK database. Q1 will be concentrating on deaths were anaemia was the primary diagnosis.

Reporting schedule

QUARTER	Mortality Governance	Effective Committee	Quality and Effectiveness Committee	Clinical Quality Review Group
Q1 : April - June	Sept 2024	Nov 2024	Dec 2024	
Q2: July - Sept	Nov 2024	Jan 2025	Feb 2025	
Q3: Oct - Dec	Feb. 2025	Mar 2025	Apr 2025	
Q4: Jan - March	May 2025	July 2025	Aug 2025	

Mandy Cumberbatch (nee Dalton)

Interim LFD Manager.

May 2025

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

LEARNING FROM DEATHS : ANNUAL REPORT 2024/25

The National Guidance on Learning from Deaths (LFD) published in March 2017 set out the framework for how Trusts should identify, report, investigate and learn from deaths in care.

The Trust produces quarterly reports on the data requirements set out in the framework which are presented to Mortality Governance and subsequently the Trust Board, via the Effectiveness Committee. At the Mortality Governance meeting in May 2025 it was agreed that an annual report be produced and be presented to Mortality Governance in June 2025. This will then be circulated to all specialty clinical governance groups by way of raising awareness of the LFD process and importance of learning from deaths.

This process runs alongside the Learning from patient safety events service (LFPSE) which specifically investigates patient safety incidents where the outcome is not necessarily death.

During 2024/25 a total of 2,151 patients died within DBHFT, this includes those who died within the Emergency department.

All (100%) of deaths undergo independent scrutiny from the Medical Examiner's office.

TIME PERIOD	In patient deaths	ED deaths	TOTAL
April '24 - March '25			2,151
Q1	452	63	515
Q2	434	51	485
Q3	526	63	589
Q4	498	64	562

Structured Judgement Review

It is nationally recommended that around 10-15% of deaths are reviewed using a standardised method of review called Structured Judgement Review (SJR)

This method of review is based on the following principles:

- It combines traditional, clinical-judgement based review methods with a standardised format
- It is usable across services, multiprofessional teams and specialties.
- It relies on trained reviewers looking at the patient records in a critical and holistic manner, commenting on specific phases of care.
- It requires safety and quality judgements and a score for each phase of care
- It uses free text and categorical variables to capture the quality of care delivered
- It does not depend on triggering harm events

A multi disciplinary group of staff received SJR training in early 2024 and since then a total of 147 SJRs have been completed by the team. This is 6.8% of the total deaths throughout the year. In addition to this team, a group of senior multidisciplinary staff are also reviewing a significant number of cases when death was due to sepsis. These will be captured fully, going forward, onto the SJR plus app. and reported on quarterly.

Although there was a significant increase of SJRs from Q2, this has now plateaued and will need additional reviewers to increase the numbers to achieve the aspiration of 12-15% of all deaths.

This table illustrates the clinical judgement scores for the 147 SJRs. Any cases where the score is 2 (poor) are escalated to the bi-monthly SJR team meetings where a senior Dr will review the case and confirm what actions are required.

Care score	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1.Very Poor	0	0	0	0
2.Poor	0	3	3	1
3.Adequate	3	4	5	4
4.Good	7	18	27	36
5.Excellent	1	8	7	10
Total SJRs	11	34	50	52

Midway through this year the Trust purchased the SJRPlus application and work has been ongoing to ensure staff have access and instruction in its use. This will enable the Trust to be able to produce reports from the large data set it holds and develop a bespoke report template during 2025/26.

Learning identified through Structured Judgement reviews has included:

- Importance of Blood Culture sampling in cases of suspected sepsis
- Delivery of appropriate and prescribed antibiotics in diagnosed sepsis must be administrated swiftly
- Completion of the sepsis IPOC is essential

- Oxygen must be prescribed before administering.
- Recognition of the need for fluid resuscitation in the case of significant hypotension and blood loss must be improved.
- Always document best interest decisions for patients with a Learning Disability
- Ensure timeliness of commencing a blood transfusion once this has been prescribed.

Good Practice identified through Structured Judgement Reviews:

An important aspect of the SJR process is that it highlights good care as well as poor care. As can be seen in the table above, good and excellent care is identified in the majority of cases Examples of frequently seen comments are:

- Senior review is good
- Recognition of deterioration is good
- Thorough comprehensive documentation
- Prompt assessment and management plan was evident
- Communication with family was very good and clear concise documentation evident.
- Good MDT input from specialist nurses.

The Mortality Governance Committee reviews the themes identified via SJRs and ensures that appropriate work streams are in place to take forward the various lessons to be learnt.

The issues raised around lack of documented evidence of either best interest decisions or capacity of the learning disability patient are being captured by the Trust learning disability lead and form part of the quality strategic objectives being taken forward by the vulnerable patient steering group.

The sepsis action team are taking forward the themes around sepsis 6.

It has been observed via the SJR process that there has been an improvement in the prescribing of oxygen. This improvement is very likely to have been as a result of the awareness raising via the various clinical teams on receipt of the quarterly learning from deaths report.

Regulation 28 Prevention of Future deaths reports.

The Coroners and Justice Act 2009 allows a coroner to issue a regulation 28 report if they believe that action needs to be taken to prevent further deaths in similar situations.

Two Regulation 28: Prevention of future deaths reports were issued to the Trust this year (both in Q4).
The matters of concern raised by HM Coroner were as follows:

- The lack of a system for prioritisation of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital
- The lack of a system for monitoring clinical parameters of urgent surgical patients awaiting transfer to DRI from the Emergency Department at Bassetlaw District General Hospital.
- Protocol for producing and disseminating radiology reports produced by a third party was both out of date and unclear.

Each of these reports are presented to the Effective Committee. Once the response has been completed, the recommendations will be noted at Mortality Governance and the Effective Committee will monitor the action plans.

Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

Many discussions have been held throughout the year on these two different metrics being used to compare mortality outcomes across Trusts. Neither of these metrics are a measure of actual quality of care or avoidability of deaths. Both metrics cause concern when figures in one Trust are much higher (or lower) than in another.

The chart below indicates the key differences between SHMI and HSMR.

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Deaths 30 days post discharge	Included	Not Included	Gives a more complete picture of mortality associated with hospitalisation & reduces the effects of differences in discharge processes and palliative care provision (hospice) in the community
Palliative Care Coding	no adjustment	adjusts	Variation in coding practice & over-adjustment concerns
Diagnosis Group, Accumulate Risk Monitoring & Banding	10 Diagnosis Groups	56 Diagnosis Groups	Groups with high numbers of deaths and statistical models that are considered to have sufficiently explained the expected variation in outcomes due to the case-mix adjustment.

Following much debate at both regional and national forums it has been decided that the Trust will now report on SHMI only.

The latest SHMI figure and accurate as of 13th May 2025 is 104.00 with a rolling 12 month average (Feb 24-Jan 25) of 106.60.

Work is ongoing with regards identifying those cases that fall in to an "outlier" category and as such, negatively affect the Trust's overall SHMI figure. These are captured on the in house DERICK dashboard and will be reviewed as part of the ongoing SJR work. Throughout the year targeted reviews have been undertaken on peritonitis, sepsis and pneumonia deaths, deaths in ED and at the time of this report, cases where anaemia was the primary diagnosis are being reviewed.

CONCLUSION

- In accordance with national mortality guidance the trust is compliant with quarterly reporting of the Learning from Deaths process
- The medical examiner role is well established with good working processes and governance, linking in with all other patient safety and patient experience processes.
- The trust is compliant with the LeDeR process, ensuring all deaths were the patient had a learning disability, significant mental health issue and/or autism are reported to LeDeR and reviewed via the SJR process.

RECOMMENDATIONS

- To maintain the current numbers of SJRs undertaken and ensure those completed by the sepsis working group are incorporated into the quarterly figures
- Consider how the learning identified can be linked into divisional priorities for the coming year
- To develop a bespoke report on the data set within the SJRPlus application to be received by Mortality Governance quarterly

Mandy Cumberbatch (nee Dalton)

Interim LFD Manager

Approved by the Mortality Governance Group 20th June 2025

2509 - B3 WINTER PLAN 2025/26

Decision Item | Denise Smith, Chief Operating Officer | 10:45

10 minutes

REFERENCES

Only PDFs are attached

- B3 - Winter Plan 2025-26.pdf
- B3 - Appendix A Winter Plan Schemes 2025.pdf
- B3 - Appendix B Board Assurance Statement (template).pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Winter Plan 2025/26**			
Executive Sponsor:	Denise Smith, Chief Operating Officer			
Authors:	Denise Smith, Chief Operating Officer Suzanne Stubbs, Deputy Chief Operating Officer			
Appendices:	Appendix A Winter plan schemes 2025/26 Appendix B Board Assurance Statement (template)			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 3			

Executive Summary – Key messages and Issues

This paper sets out the:

Winter plan schemes for 2025/26

Winter plan schemes for 2025/26 are designed to:

- Increase inpatient capacity
- Increase ambulance handover capacity
- Maintain patient flow
- Support infection prevention and control
- Increase senior decision making in ED overnight

The total cost of the schemes proposed is **£1,318,871**, of which **£974,515** relates to increasing inpatient capacity.

National winter planning and preparedness requirements for winter 2025/26

The urgent and emergency care plan, published in June 2025 (DHSC and NHSE), sets out the national expectations for winter plans for 2026/26. ICBs and Trusts are asked to develop system winter plans over the summer, and these will be 'stress-tested' at regional exercises in September.

ICBs and Trust are not required to return winter plans to NHS England. Instead, individual Boards are expected to formally sign off their own winter plans and provide assurance to NHS England via a Board Assurance Statement. A copy of the Board Assurance Statement is provided for information at Appendix B.

Recommendations

The Trust Board of Directors is asked to:

- **APPROVE** the winter plan schemes for 2025/26
- **NOTE** the national winter planning and preparedness requirements for winter 2025/26
- **DELEGATE** authority to the Finance and Performance Committee to sign off the Board Assurance Statement prior to submission

Healthier together – delivering exceptional care for all

<table>
<tr><td>Patients</td><td>Winter plan schemes support the delivery of timely access to care during peaks in winter demand</td></tr>
<tr><td>People</td><td>Winter plan schemes support colleagues to effectively manage peaks in winter demand, provide timely access to emergency care and maintain patient safety through the winter period</td></tr>
<tr><td>Partnerships</td><td></td></tr>
<tr><td>Pounds</td><td>Winter plan schemes are at an additional cost to the Trust</td></tr>
<tr><td>Health Inequalities</td><td></td></tr>
<tr><td>Legal/ Regulation:</td><td></td></tr>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Trust Leadership Team 9 June 2025
Executive Team 2 July 2025 and 16 July 2025
Finance & Performance Committee 14 August 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Approved in principle by the Executive Team, for submission to Finance and Performance Committee and Public Trust Board of Directors</td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
</table>

1. Introduction

This paper sets out the:

- Trust winter plan schemes for 2025/26
- National winter planning and preparedness requirements for winter 2025/26

2. Background

The urgent and emergency care plan, published in June 2025 (DHSC and NHSE), sets out the national expectations for winter plans for 2026/26. This included the following priority action and expected impact for patients and carers:

Action: *Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter.*

Impact:
- *improve vaccination rates.*
- *increase the number of patients receiving urgent care in primary, community, and mental health settings.*
- *meet the maximum 45-minute ambulance handover time standard.*
- *improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours and making progress on eliminating corridor care.*
- *set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings.*
- *reduce length of stay for patients who need an overnight emergency admission*

3. Winter planning timeline

The winter planning timetable for 2025/26 is summarised below:

- April – June 2025 Divisional and corporate team winter planning workshops
- 9 June 2025 Trust Leadership Team winter plan workshop
- 2 July 2025 Executive Team first review of the winter plan schemes.
- 16 July 2024 Executive Team final review of the winter plan schemes.
- 14 August 2025 Finance & Performance Committee review of the winter plan schemes.
- 2 September 2025 Trust Board of Directors (Public) receive the final winter plan schemes.
- 3 September 2025 NHS North East & Yorkshire winter planning test event
- 23 September 2025 Finance and Performance Committee receive the Board Assurance Statement
- 30 September 2025 Board Assurance Statement submitted to NHS England

4. Winter plan schemes 2025/26

The proposed winter plan schemes for 2025/26 are summarised as follows, the full details are provided at Appendix B. The total cost of the schemes proposed is £1,318,871, of which £974,515 relates to increasing inpatient capacity.

4.1 Increasing inpatient capacity

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Extend TACU opening hours	01-Dec-25	31-Mar-26	4	£146,060
Bassetlaw	Extend ESSU hours	01-Jan-26	31-Mar-26	3	£21,254
Doncaster	Winter ward	01-Dec-25	31-Mar-26	4	£286,085
Bassetlaw	Winter ward	01-Dec-25	31-Mar-26	4	£521,116
					£974,515

4.2 Increasing ambulance handover capacity

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Temporary escalation space	01-Dec-25	28-Feb-26	3	£146,060
					£146,060

4.3 Increasing senior decision maker capacity in ED overnight

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Middle grade (T4) cover overnight	01-Dec-25	28-Feb-26	3	£72,000
					£72,000

4.4 Maintaining patient flow

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Additional discharge transport	01-Jan-26	31-Mar-26	3	£66,800
Doncaster & Bassetlaw	Additional portering for diagnostics	01-Jan-26	31-Mar-26	3	£11,922
					£78,722

4.5 Infection prevention and control

Site	Scheme Title	Start Date	End Date	Duration (months)	Total cost
Doncaster	Additional cleaning in ED	01-Jan-26	31-Mar-26	3	£25,425
Doncaster	Additional cleaning in ED overnight (22:00 - 06:00)	01-Jan-26	31-Mar-26	3	£14,888
Bassetlaw	Additional resource for rapid response / HPV disinfecting service	01-Jan-26	31-Mar-26	3	£3,179
					£43,492

5. National winter planning and preparedness requirements for winter 2025/26

The urgent and emergency care plan, published in June 2025, sets out the priority actions for this coming winter, as noted earlier in the paper.

ICBs and Trusts are asked to develop system winter plans over the summer, and these will be 'stress-tested' at regional exercises in September.

ICBs and Trusts are not required to return winter plans to NHS England. Instead, individual Boards are expected to formally sign off their own winter plans and provide assurance to NHS England via a Board Assurance Statement. A copy of the Board Assurance Statement is provided for information at Appendix B. This will be completed following the NHS North East and Yorkshire winter planning test event on 3 September 2025 and submitted to Finance and Performance Committee for approval on 23 September 2025.

6. Next steps

The Trust will participate in the NHS North East and Yorkshire winter planning test event on 3 September 2025. Following this, the Trust final winter plan will be submitted to the Finance and Performance Committee in September 2025, together with the Board Assurance Statement. The Board Assurance Statement will be submitted to NHS North East and Yorkshire by 30 September 2025.

7. Recommendations

The Finance and Performance Committee is asked to:

- APPROVE the winter plan schemes for 2025/26
- NOTE the national winter planning and preparedness requirements for winter 2025/26
- DELEGATE authority to the Finance and Performance Committee to sign off the Board Assurance Statement prior to submission

Appendix A Winter Plan Schemes 2025/26

Division	Specialty	Scheme Title	Scheme detail	Start Date	End Date	Duration (months)	Total cost	Monthly cost
Surgery	Orthopaedics	Extend TACU opening hours	Keep TACU open 24/7	01-Dec-25	31-Mar-26	4	£ 146,060	£ 36,515
CSS	ESSU	Extend ESSU hours	Keep ESSU open 24/7	01-Jan-26	31-Mar-26	3	£ 21,254	£ 7,085
Medicine	All	Winter ward DRI	DRI - Winter ward	01-Dec-25	31-Mar-26	4	£ 286,085	£ 71,521
Medicine	All	Winter ward staffing BDGH	Bassetlaw - full time locum for period of winter ward	01-Dec-25	31-Mar-26	4	£ 53,539	£ 13,385
Medicine	All	Winter ward BDGH	Bassetlaw - Winter ward	Dec and March		2	£ 202,237	£ 101,119
			Bassetlaw - Winter ward	Jan and Feb		2	£ 265,340	£ 132,670
E&F	Facilities		Dedicated Porter MRI/CT/Diagnostics at DRI & BH sites only	01-Jan-26	31-Mar-26	3	£ 35,765	£ 11,922
E&F	Facilities		Additional cleaning in ED	01-Jan-26	31-Mar-26	3	£ 25,425	£ 8,475
E&F	Facilities	Additional Cleaning in ED at DRI only from 10pm until 6am to facilitate cubicle & trolley space turnaround during high demand.	Additional night cleaning in ED	01-Jan-26	31-Mar-26	3	£ 14,888	£ 4,963
E&F	Facilities	Additional resource input for rapid response / HPV disinfecting service to provide extended coverage to 10pm at BDGH.	Additional resource input for Rapid Response Team at BH to extend to 10pm.	01-Jan-26	31-Mar-26	3	£ 3,179	£ 1,060
E&F	Facilities	Discharge Transport	Additional Transport 10pm to 3am	01-Jan-26	31-Mar-26	3	£ 66,800	£ 22,267
UEC	Emergency Medicine	Temporary Escalation Space (Ambulance handover)	Due to increased demand within the Emergency Dept over the Winter Period - One x RN and One 1 x CSW are required 1 Dec 25 to 28 Feb 26.	01-Dec-25	28-Feb-26	3	£ 126,299	£ 42,100
UEC	Emergency Medicine	Middle Grade (T4) Cover Overnight	Additional Senior Decision Maker Required Overnight to allow more timely Decision Making and Flow of patients.	01-Dec-25	28-Feb-26	3	£ 72,000	£ 24,000
							£ 1,318,871	**£ 477,079**

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.		
The Trust's plan was developed with appropriate input from and engagement with all system partners.		
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.		
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.		
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.		
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.		
8. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.		
Leadership		

9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.		
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.		
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

2509 - B4 DBTH TACKLING HEALTH INEQUALITIES UPDATE

Decision Item | Zara Jones, Deputy Chief Executive | 10:55

10 minutes

REFERENCES

Only PDFs are attached

B4 - DBTH Tackling Health Inequalities Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**DBTH Tackling Health Inequalities Update**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Dr Kelly Mackenzie, Consultant in Public Health (DBTH) and Clinical Senior Lecturer in Public Health (University of Sheffield) Richard Woodhouse, Health Inequalities Development Manager			
Appendices:	DBTH Tackling Health Inequalities Update Appendix 1 – Updated action plan Appendix 2 – Examples of Equity Index			
Purpose of the report	**Assurance**	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1, BAF 2, BAF 3, BAF 5, BAF 6, BAF 7			

Executive Summary – Key messages and Issues

To provide an update on the tackling health inequalities work. The information in the report provides a summary of the key work undertaken by the Health Inequalities Team since our last update in March 2025.

Recommendations

The Board of Directors is asked to note progress to date, and we are seeking approval from the Board for a proposed programme of work for the remainder of 2025/26 and for 2026/27. This will cover:

1. Education and awareness
2. Evidence-based interventions – fair waiting list pilot, targeted DNA and WNB reduction, improving access to our Women's and Children's services, delivering targeted health inequalities research
3. Embedding tackling health inequalities into everything we do.

Healthier together – delivering exceptional care for all	
Patients	Tackling health inequalities will improve care for all our patients.
People	We have identified specific streams of work to reduce health inequalities for our people.
Partnerships	To effectively tackle health inequalities, we need to work with our partners as many of the root causes of inequalities relate to the wider determinants of health which our community/voluntary sector and local authority partners are best placed to support us.
Pounds	By tackling health inequalities and supporting our underserved populations, we aim to reduce demand for our services, particularly within unplanned care pathways.
Health Inequalities	This report provides an update on the health inequalities work due to be/being undertaken by the trust's Health Inequalities team.
Legal/ Regulation:	There are 8 CQC Key Lines of Enquiry Measures relating to health inequalities. The information presented in this paper will support the provision of evidence that we are meeting these Key Lines of Enquiry Measures. Tackling health inequalities is mandated in the Health and Social Care Act 2022 – "…considerations also need to be given to the effects [of decisions] in relation to health inequalities. This applies to ICBs, NHS England and foundation trusts, and trust in England (the relevant bodies)." The information presented in this paper will support the provision of evidence that we are taking action to tackle health inequalities.

<table>
<tr><td>Partner ICB strategies</td><td>Tackling health inequalities are strategic objectives of both partner ICBs.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>N/A</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>N/A</td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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DBTH Tackling Health Inequalities Update

1. Background

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". They mean that some population groups have significantly worse health experiences and outcomes than others. Health inequalities are experienced by our people as well as our patients. DBTH's Health Inequalities (HI) Team, led by Dr Kelly Mackenzie, Consultant in Public Health, and Richard Woodhouse, Health Inequalities Development Manager, has been progressing the health inequalities agenda across the Trust at pace, with the direction and support of the Deputy Chief Executive Zara Jones.

The new DBTH Trust Strategy "Healthier Together" has identified tackling health inequalities as key to delivering the trusts overall vision of delivering exceptional care for all. As such, tackling health inequalities is one of four new strategic ambitions for the trust, where "we prioritise health equity through prevention, partnerships, training and targeted support for underserved communities".

To deliver the strategic ambition, the HI Team has three main areas of focus for the coming year (2025/26):

1. Education and raising awareness of health inequalities amongst DBTH staff to build capacity across the Trust, acknowledging that the HI Team cannot tackle inequalities alone.
2. Evidence-based interventions which encompasses several discrete projects including research and innovation opportunities, which the HI Team will either lead on or support others to undertake.
3. Developing a culture where tackling health inequalities becomes business as usual for our Trust which links back the overall aim of our Tackling Health Inequalities Enabling Plan and essentially refers to our pillars (including the development of data systems) and three-tiered framework.

We also developed an action plan (see Appendix 1) based on the discussions in the Board Development Session in February 2025 and approved by Board in March 2025 which outlines the key actions relating to tackling health inequalities for 2025/26.

We will highlight our progress to date under the sub-heading relating to our main areas of focus

2. Education and awareness

This has been the main area of focus for the HI Team over the last year and will continue to be going forwards. Building capacity within the Trust by training staff about what health inequalities are and how to tackle them ensures that tackling inequalities becomes a focus for everyone and part of business as usual.

Here are some specific achievements/areas of progress:

- Continued roll-out of the Change Initiator Training, with 193 staff trained to date, receiving overwhelmingly positive feedback (see Figs 1 and 2).
- Launch of Heath inequalities training in SET + in March 2025, and to date 83% of our people have completed this (n=5656).
- A pilot of the Health Inequalities Advocate Training, using the ECHO model to enhance accessibility, was conducted as part of the Aspiring Matrons Programme (n=20). We are waiting for this training to go through the Role Specific Training (ReST) Approval Panel (RAP) so it can be added to ESR for those who are eligible.
- Our HI training pyramid (see Fig 3) has been recognised as best practice by South Yorkshire ICB. There are therefore plans for our training pyramid to be rolled-out across all SY acute trusts with developing plans for a "train the trainer" approach to increase the teaching faculty to deliver the different training levels. We have also had discussions with colleagues from acute trusts/ICBs further afield including West Yorkshire ICB, Sherwood Forest Hospital Trust, Kings College London, York and Scarborough Teaching who are also interested in adopting our training model.
- With the support of the Communications Team, we have reviewed and updated our existing comms plan to ensure regular updates on our HI work and opportune links to HIs (where appropriate) are disseminated via our comms channels.

Fig 1: Change Initiator training numbers

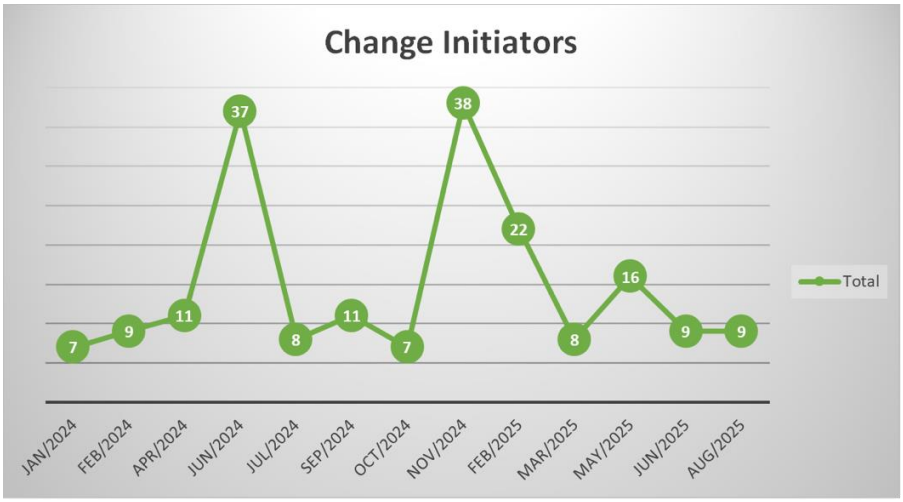
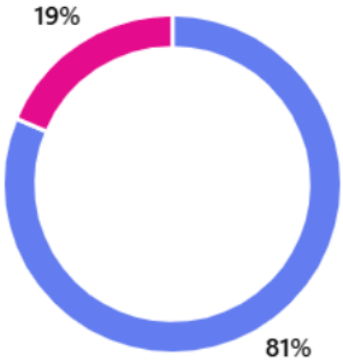


Fig 2: Snapshot of the feedback from Change Initiator training

The training content and level was appropriate and useful to me in my role and development:



The training has made me feel more confident and competent in identifying and tackling health inequalities:

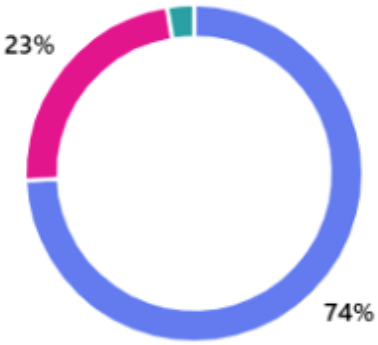
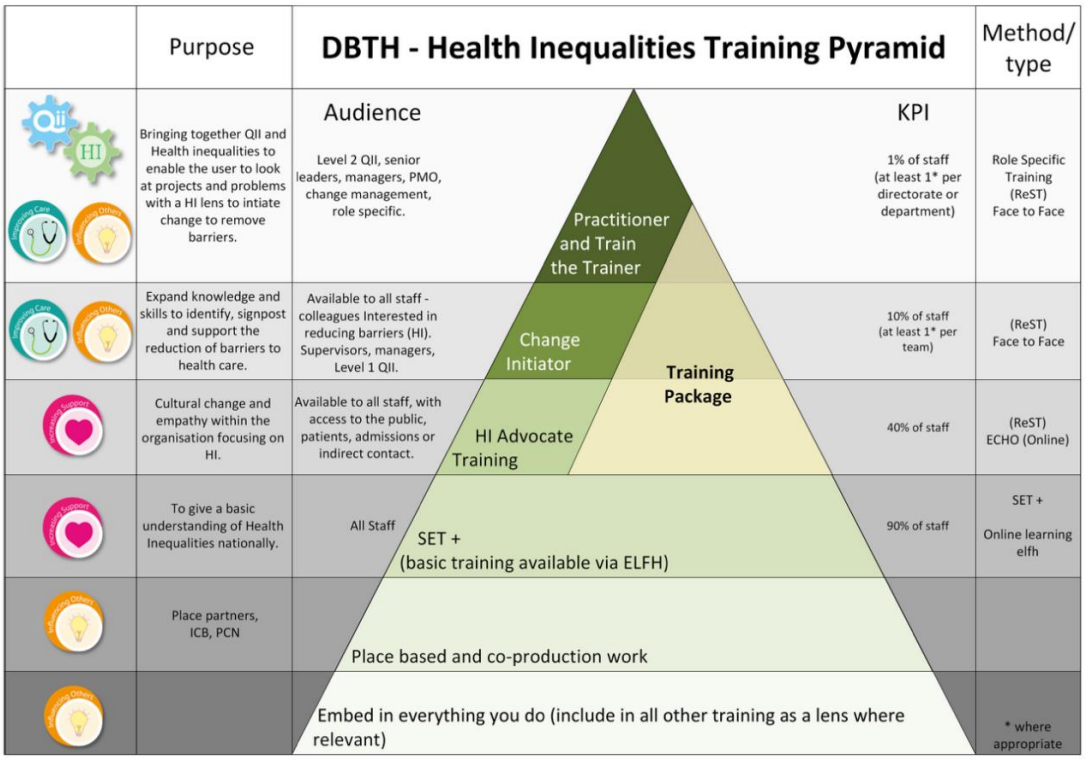


Fig 3: DBTH Tackling Health Inequalities Training Pyramid



3. Evidence-based interventions

We intend to use data (in the form of our equity index, see point 4 below for details) to help prioritise which discrete projects we undertake. However, there is also national level guidance to steer us, such NHS England's Reforming Elective Care for Patients report, the Darzi report, the 10 Year Health Plan for England – Fit for the Future and the NHS Oversight Framework. Based on this guidance, and early data from our Equity Index a key priority area will be reviewing elective care pathways with a health inequalities lens. This will involve two workstreams:

- Fair waiting list pilot – at the Board Development Session in February, use of the Coventry and Warwickshire HEARTT tool was discussed, a waiting list prioritisation tool. However, there is a cost to this (circa £25k per year). Barnsley Foundation Trust have developed and successfully piloted their own tool, WHaLES (Waiting Healthy – a List Equity Score). This is now being made available across South Yorkshire. Not only does this intend to support a reduction in HIs but it will also support efficiencies in the waiting list more broadly. We plan to review the tool and with support from Quality Improvement colleagues, will seek to pilot it in DBTH.
- Targeted Did Not Attend (DNA) / Was Not Brought (WNB) rate reductions – work is ongoing to reduce DNA/WNB rates, which we will support and develop to ensure it is being conducted in an equitable and targeted way and is reducing inequalities.

A third workstream will involve an equity-focused approach to improving access to our Women's and Children's services. This has been identified as a priority area due to the link to NHS England's Core20PLUS5 frameworks for adults and for children and young people, the Women's Health Strategy for England and the most recent MBRRACE-UK Report. In addition, local insights have identified female healthy life expectancy as 57 years in Doncaster and 62 years in Bassetlaw (England average = 63.1 years) and this priority area compliments Doncaster Council's Health and Wellbeing Strategy 2024-2030 which has a focus on "closing the gap" in women's and children's health. Finally, this priority area links to research and innovation opportunities that the HI team are already involved in (see below for further details), which will further support this workstream.

There is also involvement in research projects (particularly because of Kelly Mackenzie's joint clinical academic post). Current planned/ongoing research includes:

- With the support of DBTH Charities, we have submitted a grant application to NHS Charities Together (approx. £200k) and proposed research which will enable us to gain an in-depth understanding of the health and wellbeing inequalities of our people, then use this data to co-design 2/3 interventions which will then be implemented and evaluated. We expect to find out whether we have been successful in September 2025.
- A National Institute for Health and Care Research (NIHR) grant application has just been submitted (approx. £150k) which plans to understand the prevalence of period poverty and menstrual health inequalities amongst the NHS workforce. Although this will be a national-level project, there will be a DBTH focus (if successful) with DBTH co-applicants included in the application.
- A NIHR intervention development project (approx. £240k) which aims to understand the barriers to accessing perinatal mental health care for women/pregnant people whose needs are not met by existing services in South Yorkshire. This project began in October 2024 and will run for 18 months. KM is the Principal Investigator on this project. Doncaster colleagues have been included in this research.
- A large NIHR maternity inequalities challenge which is looking to tackle the "causes of the causes" of maternity inequalities. KM is part of a larger team at the University of Sheffield which is working together on this project as part of a consortium with colleagues from the London School of Hygiene and Tropical Medicine and the Institute for Fiscal Studies. The consortium is currently in the research priority-setting phase with specific projects anticipated to begin in 2026.

In terms of ongoing work, a project is underway to assess the access, experience, and outcomes for inclusion health groups (e.g., people experiencing homelessness, sex workers, those with substance misuse issues) within Emergency Departments (ED). A face-to-face workshop held on 6th March brought key stakeholders together to better understand the challenges being faced by this cohort of patients and key actions to improve care were determined. A follow-up meeting (online) was held on 12th June to review what has been achieved since the workshop and develop further actions. Key actions have included:

- The sharing of the ED "nurse in charge phone number" with community and voluntary sector organisations to enable quick communications to support the care of these patients when presenting to our services.
- Development of a contacts list to facilitate communications between colleagues and partners.
- Development of an MDT-style meeting bringing together key partners to better support these patients (using a similar model to the High Intensity User Group meetings).

This work aligns with wider Doncaster Place work that Pathway (a national homelessness and inclusion health charity) are undertaking, commissioned by RDaSH, which is looking at improving health for people experiencing homelessness and other inclusion health groups.

4. Developing a "tackling health inequalities" culture

Since the Board Development Session in February, a sub-group of the Board along with the HI Team completed the HI Self-Assessment tool. This tool provides a score and maturity rating for the Trust's position across four domains, and our results were as follows:

- Building public health capacity and capability – 88% (thriving)
- Data insight, evidence and evaluation – 29% (developing)
- Strategic leadership and accountability – 67% (maturing)
- Systems partnerships – 60% (maturing)

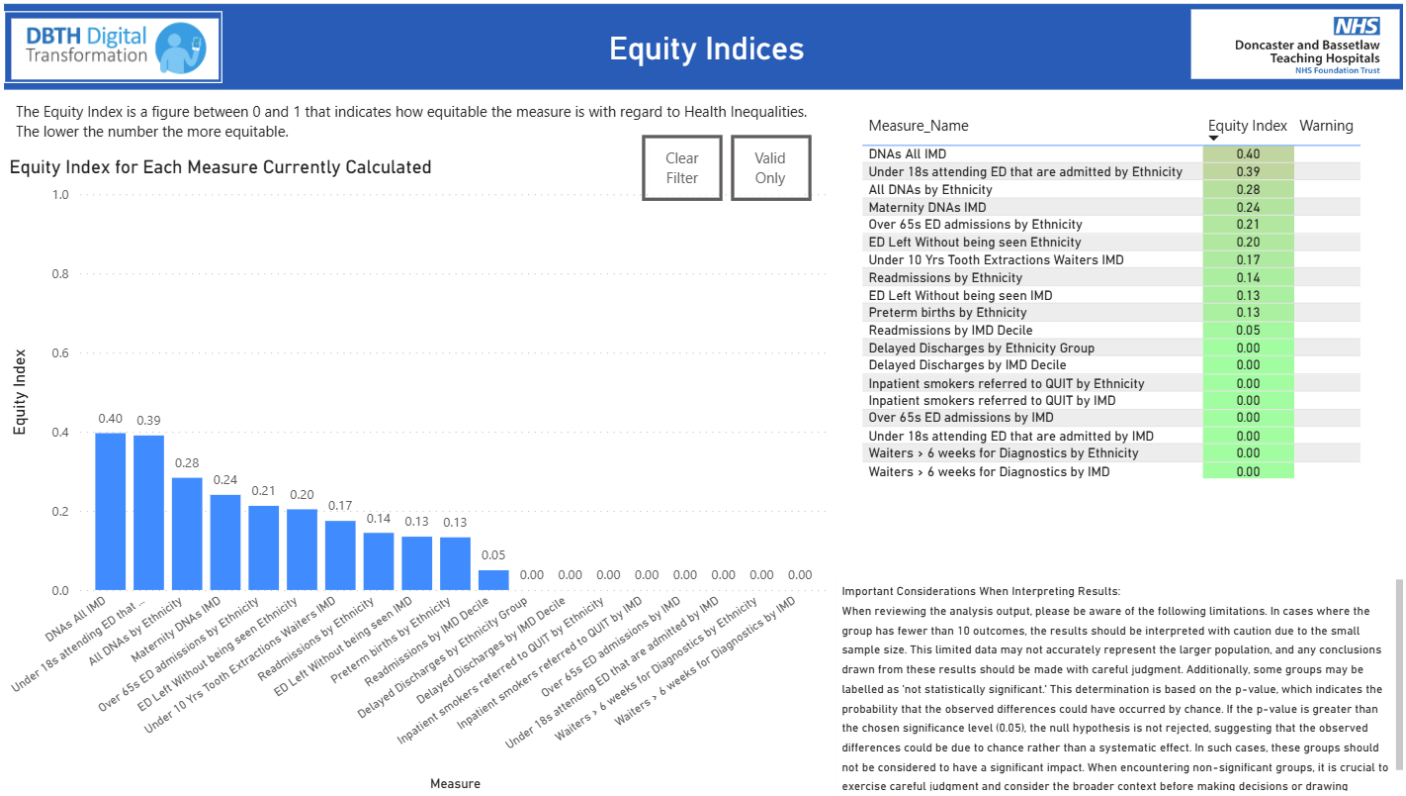
The full report from the completion of this tool was shared with Board members in May. Data insight is a clear area of development for us. This finding aligns with our existing action plan (see Appendix 1), which has identified the need to focus on health inequalities data improvements, helping to embed tackling health inequalities into everything we do. The self-assessment tool will be re-done in 12 months (April 2026) to track progress, aiming for an increasing in our percentage completion of the data domain.

The HI Team is working with our data analysts to embed health inequalities data into Board reports via the IQPR process. We are also developing and rolling out an Equity Index, which will allow us to determine where our greatest disparities lie and therefore will inform our priority setting work and allow us to track progress over time. The index provides a number between 0 (complete equity) and 1 (complete inequity) which highlights the extent of the inequity by either deprivation (using the Index of Multiple Deprivation (IMD) or ethnicity. To date, 6 metrics have been completed, with 3 further metrics in progress (see Fig 4 below for a screenshot of the equity indices dashboard and Appendix 2 for examples of the index). To support this work, we have developed a data plan which our data analyst colleagues are working towards. We aim to have the initial phase of the Equity Index work (development across all requested metrics) completed by January 2026. We will then need to plan implementation of the Equity Index to ensure it is utilised appropriately.

Other areas of work to embed tackling health inequalities into everything we do include:

- Board member HI pledges – we now have received pledges from all Board members. With the support of the Communications Team, we plan to share the pledges at opportune times, integrating into existing updates and where appropriate link into other comms pieces (that are not explicitly about HIs).
- Development of the Trust's coversheets to include health inequalities impacts and opportunities. We now need to review how this is being implemented to ensure it is being utilised correctly.
- Plans to incorporate health inequalities case studies / presentations onto the agenda of the Public Board meetings. An initial trial of this will be held at the November Board meeting.
- Working with the Healthy Hospitals Programme Team to look at prevention with a health inequalities lens.
- Supporting the development of DBTH's Citizen's Panel which will bring lived experience voices into everything we do at the trust.

Fig 4: Screenshot of our Equity Indices Dashboard



5. Next steps

We are seeking support from the Board to progress our proposed programme of work for the remainder of 2025/26 and for 2026/27. We recognise the need to remain flexible in our focus to ensure the Trust delivers against national requirements and this is built into the approach to prioritising the focus of the team.

Our current proposed programme includes:

1. Education and awareness – continued roll-out of our Advocate, Change Initiators and Practitioners levels of training
2. Evidence-based interventions ("top priorities") – will involve trust-level quality improvement work, support from the QI team will be sought as well as relevant clinical input:
    a. Fair waiting list pilot
    b. Targeted DNA and WNB reduction with a focus on tackling health inequalities
    c. Using an equity-focused approach to improving access to our Women's and Children's services
    d. Delivering targeted health inequalities research with a focus on improving health and wellbeing inequalities of our people
3. Embedding tackling health inequalities into everything we do – data development and implementation, Board member pledges and comms, review implementation of inclusion of "health inequalities" onto coversheets and within business cases, including health inequalities case studies on the agenda of Public Board Meetings, reviewing the prevention agenda through a health inequalities lens, and continued development of the Citizen's Panel.

6. Risks and issues

Governance structure:

There is an HI Steering Group forum with great engagement, discussion, ideas generation, sharing best practice and sharing DBTH and wider Place updates. It is recognised that a review of the governance arrangements is required to align Health Inequalities deliverables with wider priorities including partnership working and quality improvement. Proposals for this will be developed through the Executive Team in coming months.

The following risks are ongoing:

- Capacity – the HI Team comprises 1 x FTE HI Development Manager (Band 7) and 0.5 x FTE Consultant in Public Health. Thus, we are limited in what we can achieve in a timely manner. We are also working to build capacity across the Trust.
- Prioritisation – there is no specific ring-fenced budget to support the delivery of agreed HI priorities. Funding for discrete projects and other initiatives would accelerate delivery and impact, yet it is recognised that the financial environment is constrained, and investments would require business cases to support.
- Cultural change and embedding improvements – whilst addressing health inequalities remains a key priority for the organisation, wider changes to working practices, processes and governance will be required to truly embrace the agenda and underpin delivery of the transformative improvements required.

Appendix 1: Tackling Health Inequalities Action Plan

	Actions	Lead	Timescale	Next Steps	Expected Outcomes	Updates Sept 2025
Data and evidence	Start using national and local dashboards to report our HI data as part of IQPR and other reports as relevant	HI Team & Performance Team	6 months	HI & Performance teams to meet to discuss	HI data incorporated into IQPRs and other reports as appropriate allowing us to determine the extent of the inequality, prioritise work and track progress over time.	Equity index has been developed for 6 metrics. All metrics should be completed by Jan 2026 at which point we will need to consider implementation to enhance the use of the data. In addition, we need to progress work involving including HI data into IQPRs and other reports.
	Look at Coventry and Warwickshire tool and whether it is a good investment to use and compare to the pilot being developed in Barnsley NHS FT and have follow up discussions re. ethics and approach of HI prioritisation of waiting lists	HI Team & Deputy COO (elective)	2 months	HI Team to undertake a review of the UHCW wait-list prioritisation tool	Decision to be made about whether to incorporate this tool or the Barnsley model or neither into our waiting lists.	Barnsley model to be piloted across all SY acute trusts.
	Examine whether there is evidence of changes in deprivation in areas where there has been investment to support future decision making and benefits realisation	HI Team & Place partner colleagues (LA / ICB)	2 months	HI Team to contact Place partner colleagues	Provide a short report assessing the changes in deprivation in areas where there have been significant investments.	Library services have supported this and are putting together a report. They have found evidence which suggested that if you remove investment from an area then inequalities worsen, but they haven't been able to find evidence that supports investment into areas resulting in reductions in inequalities. This is likely due to issues of establishing causality. Causes of inequalities are multi-factorial so increasing investment alone won't necessarily reduce inequalities.
Leadership and	Complete self-assessment tool (small sub-group of the Board)	HI Team, Deputy CE	2 months	HI Team & Dep CE to establish a sub-group	Baseline completion of HI Self-Assessment Tool which we can then use to	Completed baseline assessment. Data identified as an area requiring focus. Will repeat the

Board action	and use as a benchmark to improve on over 12 months	plus other Board member volunteers			monitor progress over time.	assessment in April 2026 to check for improvements.
	Agree Board member HI pledges which can be communicated across the organisation to share the word	Deputy CE	2 months	Deputy CE to communicate with the Board to obtain each member's pledge	A series of pledges on what the Board and its members will do to tackle health inequalities.	All pledges received. Now need to develop a plan with comms re. how and when the pledges will be used.
	Include HI case studies / presentations on agenda of Public Board	HI Team & Place partner colleagues (inc PFG)	Ongoing	HI Team to reach out to HI Steering Group members and Place partners for ideas and suggestions	Increased awareness and focus on the health inequalities agenda at a Board-level.	Trial of this to take place in Nov 2025 Public Board meeting.
Process and governance	Include HI impacts and opportunities on coversheets and in business cases to ensure HI is more evident in our decision making	Trust Board Secretary & HI Team	2 months	Trust Board Secretary to liaise with HI Team to determine appropriate wording	Health inequalities impacts explicitly considered in decision-making, raising awareness and encouraging our people to focus on initiatives that tackle inequalities.	A statement on HI impacts and opportunities is now required on coversheets but we now need to review how this is being implemented to ensure it is being utilised appropriately.
Specific initiatives	Determine 'top' priorities the Board should focus on which would have the biggest impact, then select these. Elective, UEC and DNAs mentioned as well for consideration.	HI Team	4 months	HI Team to review initiatives that have the greatest impact	Report with a list of top priorities for the Board to consider in terms of areas of focus for the HI Team and the Trust as a whole.	Seeking Board approval for these: • Fair waiting list pilot – WHaLES tool • Targeted DNA/WNA reductions with an equity-focused approach • Women's and children's health – improving equitable access
	Summarise HI elements of Division/Directorate 25/26 planning returns for a stocktake on priorities and gaps	HI Team	2 months	HI Team to review all annual planning returns and summarise HI areas of focus	Summary report to share with the Board and Divisions / Directorates with key learning / future considerations.	We have only recently received the compilation of planning returns from the Planning Team, so have not been able to action this yet. Plan to complete by Nov 2025.

	Identify opportunities for HI action within current wellbeing offer	POD/Health and Wellbeing & HI Teams	6 months	POD/HWB & HI Teams to work together to map current wellbeing offer to HI opportunities	Mapping report with a view to establishing actions on HI linked to wellbeing initiatives.	This action and the one below have been combined together and then incorporated into the NHS Charities Together Grant application focusing on understanding the inequalities our people face and then co-designing and implementing targeted interventions based on these insights.
	Explore potential for 'competitions' to encourage teams to deliver HI improvements	Comms & HI Teams	4 months	Scope out what such a competition might look like and develop a pilot competition as a trial	Develop a pilot competition and trial it – gain feedback as part of an evaluation.	See comment above.

Appendix 2: Examples of Equity Index by IMD and Ethnicity

DBTH Digital Transformation

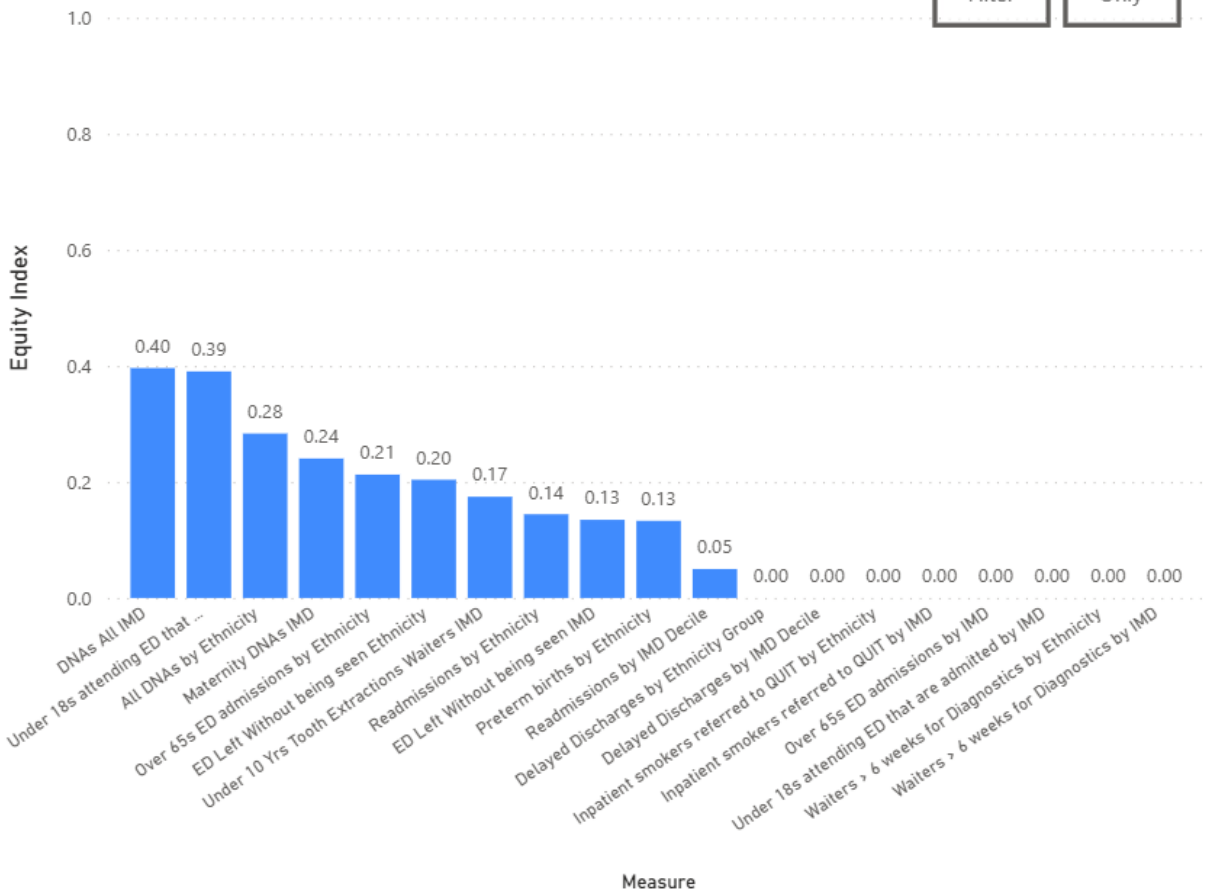
Equity Indices

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

The Equity Index is a figure between 0 and 1 that indicates how equitable the measure is with regard to Health Inequalities. The lower the number the more equitable.

Clear Filter | Valid Only

Equity Index for Each Measure Currently Calculated



Measure_Name	Equity Index	Warning
DNAs All IMD	0.40	
Under 18s attending ED that are admitted by Ethnicity	0.39	
All DNAs by Ethnicity	0.28	
Maternity DNAs IMD	0.24	
Over 65s ED admissions by Ethnicity	0.21	
ED Left Without being seen Ethnicity	0.20	
Under 10 Yrs Tooth Extractions Waiters IMD	0.17	
Readmissions by Ethnicity	0.14	
ED Left Without being seen IMD	0.13	
Preterm births by Ethnicity	0.13	
Readmissions by IMD Decile	0.05	
Delayed Discharges by Ethnicity Group	0.00	
Delayed Discharges by IMD Decile	0.00	
Inpatient smokers referred to QUIT by Ethnicity	0.00	
Inpatient smokers referred to QUIT by IMD	0.00	
Over 65s ED admissions by IMD	0.00	
Under 18s attending ED that are admitted by IMD	0.00	
Waiters > 6 weeks for Diagnostics by Ethnicity	0.00	
Waiters > 6 weeks for Diagnostics by IMD	0.00	

Important Considerations When Interpreting Results:

When reviewing the analysis output, please be aware of the following limitations. In cases where the group has fewer than 10 outcomes, the results should be interpreted with caution due to the small sample size. This limited data may not accurately represent the larger population, and any conclusions drawn from these results should be made with careful judgment. Additionally, some groups may be labelled as 'not statistically significant.' This determination is based on the p-value, which indicates the probability that the observed differences could have occurred by chance. If the p-value is greater than the chosen significance level (0.05), the null hypothesis is not rejected, suggesting that the observed differences could be due to chance rather than a systematic effect. In such cases, these groups should not be considered to have a significant impact. When encountering non-significant groups, it is crucial to exercise careful judgment and consider the broader context before making decisions or drawing

DNAs All IMD

0.40

Equity Index

Definition

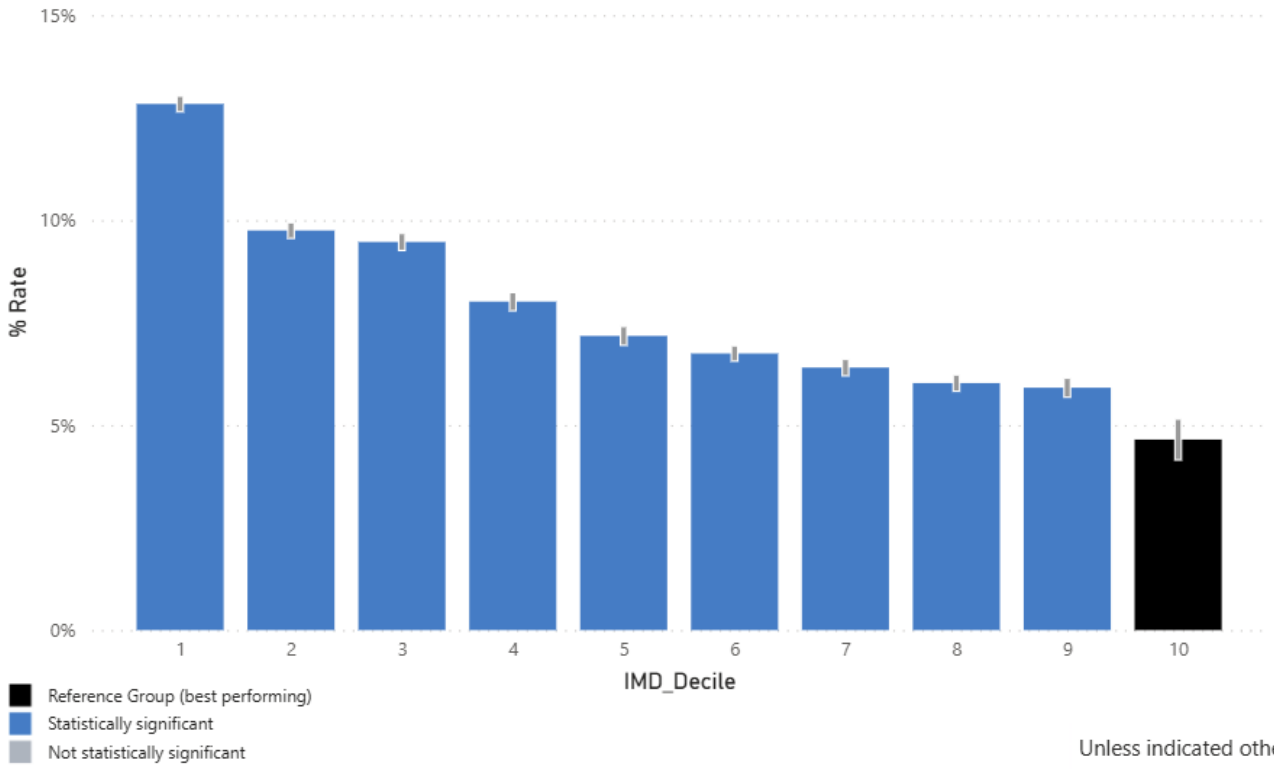
The Did Not Attend instances broken down by IMD decile for the 12month period ending as the end of last month

Important Considerations When Interpreting Results:

Select Measure

DNAs All IMD

DNAs All IMD



Attended	Count DNA	Total Observations
567,072	53,789	620,861

IMD_Decile	Rate	Attended	Count DNA
1	12.83%	102,850	15,144
2	9.75%	83,668	9,036
3	9.47%	68,905	7,206
4	8.01%	52,578	4,580
5	7.18%	45,364	3,507
6	6.75%	64,318	4,654
7	6.40%	53,857	3,685
8	6.03%	51,528	3,304
9	5.91%	37,459	2,354
10	4.65%	6,545	319

Unless indicated otherwise, the date range of the data source is the previous 12 full calendar months

All DNAs by Ethnicity

DBTH Digital Transformation

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

0.28
Equity Index

Definition

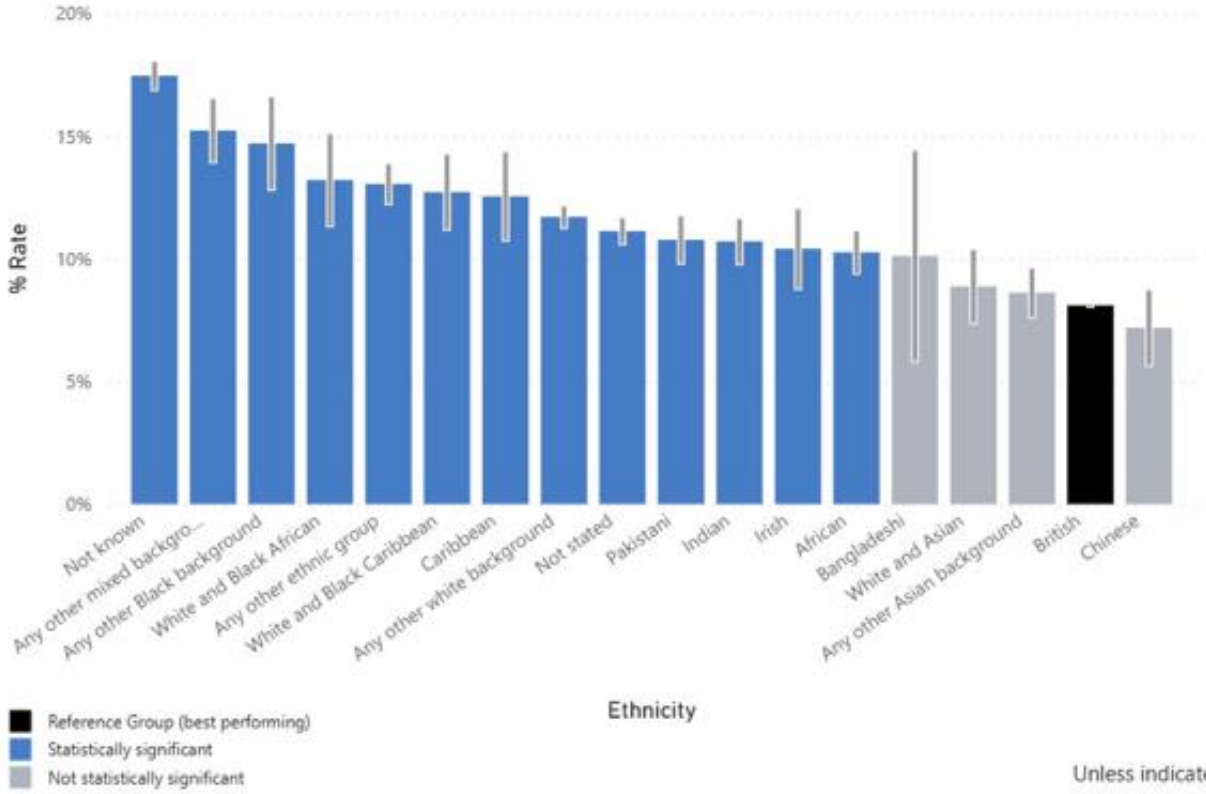
All DNAs by Ethnicity last 12 months ending last month

Important Considerations When Interpreting Results:

Select Measure

All DNAs by Ethnicity

All DNAs by Ethnicity



Attended	Count DNA	Total Observations
561,902	53,468	615,370

Ethnicity	Rate	Attended	Count DNA
Chinese	7.18%	982	76
British	8.09%	491,598	43,299
Any other Asian background	8.61%	2,684	253
White and Asian	8.87%	1,233	120
Bangladeshi	10.11%	169	19
African	10.26%	4,085	467
Irish	10.40%	1,180	137
Indian	10.70%	3,688	442
Pakistani	10.77%	3,381	408
Not stated	11.12%	11,316	1,416
Any other white background	11.70%	15,957	2,114
Caribbean	12.54%	1,116	160
White and Black Caribbean	12.71%	1,559	227
Any other ethnic group	13.04%	5,481	822
White and Black African	13.20%	1,065	162
Any other Black background	14.69%	1,132	195
Any other mixed background	15.22%	2,457	441
Not known	17.45%	12,819	2,710

Unless indicated otherwise, the date range of the data source is the previous 12 full calendar months

Maternity DNAs IMD

DBTH Digital Transformation

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

0.24

Equity Index

Definition

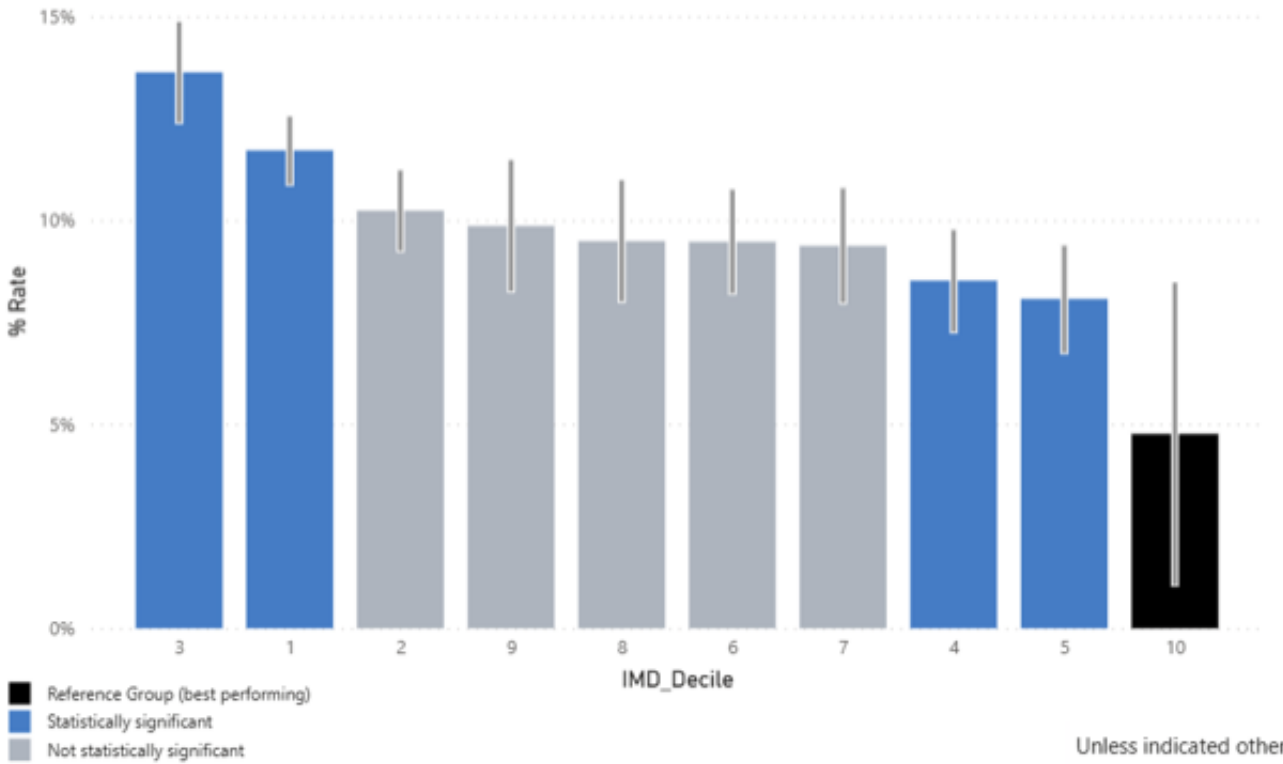
The Did Not Attend instances broken down by IMD decile for the 12month period ending as the end of last month, for maternity appointments

Important Considerations When Interpreting Results:

Select Measure

Maternity DNAs IMD

Maternity DNAs IMD



Attended	Count DNA	Total Observations
19,531	2,294	21,825

IMD_Decile	Rate	Attended	Count DNA
3	13.63%	2,472	390
1	11.71%	4,887	648
2	10.23%	3,158	360
9	9.86%	1,161	127
8	9.49%	1,316	138
6	9.47%	1,787	187
7	9.37%	1,460	151
4	8.51%	1,699	158
5	8.06%	1,471	129
10	4.76%	120	6

Unless indicated otherwise, the date range of the data source is the previous 12 full calendar months

ED Left Without being seen Ethnicity

0.20
Equity Index

Definition

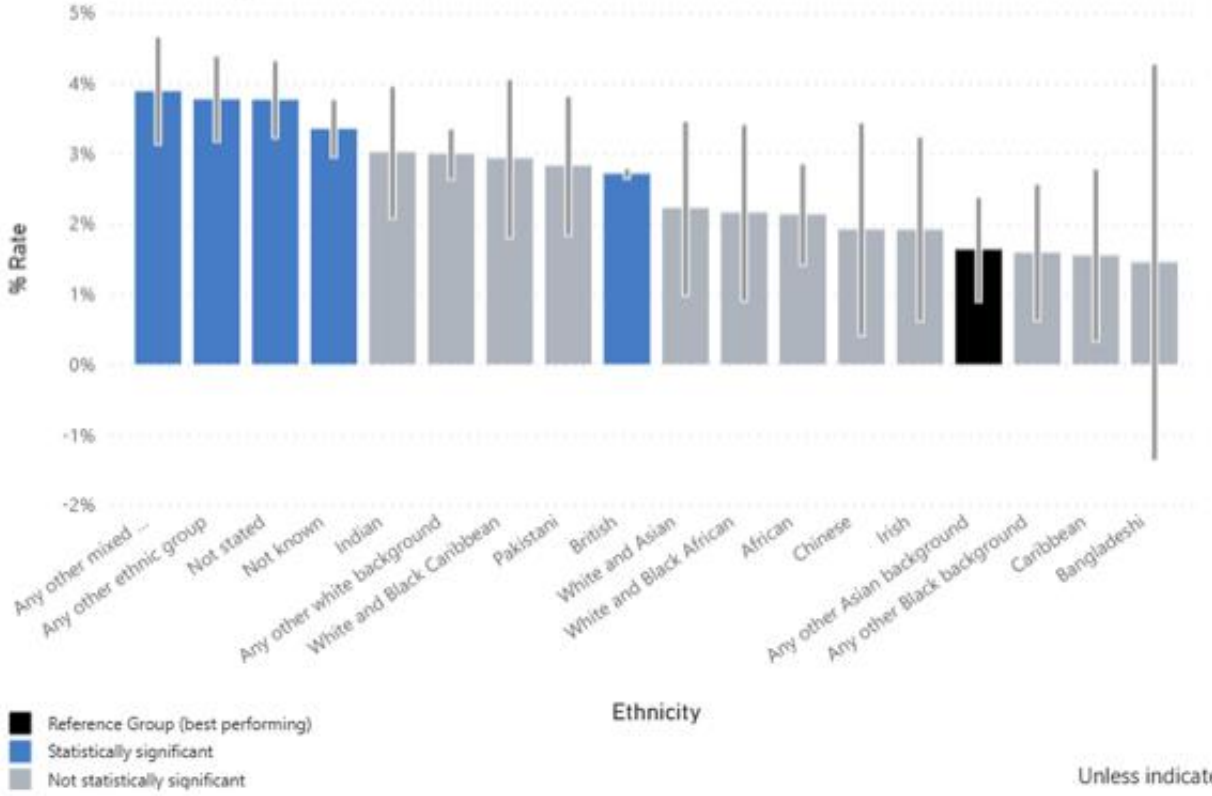
ED Left Without being seen Ethnicity last 365 days data

Important Considerations When Interpreting Results:

Select Measure

ED Left Without being seen Ethnicity

ED Left Without being seen Ethnicity



Attended	Left W/O being seen	Total Observations
212,768	6,070	218,838

Ethnicity	Rate	Attended	Left W/O being seen
Bangladeshi	1.45%	68	1
Caribbean	1.55%	382	6
Any other Black background	1.58%	621	10
Any other Asian background	1.63%	1,087	18
Irish	1.91%	410	8
Chinese	1.92%	307	6
African	2.13%	1,517	33
White and Black African	2.15%	500	11
White and Asian	2.22%	529	12
British	2.71%	178,723	4,970
Pakistani	2.82%	1,034	30
White and Black Caribbean	2.92%	830	25
Any other white background	2.99%	8,252	254
Indian	3.01%	1,224	38
Not known	3.35%	6,984	242
Not stated	3.76%	4,374	171
Any other ethnic group	3.77%	3,600	141
Any other mixed background	3.88%	2,326	94

Unless indicated otherwise, the date range of the data source is the previous 12 full calendar months

2509 - C1 PEOPLE

2509 - C1 JOB EVALUATION ? UPDATED NURSING & MIDWIFERY PROFILES AND DATA COLLECTION FOR BOARD OVERSIGHT

Discussion Item | Zoe Lintin, Chief People Officer | 11:05

5 minutes

REFERENCES

Only PDFs are attached

C1 - Job Evaluation - Updated Nursing & Midwifery Profiles & Data Collection.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Job Evaluation – Updated Nursing & Midwifery Profiles and Data Collection**			
Executive Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance			
Appendices:	None			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	The requirements outlined in this paper link to BAF risk 2 – Our People and Culture			

Executive Summary – Key messages and Issues

Purpose of the Report

This report provides the information necessary for the Board to be aware of the national and local work underway on the nursing and midwifery profiles and the data collection that is required to support this.

Summary

The 2023 Agenda for Change (AfC) pay deal included ten commitments to look at issues that impact NHS employees that are not linked directly to pay. This work supports with that national commitment for accurate and consistent application of the NHS Job Evaluation Scheme (JES). As part of this workstream there will be a requirement for providers to support with a national data collection exercise early in Autumn 2025 and there are expectations of Trust boards in relation to awareness and oversight. The following are the key requirements for the Board to note:

- For boards to be aware of these requirements and to have appointed a Board Level SRO to sponsor the JE process. For DBTH this is Zoe Lintin, Chief People Officer
- DBTH are already engaging fully with this process and are getting ready to deliver the requirements of this request
- At an operational level this is managed through the SRO oversight within the Trust
- The Executive has ongoing oversight through the Executive Team meeting
- The People Committee monitor assurance of these processes through more detailed scrutiny and reporting, with an update on the nursing profiles work being reported at the June 2025 meeting.

DBTH are committed to ensuring robust JE practice and continue to support this process.

Recommendations

The Board of Directors is asked to:

- note the workstreams outlined above at national and local level
- take assurance on the monitoring and management of this work at DBTH

Healthier together – delivering exceptional care for all

Patients	Adherence to the JES supports the delivery of safe and effective services.
People	Adherence to the JES retains our people and supports them to deliver safe and effective care.
Partnerships	Adherence to the JES supports consistency across our partner organisations.
Pounds	Adherence to the JES supports effective use of resources and consistency of pay.
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities while none have been identified in this paper.

<table>
<tr><td>Legal/ Regulation</td><td>Adherence to the JES ensures compliance to the national regulations.</td></tr>
<tr><td>Partner ICB strategies</td><td>These documents have no positive or negative impact on ICB Strategies.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Executive Team 20/08/2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>These requirements will continue to be monitored through the People Committee and have executive oversight</td></tr>
<tr><td>In line with Current risk appetite

Yes</td><td>Risk Appetite levels: - highlight only if this report is outside of Board Assessment
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
</table>

2509 - D ASSURANCE & GOVERNANCE

11:10

2509 - D1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 11:10

20 minutes

REFERENCES

Only PDFs are attached

D1 - Integrated Quality & Performance Report.pdf

D1 - IQPR July 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Integrated Quality & Performance Report**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Acting Executive Medical Director Sam Wilde, Chief Finance Officer Denise Smith, Chief Operating Officer			
Appendices:	None			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			

Executive Summary – Key messages and Issues

Access

4 of the 14 available measures were on track for this month. The Trust was 0.2% off plan for the 4-hour emergency care standard in July; it is noted that ED attendances were 1.98% above plan. Ambulance handover performance improved across all four metrics and the plan to eliminate 45-minute handovers at Doncaster was implemented during the month. The Trust is in Tier 2 for Elective Care, due to the long waits in ENT and Trauma & Orthopaedics, improvement plans are in place for both specialties. The Trust delivered the 31-day cancer standard and was off plan for 62-day performance in month.

Quality

11 of the 26 available measures were on track for this month. A recent mortality deep dive (to be presented to the Board's Quality Committee in October 2025) reviewed the mortality improvement work that has taken place since the beginning of 2023, and the impact of this. Improvements have been made across all areas of mortality performance, including clinical coding, sepsis, structured judgement reviews highlighting good care, and mortality governance. Plans are in place to continue and sustain the current improvement trend. There is a focus on NICE compliance at Effective Committee to improve quality of care.

Finance

3 of the 10 available measures were on track for this month.

People

2 of the 7 available measures were on track for this month. Focus remains on medical appraisal and job plan performance with robust processes embedded. In an email from the Regional Medical Director in August 2025, the acting Executive Medical Director and team were commended on job planning improvement and the development of robust systems and processes, with a request to share successes with others.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board is asked to receive the report for assurance.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>Regular review and assessment of Trust performance support the delivery of safe and effective services.</td></tr>
<tr><td>People</td><td>Regular review and assessment of Trust Performance, support our people to deliver safe and effective care.</td></tr>
<tr><td>Partnerships</td><td>This paper has no positive or negative impact on partnerships.</td></tr>
<tr><td>Pounds</td><td>Regular review and assessment of Trust Performance, supports delivery of the strategic priority to be sustainable and spend money wisely.</td></tr>
<tr><td>Health Inequalities</td><td>Health inequality data is not currently broken down in the IQPR .</td></tr>
<tr><td>Legal/ Regulation:</td><td>CQC (reg 12) - Safe Care and Treatment
NHSE - National Quality Board staffing reporting requirements</td></tr>
<tr><td>Partner ICB strategies</td><td>The document has no positive or negative impact on ICB Strategies.</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Contents shared with Finance & Performance Committee, Quality Committee and People Committee</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

N/A</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
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</table></td></tr>
</table>

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

July 2025

Contents

1. Executive Summary

2. Key Performance Indicators

3. Assurance reports
   - Assurance reports are currently generated where a metric is falling short in month against a local or national target.

Executive Summary

Access

4 of the 14 available measures were on track for this month. The Trust was 0.2% off plan for the 4-hour emergency care standard in July; it is noted that ED attendances were 1.98% above plan. Ambulance handover performance improved across all four metrics and the plan to eliminate 45-minute handovers at Doncaster was implemented during the month. The Trust is in Tier 2 for Elective Care, due to the long waits in ENT and Trauma & Orthopaedics, improvement plans are in place for both specialties. The Trust delivered the 31-day cancer standard and was off plan for 62-day performance in month.

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What is an SPC chart

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Recalculations

After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines

Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons

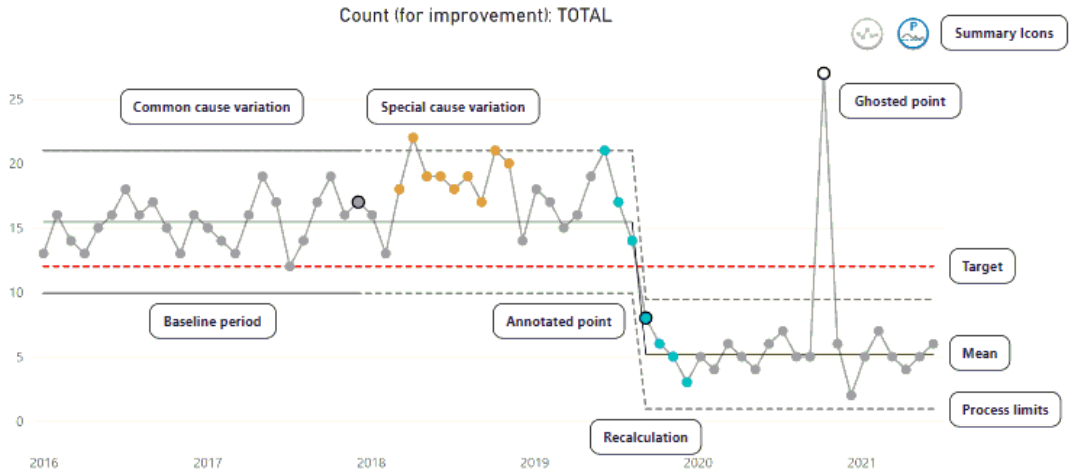
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

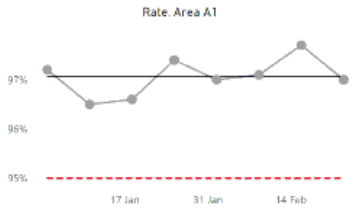
Annotations

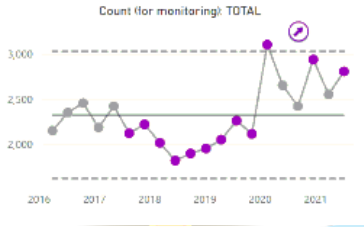
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.





Icon descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(common cause)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(blank)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

At a glance

	Will consistently achieve the target if nothing changes	Will not consistently pass or fall below the target if nothing changes.	Will consistently fall below the target if nothing changes	No Target
Improving variation (High or Low).	NICE Guidance Response Rate Compliance	NICE Guidance % Non & Partial Compliance Completed SET Training MSA 31 day combined 12 hours in department Ambulance handovers - 60 minutes Average Ambulance handover times HAPU Cat 4	4 hour Performance Ambulance handovers - 15 minutes Ambulance handovers - 30 minutes Ambulance handovers - 45 minutes Consultants Signed off Job Plans	Percentage of patients waiting no longer than 18 weeks for a first appointment
No significant change.	Planned Vs Actual CHPPD RN Planned Vs Actual CHPPD RM	VTE Faster Diagnosis Standard 62 day combined MRSA Cases Reported in Month COHA & HOHA C.Diff cases in month % Over 18 in-hospital deaths scrutinised by Medical Examiner Team Cancelled Operations Never Events PSIIs in Month SHMI Monthly E-Coli MSSA Klebsiella Pseudominas Planned Vs Actual CHPPD Total	FFT (% positive) – Trust SEPSIS 1 Hour Screening SEPSIS 1 Hour Antibiotics Overall Sickness Absence Time to Hire	Number of Complaints Received in Month Claims CNST (patients) - new in month Claims LTPS - (staff) new in month
Concerning variation (High or Low).		% patients waiting less than 18 weeks from referral to treatment	RTT % waits over 52 weeks for incomplete pathways SHMI (12 month rolling)	Severe harm falls
Variance where up or down is may not be improving or concerning.				

Metric notes

Metrics with a * denote that the figures for the metric will always show a Year to Date (YTD) position when being reported for the most recent month. This is because the metric is showing the current number of patients who are actively waiting for further action (appointment/admission/test) to take place which would cause their waiting time clock to stop. Therefore, the most recent month and year to date position will always match.

Metrics with a ** denote that these figures are based on a rolling 12-month position therefore, the most recent month and year to date position will always match.

Metrics with a *** denote that these figures are based on snapshot taken of the current number of open incidents therefore, the most recent month and year to date position will always match.

Key performance indicators - Access

					Current month			Year to date				
Group	Section	Metric	Standard/ threshold 25/	Latest mo reported	Local ta	Actual	Varianc	Local tar	Actual	Varian	Assur e Stal	Variat Stat
Access	UEC	4 hour ED	78% by March 2026	Jul-25	74.1%	73.9%	-0.2%	73.4%	74.3%	0.9%	F	H
Access	UEC	12 hours in department	No more than 2%	Jul-25	2.0%	2.2%	0.2%	2.0%	2.4%	0.4%	?	L
Access	UEC	Ambulance handovers - 15 minutes	65%	Jul-25	N/A	53.6%	-11.4%	65.0%	48.0%	-17.0%	F	H
Access	UEC	Ambulance handovers - 30 minutes	95%	Jul-25	N/A	88.7%	-6.3%	95.0%	84.0%	-11.0%	F	H
Access	UEC	Ambulance handovers - 45 minutes	0%	Jul-25	N/A	3.4%	3.4%	0.0%	6.0%	6.0%	F	L
Access	UEC	Ambulance handovers - 60 minutes	0%	Jul-25	N/A	1.4%	1.4%	0.0%	2.6%	2.6%	?	L
Access	UEC	Average ambulance handover times	N/A	Jul-25	22	00:17:52	00:04:08	23	00:20:11	00:02:49	?	L
Access	Diagnostics	Diagnostic waiting times*	Operational guidance 95%	July 25 data not reported. Extension granted for national submission due to go-live of new Radiology system.								
Access	Elective Care	% patients waiting less than 18 weeks from referral to treatment*	63.6%	Jul-25	60.8%	61.3%	0.5%	60.8%	61.3%	0.5%	?	L
Access	Elective Care	RTT % waits over 52 weeks for incomplete pathways *	< 1% by March 2026	Jul-25	0%	3.1%	3.1%	0%	3.1%	3.1%	F	H
Access	Elective Care	Percentage of patients waiting no longer than 18 weeks for a first appointment *	72% by March 2026	Jul-25	N/A	71.0%			71.0%			H
Access	Cancer	28 day Faster Diagnosis Standard	80% by March 2026	Jun-25	81.5%	82.6%	1.1%	81.4%	78.5%	-2.9%	?	
Access	Cancer	31 day combined	96%	Jun-25	96.0%	97.2%	1.2%	96.0%	97.0%	1.0%	?	H
Access	Cancer	62 day combined	>= 75% by March 2026	Jun-25	73.5%	70.0%	-3.5%	73.4%	72.7%	-0.7%	?	
Access	Elective Care	Cancelled Operations Not Rebooked within 28 Days	0	Jul-25	0	3	3	0	19	19	?	
Access	Patient flow	Mixed Sex Accommodation - nationally reported breaches in month	0	Jul-25	0	1	1	0	4	4	?	L

Key performance indicators - Quality

					Current month			Year to date				
Group	Section	Metric	Standard/ threshold 25/26	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Quality		Workbook last modified: Just now Rolling)	<100	Apr-25	100	114.0	14.0	100	114.0	14.0	F	H
Quality	Mortality	SHMI (Monthly)	<100	Apr-25	100	107.6	7.6	100	107.6	7.6	?	?
Quality	IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month		Jul-25	1	2	1	4	9	5	?	?
Quality	IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0	Jul-25	0	0	0	0	0	0	?	?
Quality	IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month		Jul-25	5.8	7	1.2	20.6	30	9.4	?	?
Quality	IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month									?	?
Quality	IPC	Overall Number of HAPUs / 1000 bed days										
Quality	IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4		Jul-25	0	0	0	0	0	0	?	L
Quality	IPC	e.coli		Jul-25	6.1	6	-0.1	32.1	36	3.9	?	?
Quality	IPC	MSSA		Jul-25	1.1	6	5	10.8	24	24	?	?
Quality	IPC	Klebsiella		Jul-25	0.9	5	4	9.6	10	0.4	?	?
Quality	IPC	Pseudomonas		Jul-25	3.8	0	-3.8	13.5	6	-7.5	?	?
Quality	Falls	Severe harm falls	0	Jul-25	0	2	2	0	6	6		H

Key performance indicators - Quality

				Current month			Year to date				
Section	Metric	Standard/ threshold 25/26	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Complaints	Number of Complaints Received in Month		Jul-25	0	57	57	0	239	239		
Claims	Claims CNST (patients) - new in month		Jul-25	0	6	6	0	28	28		
Claims	Claims LTPS - (staff) new in month		Jul-25	0	0	0	0	0	0		
FFT	Friends & Family Positive Response Score - Trust		Jul-25	95%	89.2%	-5.8%	95%	88.6%	-6.4%	F	
Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%	Jul-25	100%	100.0%	0%	100%	100.0%	0%	?	
Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%	Jul-25	95%	97.5%	2.5%	95%	97.1%	2.1%	?	
Nice Guidance	NICE Guidance Response Rate Compliance	90%	Jul-25	90%	97.5%	7.5%	90%	97.4%	7.4%	P	H
Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%	Jul-25	10%	8.9%	-1.1%	10%	8.6%	-1.4%	?	L
CHPPD	Planned Vs Actual CHPPD RM	90%	Jul-25	90%	86.1%	-3.9%	90%	88.1%	-1.9%	?	
CHPPD	Planned Vs Actual CHPPD RN	90%	Jul-25	90%	97.8%	7.8%	90%	99.2%	9.2%	P	
CHPPD	Planned Vs Actual CHPPD Total	90%	Jul-25	90%	96.6%	6.6%	90%	98.1%	8.1%	P	
Sepsis	Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of	90%	Jul-25	90%	53.1%	-36.9%	90%	47.7%	-42.3%	F	
Sepsis	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic reatment within 1 hour of diagnosis	90%	Jul-25	90%	59.0%	-31.0%	90%	59.7%	-30.3%	F	
Patient Safety	Never Events - Reported in month	0	Jul-25	0	0	0	0	0	0	?	
Patient Safety	PSIIs reported in month		Jul-25	0	1	1	0	4	4	?	

Key performance indicators - Finance

Metric	Standard/threshold 24/25	Latest month reported	Current month				Year to date (YTD)			
			Plan £'000	Actual £'000	Variance £'000		Plan £'000	Actual £'000	Variance £'000	
YTD distance from financial plan I&E	No variance to plan	Jul-25	(211)	(208)	3	A	1,858	1,857	(1)	F
ERF position	Month 11 FOT 2024-25	Jul-25	10,978	11,083	105	F	39,617	41,688	2,071	F
CIP delivery -vs Plan	No variance to plan	Jul-25	3,069	3,070	0	A	9,358	9,358	0	F
Total pay spend against plan		Jul-25	34,585	36,650	2,065	A	137,240	142,471	5,231	A
Reduction in Additional sessions	24/25 spend - 40% reduction	Jul-25	774	1,838	1,064	A	3,096	6,077	2,981	A
Reduction in Bank pay	24/25 spend - 10% reduction	Jul-25	1,346	1,376	30	A	5,384	5,571	186	A
Reduction in Agency pay	24/25 spend - 40% reduction	Jul-25	671	1,254	582	A	2,685	4,474	1,789	A
Capital position YTD versus plan	No variance to plan	Jul-25	5,474	285	(5,189)	F	17,417	2,377	(15,040)	F
Cash balance	No variance to plan	Jul-25	15,815	22,405	6,590	F	15,815	22,405	6,590	F
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Jul-25	95.0%	81.3%	-13.7%	A	95.0%	81.3%	-13.7%	A

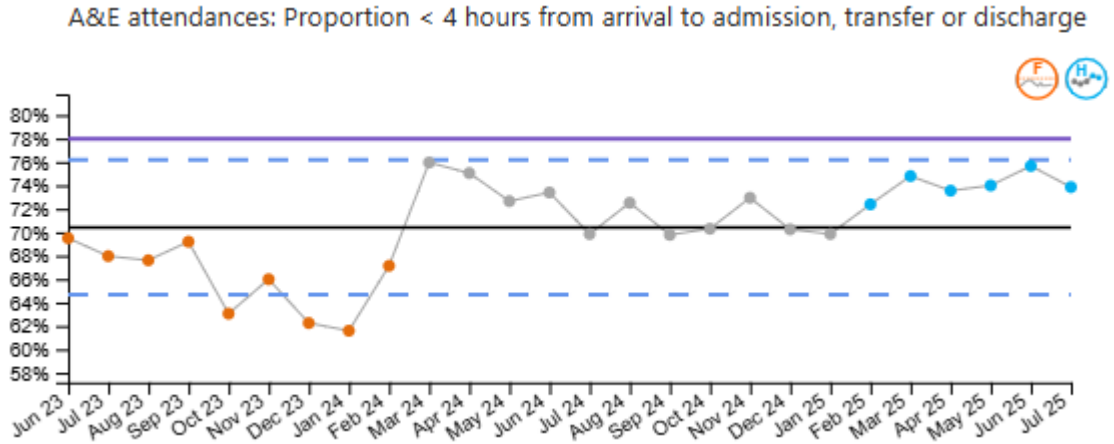
Key performance indicators - People

			Current month			Year to date				
Metric	Standard/ threshold 25/26	Latest month reported	Local target	Actual	Variance	Local target	Actual	Variance	Assurance Status	Variation Status
Consultants with Signed Off Job Plans in EJP	90%	Jul-25	90%	76.0%	-14.0%	90%	76.5%	-13.5%	F	H
Employee Turnover	10%	Jul-25	10%	10.4%	0.4%	10%	10.4%	0.4%	F	
Overall Sickness Absence	5%	Jul-25	5.0%	5.7%	0.7%	5.0%	5.8%	0.8%	F	
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days	Jul-25	47	59.6	12.6	47	59.6	12.6	F	
Completed SET Training	90%	Jul-25	90.0%	90.5%	0.5%	90.0%	90.0%	0.0%	?	
Completed Appraisals	90% end July	Jul-25	90.0%	93.3%	3.3%					
Medical Appraisals completed	90%	Jun-25	90.0%	64.0%	-26.0%	90.0%	64.0%	-26.0%	F	H

Assurance report

A&E attendances: Proportion < 4 hours from arrival to admission, transfer or discharge

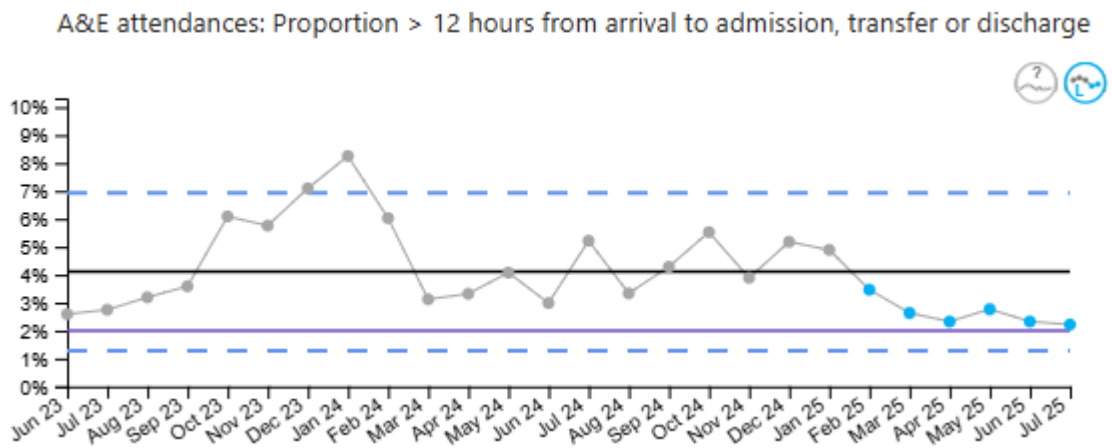
Summary of challenges & risks	In July 2025, 73.9% of patients were in the Emergency Department < 4 hours from arrival, against the local trajectory of 74.1%. Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Emergency Department attendances were above plan in July, with 18,807 patients attending, against the plan of 18,441. Actions to address the underperformance include: • Maximising streaming to the primary care front door services at Bassetlaw and Doncaster • Improving the proportion of patients seen by a senior decision maker within 60 minutes of arrival • Improving non-admitted performance, with appropriate allocation of medical staff to these patients, particularly during peaks in demand • Implementation of the new rota for Resident Doctors, moving from a 9 / 10 hour shift to an 8 hour shift • Review of the clinical observation process to identify any opportunities to improve efficiency
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care



Assurance report

A&E attendances: Proportion > 12 hours from arrival to admission, transfer or discharge

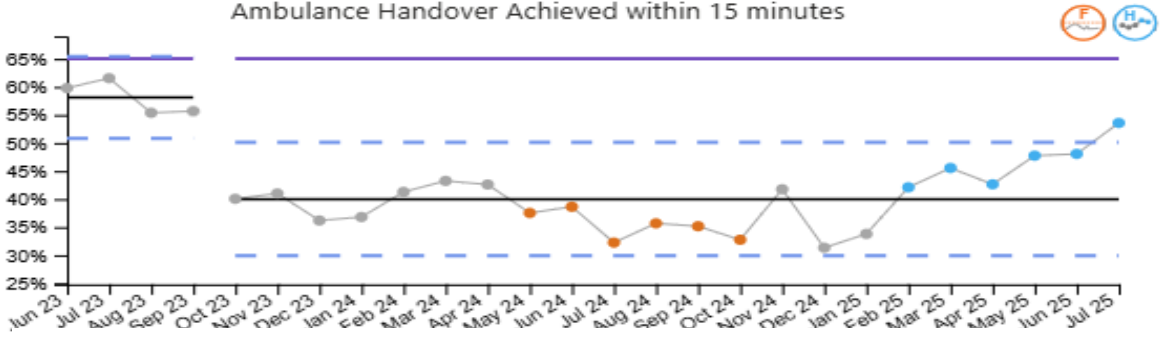
Summary of challenges & risks	In July 2025, 2.2% of patients were in the Emergency Department > 12 hours from arrival, against the national standard of no more than 2% Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sustained improvements since the winter period are noted, with July 2025 showing the best performance in 24 months. Actions to sustain the improvements include: • Maximising streaming to the primary care front door services at Bassetlaw and Doncaster • Improving the proportion of patients seen by a senior decision maker within 60 minutes of arrival • Implementation of the 'Next Patient' SOP to maintain flow out of the Emergency Department to inpatient beds and to maximise utilisation of the discharge lounge. • Implementation of the patient tracker across the Division of Surgery to take place in August 2025, this will support timely decision making for surgical patients
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

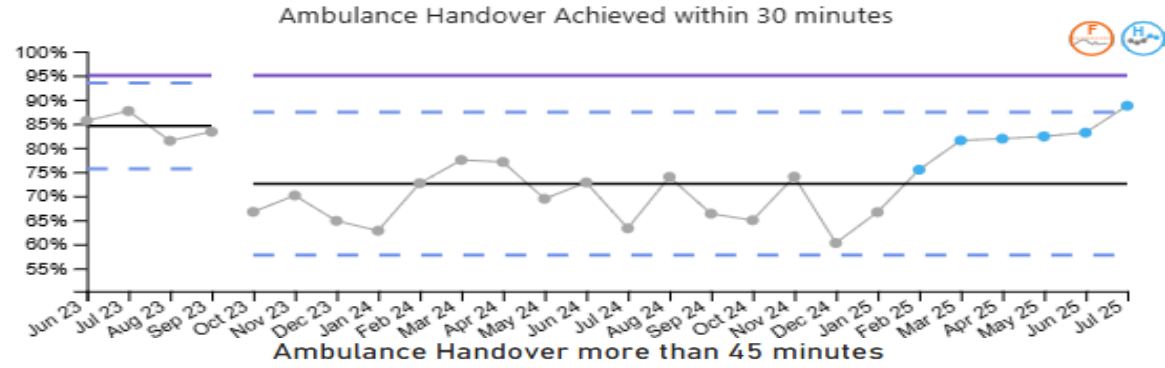


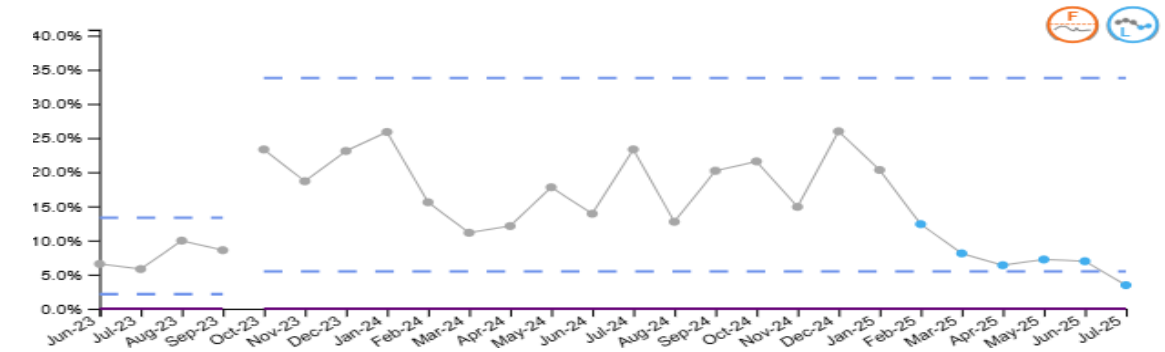
Assurance report

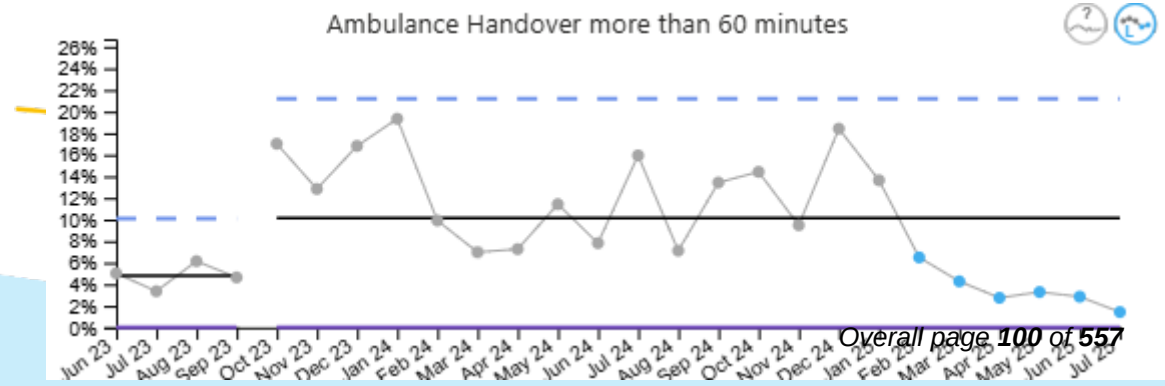
Ambulance handover within 15/30/45/60 mins

Summary of challenges & risks	In July 2025, 53.6% of ambulance handovers took place within 15 minutes against the standard of 65%, 88.7% took place within 30 minutes against the standard of 95%, and 98.6% took place within 60 minutes against the standard of 100%. 96.6% were within 45 minutes. **Ambulance Handover 15 and 30 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. **Ambulance Handover 45 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. **Ambulance Handover 60 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits. Re-basing has taken place in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sustained improvement has been seen across all metrics. A joint improvement plan is in place with YAS to eliminate handover waits > 45 minutes from July 2025 at Doncaster, this will then be rolled out to Bassetlaw, in conjunction with EMAS.
Action timescales and assurance group or committee	Eliminating handovers > 45 minutes from mid July 2025. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care





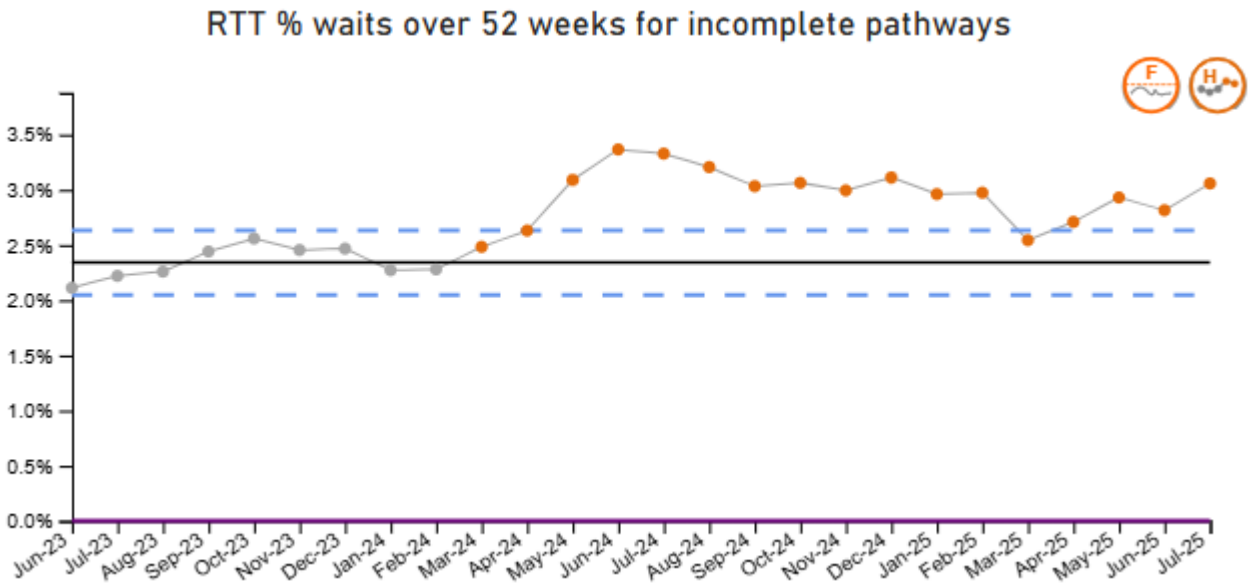




Assurance report

RTT % waits over 52 weeks for incomplete pathways

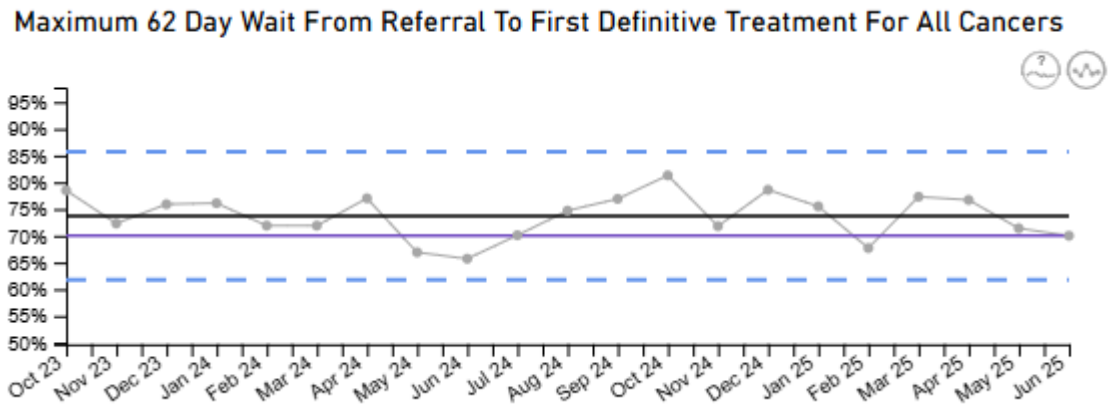
Summary of challenges & risks	In July 2025 3.1% of the patients on an incomplete pathway have been waiting for more than 52 weeks against the standard of no more than 1% by March 2026. Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The Elective Improvement Support Team is working with the Trust to undertake demand and capacity modelling for T&O and ENT and will support with the development of improvement plans to reduce the number and proportion of long waiting patients.
Action timescales and assurance group or committee	Improvement trajectory to be agreed. Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



Assurance report

Cancer 62 day wait from referral to first definitive treatment for all cancers

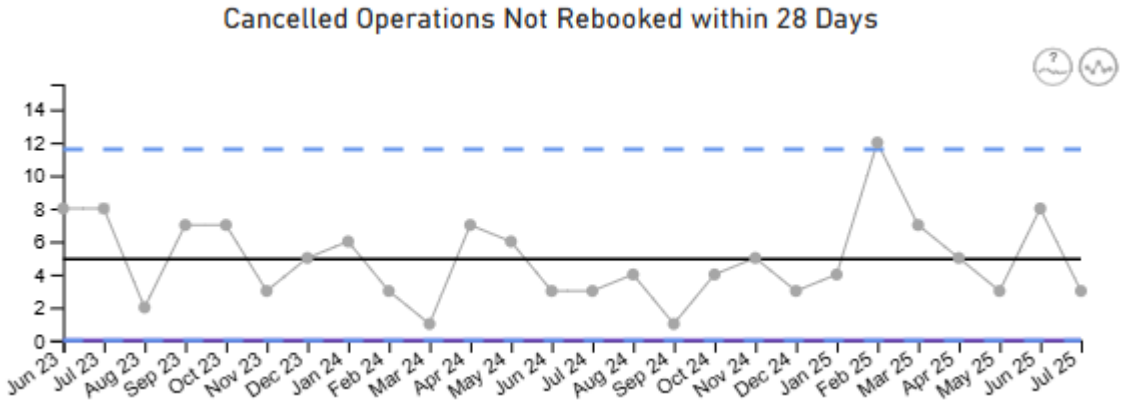
Summary of challenges & risks	In June 2025, 70% of patients had a maximum wait of 62 days from referral to first definitive treatment for all cancers against the trajectory of 73.5%. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The following tumour sites are delivering, or ahead of, plan in June 2025: Lung, Skin, Upper GI The following tumour sites are off plan in June 2025: Breast, Gynaecology, Haematology, Head & Neck, Lower GI, Urology Key factors causing the underperformance include: • Diagnostic and staging capacity pressures, in particular for those patients required tertiary centre input • Capacity pressure in Breast services Key actions to improve performance include: • Review of the LGI straight to test pathway • Review of the PTL process and escalation process implemented • Additional capacity at tumour site level where this can be sourced
Action timescales and assurance group or committee	Monthly trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	N/A



Assurance report

Cancelled Operations Not Rebooked within 28 Days

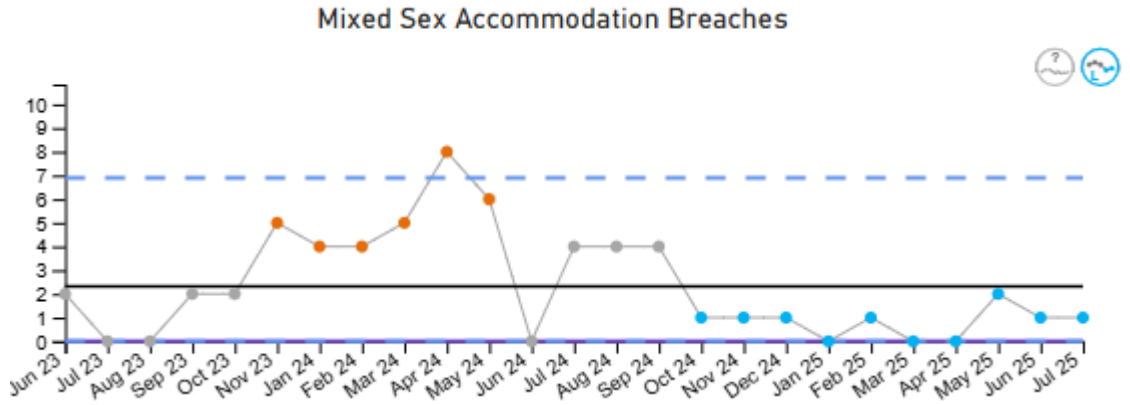
Summary of challenges & risks	There were 3 breaches of the 28-day guarantee in July 2025. Common variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	As part of the Theatre Improvement Programme for 2025/26 the escalation process for on the day cancellations is under review to ensure the Divisional Leadership Team is aware of any potential cancellations prior to cancellation so actions can be taken to avoid where possible. Within the Division of Surgery, the monitoring process for re-booking any patients within 28 days is also being reviewed to ensure operational oversight and escalation where a patient is not re-booked within 28 days.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



Assurance report

Mixed Sex Accommodation

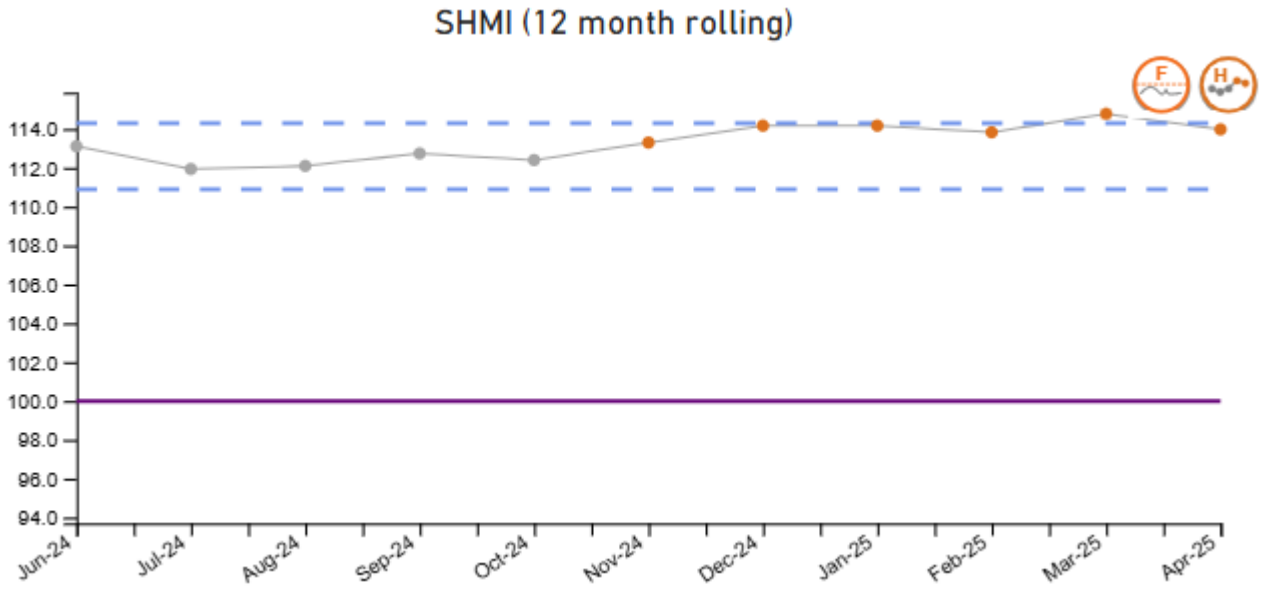
Summary of challenges & risks	There was 1 mixed sex accommodation breach in July 2025. Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The breach occurred due to a delay in step down from Critical Care at Bassetlaw as a suitable ward bed was not available within the required timescales. A robust escalation process in place, with 3 x daily touchpoints to monitor progress as part of the Capacity and Flow meetings
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

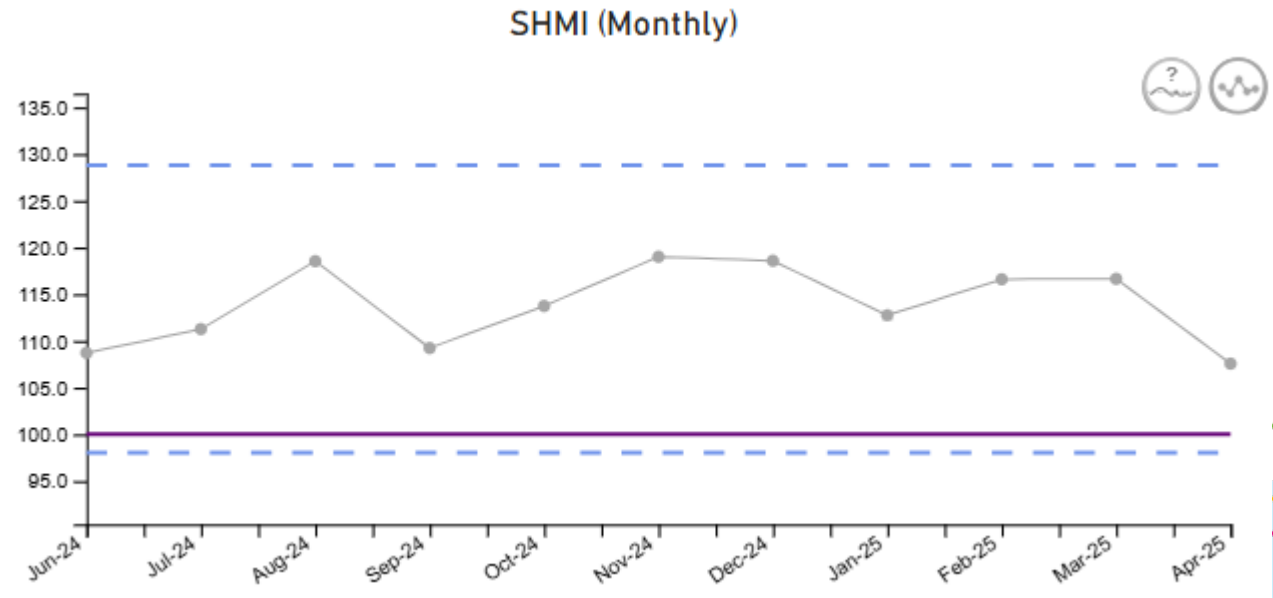


Assurance report

SHMI

Summary of challenges & risks	The 12 month rolling SHMI in April 2025 was 114.0. Monthly SHMI in April 2025 was 107.6. **SHMI (12 month rolling)** Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. **SHMI (Monthly)** Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Action Plans in place to recover mortality position. Now starting to show improvement as seen in the SHMI monthly and 12 month rolling data. • This is mirrored in improvements with clinical coding and depth of coding which benefits the accuracy of SHMI scores. • Forecast data to May 2025 shows a predicted continuation of this trend with the Trust mortality rate returning within expected range.
Action timescales and assurance group or committee	Action plans ongoing to ensure focus on mortality and sustained improvement. Monitored via the Mortality Data Assurance Group.
Risk register	No

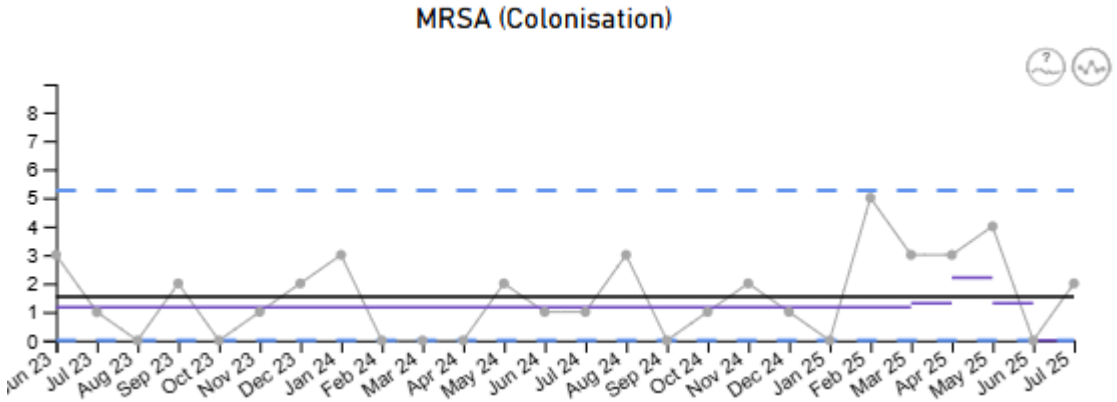




Assurance report

Hospital acquired MRSA cases reported in month

Summary of challenges & risks	In July 2025 there were 2 cases of Hospital Acquired MRSA (Colonisation) Cases Reported in Month Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Monitoring and surveillance of all cases to facilitate timely isolation of patients and decolonisation treatment. Review of cases with clinical teams Typing of cases where required to inform further actions if required. Screening regimes include screening of all admissions, weekly for patients with invasive devices and monthly for long stay patients. Enhanced cleaning of side rooms accommodating patients with MRSA. Deep clean programme Education of staff on risks and transmission
Action timescales and assurance group or committee	All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group All actions are ongoing business as usual
Risk register	N/A

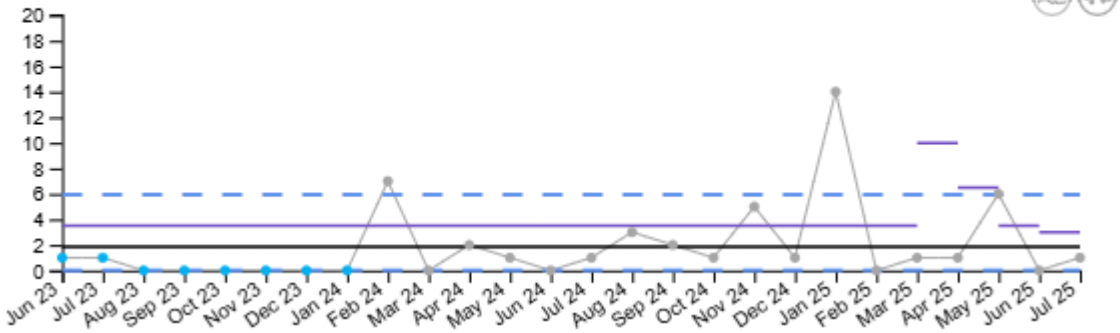


Assurance report

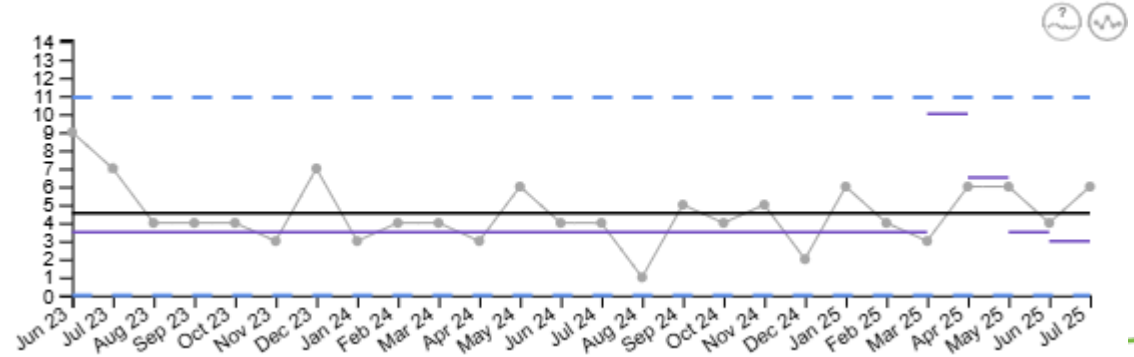
Number of C.Diff cases in month

Summary of challenges & risks	In July 2025 there were 7 cases of Hospital or Community Onset Healthcare associated C.Diff cases Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ongoing project to 'search' for carriers so that they can be proactively managed before CDI develops. Weekly review of all cases by DIPC and DDIPC Review of cases for identification of new learning Feedback through divisional governance Quality summit where appropriate FOCUS weeks in areas of concern AMS – audit, surveillance and feedback Project underway to improve diagnostic stewardship to narrow antibiotic use Routine IPC interventions and hand hygiene Deep clean programme Follow up of patients for three months in the community post discharge Communication through Accurx with GPs Diagnostic stewardship in community care home residents – review of antibiotic prescriptions and sensitivities to support AMS
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	Risk ID 3517

Number of Community Onset Healthcare associated (COHA) C.Diff cases in month



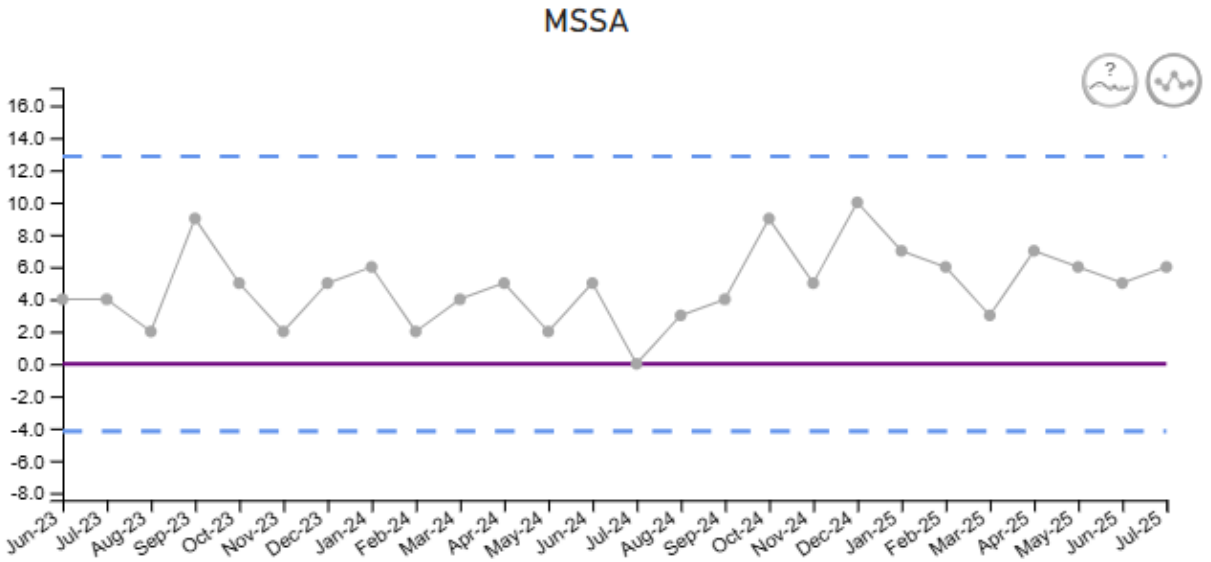
Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month



Assurance report

MSSA

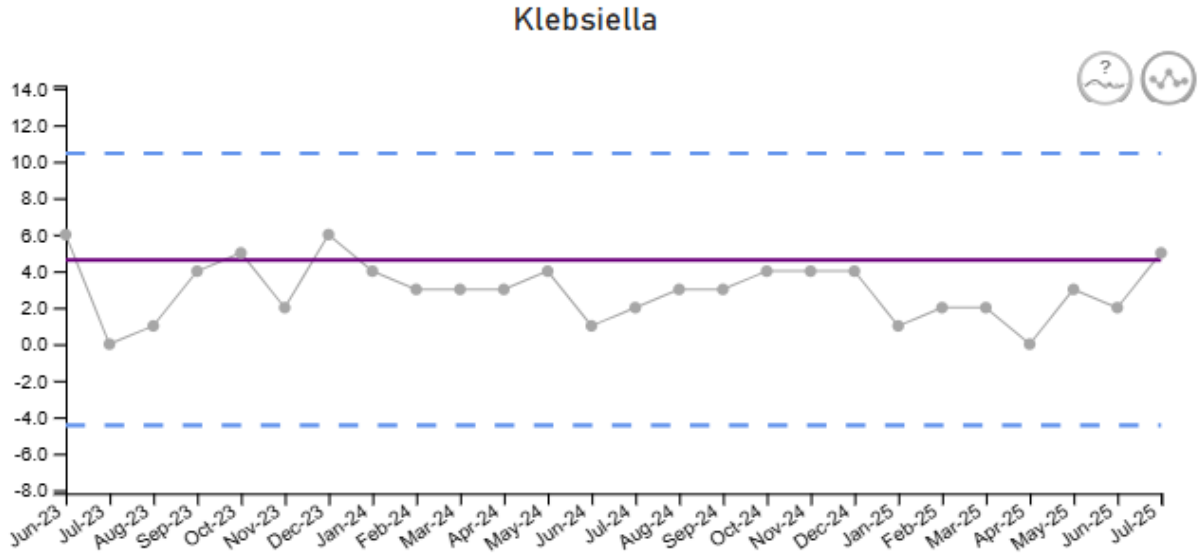
Summary of challenges & risks	In July 2025 there were 6 cases of MSSA. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	MSSA is carried on the skin of third of the population as normal bacteria. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepucture. Extensive work underway in ED and AMU DRI in relation to blood culture taking, volumes, diagnostic stewardship, time to analyser. Specific QI project within Renal – screening and decolonisation of patients who have invasive lines. Chlorhexidine dressings used. Ongoing education and surveillance in relation to VIP scoring/line care across the organisation.
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

Klebsiella

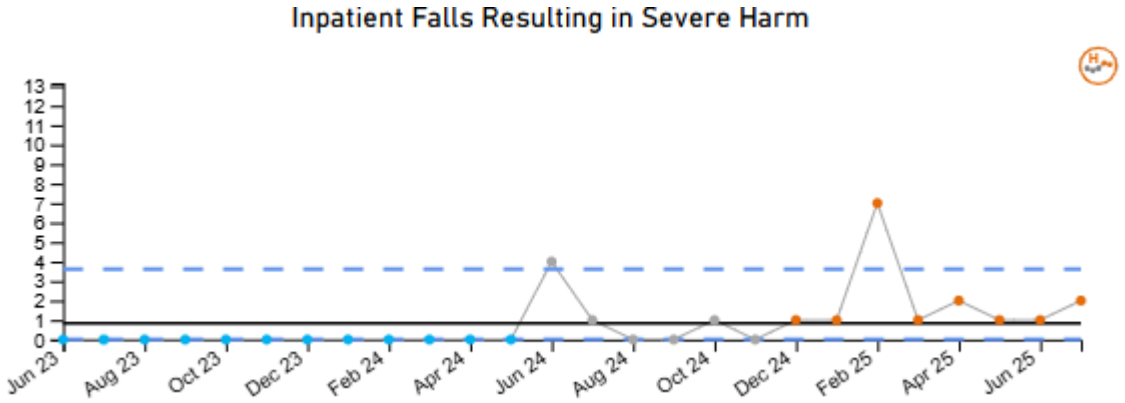
Summary of challenges & risks	In July 2025 there were 5 cases of Klebsiella. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	All gram negative blood stream infections are rising nationally. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepucture. Ongoing education, monitoring and surveillance of IPC interventions followed by feedback. Promotion of good hydration in inpatients and in care home residents Education and promotion of good catheter care External urine management device trial underway
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

Severe harm falls

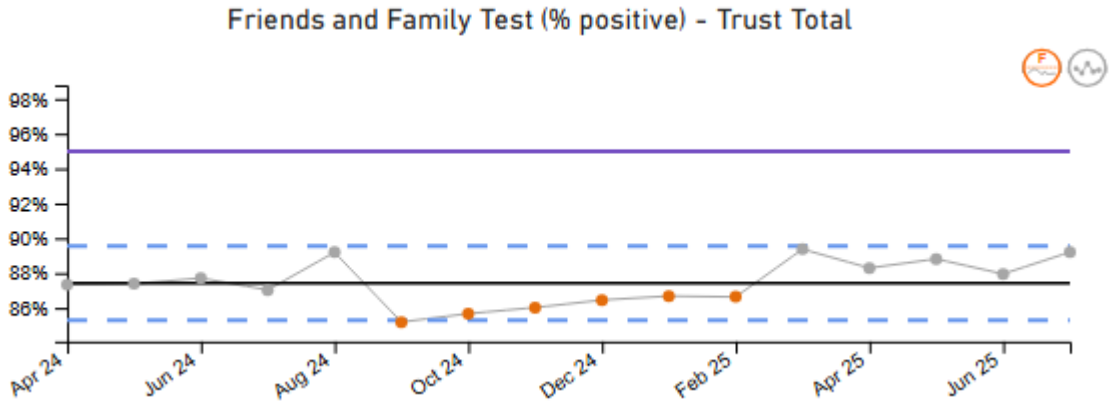
Summary of challenges & risks	There were 2 fall resulting in severe harm in July 2025. Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Patient Safety Incident Response Framework (PSIRF) process utilised for all post fall review meetings and outcomes extracted for shared learning. Local learning shared immediately with ward teams following swarm huddle PIRF process and local action plan produced. Falls Improvement Plan in Place and shared Trust wide for Local Implementation. Adoption of National Association of Inpatient Falls (NAIF) Key Performance Indicators (KPI's) Falls activity monitored through Trust Incident reporting system & Quality dashboard to ensure national and local standards and policies are being maintained. Quality Initiative activity aligned with learning extracted from falls activity. Falls Champions in place with bi-monthly meetings facilitated by Falls lead to discuss themes, trends and new developments.
Action timescales and assurance group or committee	Monthly review at Trust Falls Learning Group of all falls resulting in moderate harm and above. Monthly Falls Report presented to Patient Safety Review Group with an Annual report to SAFE Committee for oversight. Learning action plans reviewed by Trust Falls Learning group at 3 & 6 month intervals in line with Trust Falls PSIRF processes.
Risk register	n/a



Assurance report

Friends and Family Test (% positive) – Trust Total

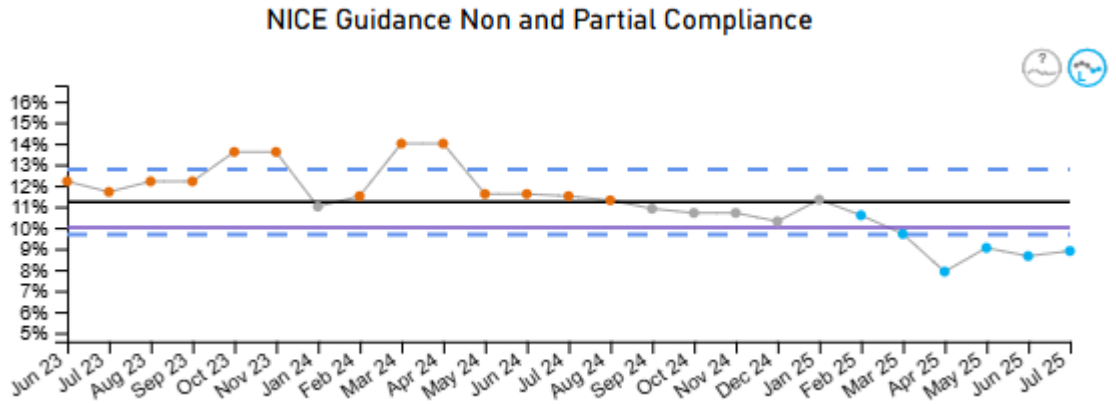
Summary of challenges & risks	The Trust position was 89.2% for July 2025. Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Increase response rate on a consistent basis utilising digital platforms Establish patient experience volunteers to support effective digital survey processes Establish learner placements within PALs to support effective digital survey processes Procurement of digital devices to increase digital survey returns in ward-based areas linked to previous actions. Utilise support from ward-based admin teams to reduce rejected paper-based returns and maximise use of digital platforms. Incorporate Divisional FFT action plans into Bimonthly Patient Experience and Involvement Group – focused on the impact on response rate, positivity rating and pulling out themes from free text comments.
Action timescales and assurance group or committee	FFT is discussed and monitored through: Monthly Divisional Clinical Governance processes Bi-Monthly Patient Experience Operational meeting Quarterly Caring Group.
Risk register	N/A



Assurance report

NICE Guidance % non & partial compliance

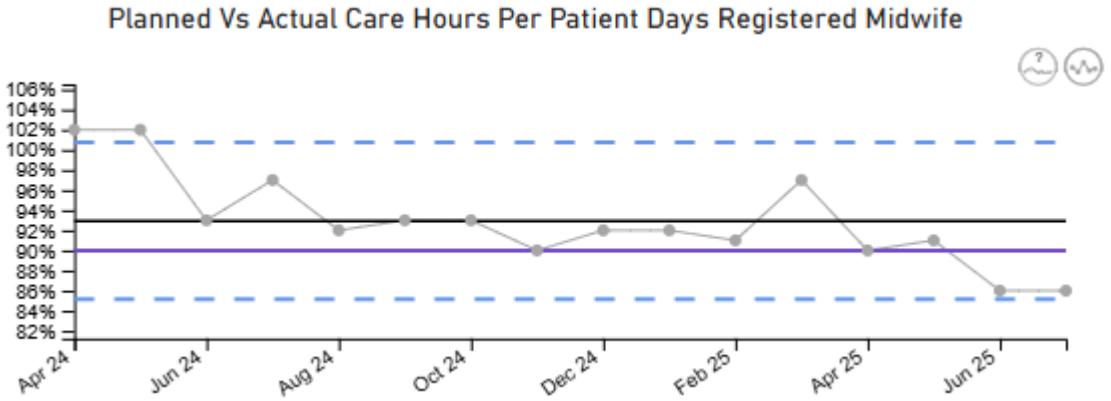
Summary of challenges & risks	For July 2025, the Trust achieved 8.9%. Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• NICE guidance compliance is reported to Effective Committee in a divisional highlight report • Data pulled from Monday.com and narrative provided to address compliance where appropriate, with actions detailed around planned audits/re-audits and timescales • All divisions requested to provide rationale to support decisions around not adopting guidance. Any NICE guidance not appropriate for a specific specialty/division will be removed with explicit rationale why • Out of 427 NICE guidance to be adopted there are 38 showing as non/partially compliant of those there are 9 which are unlikely to be adopted for a number of factors, such as relating to services that DBTH does not provide. • These are monitored constantly and reported to the AEF and Effectiveness Committee by the DQACs
Action timescales and assurance group or committee	Updates on compliance and rationale for non-adoption to be presented to Effective Committee September 2025.
Risk register	No.



Assurance report

Planned Vs Actual CHPPD – Registered Midwife

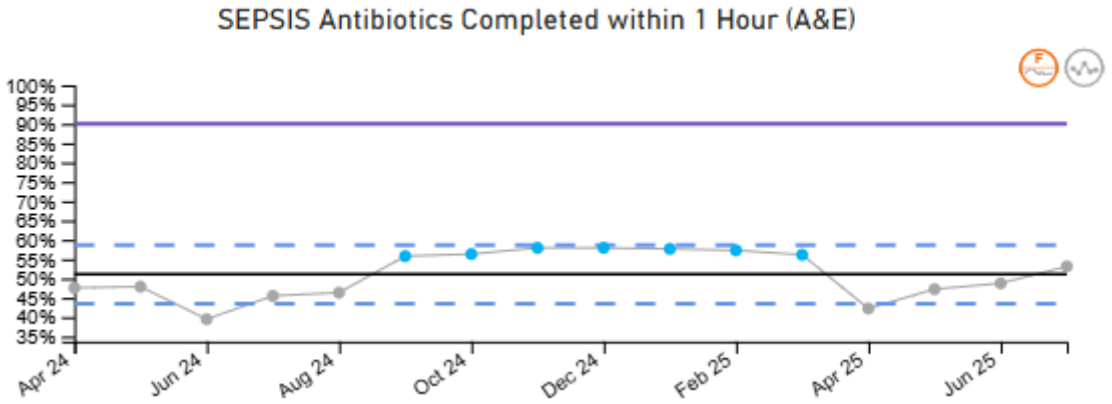
Summary of challenges & risks	In July 2025 Planned Vs Actual CHPPD for Registered Midwifes was 86.1%. Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Vacancies currently 20.43 WTE – 12.8 WTE already recruited to by the NQM expected in October Monday meeting to review next 2 weeks rosters held and all NHSP shift sent out on Daily Manager of the day / Senior manager to manage daily operational risks related to staffing across the whole service LMNS escalation process in place 3 x weekly meetings to update OPEL position. Additional escalation possible via the LMNS & Gold 24/7 Diversions between sites utilised to maintain safety & full closure possible if whole service unsafe through LMNS escalation process All sickness proactively managed
Action timescales and assurance group or committee	12.8 WTE NQM starting early Oct Advert out for other vacancies B5/6 closes on 26.8.25 National monies possible (letter on 12.8.25) to convert MSW posts to B5 – expressed interest to convert 5.6 WTE B2 to B5 (subject to funding) Discussed and monitored at: DLT Divisional governance Maternity Safety and Quality Group Trust Board Quality Committee Plan for fully / over recruited (subject to funding by Oct / Nov 2025)
Risk register	Risk 3798

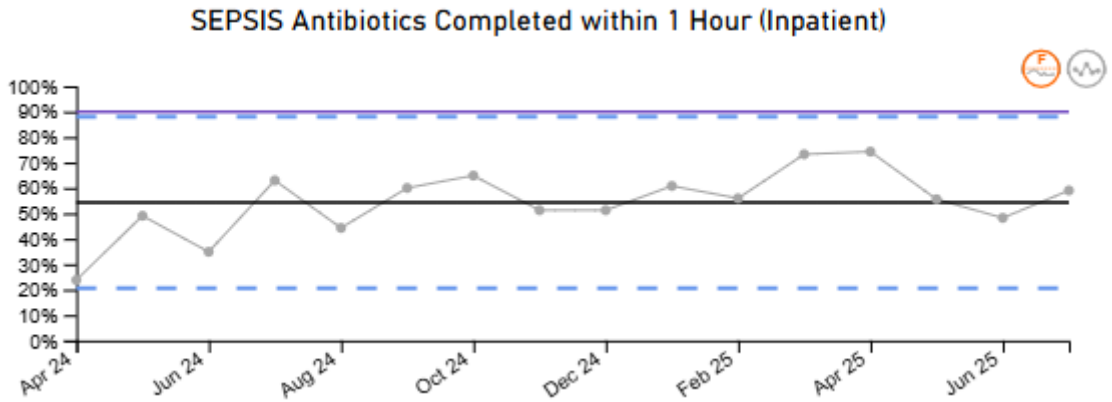


Assurance report

Sepsis antibiotics completed within 1 hour

Summary of challenges & risks	For July 2025, the Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis in A&E was 59.0% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign. For July 2025, the proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis as an Inpatient was 53.1% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sepsis strategy recently launched which includes: • Mandatory sepsis screening – trust wide • Sepsis alerts in acute medicine tracker and ED sepsis tracker – real time monitoring of sepsis six compliance • Integration with symphony and nervecentre • Standardised and streamlined care pathways • IPOCs in place • Treatment and investigation bundles on ICE • Education and awareness – ongoing training for staff and raising awareness for patients • Ongoing clinical audit/feedback for continuous improvement
Action timescales and assurance group or committee	Delivery of sepsis actions overseen by Sepsis Action Group
Risk register	No

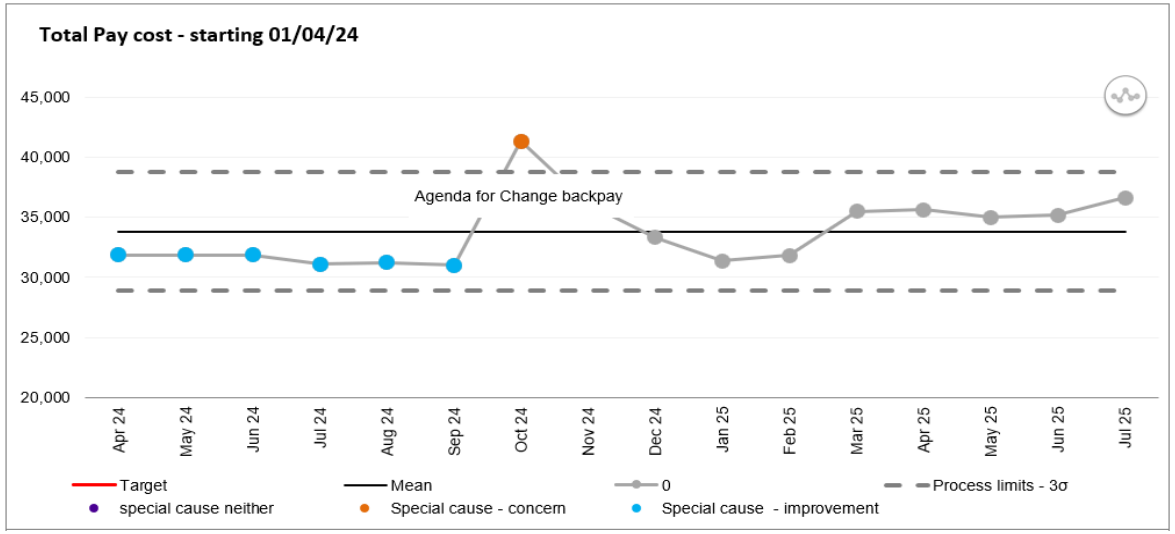




Assurance report

Pay spend against plan including substantive, additional sessions, bank and agency

Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,244	6,099	-144	F	-260	F
Apprenticeship Levy	131	125	-5	F	-19	F
Allied health professionals	2,939	2,822	-117	F	-337	F
Healthcare science staff	21	15	-5	F	-22	F
Medical and dental	10,367	11,831	1,464	A	4,279	A
Nursing & midwifery	12,528	12,756	227	A	1,316	A
Comprising:						
Registered nursing	9,336	9,223	-113	F	-483	F
Unregistered nursing	3,193	3,533	340	A	1,799	A
Scientific, therapeutic and tech	801	863	62	A	214	A
Reserves	1,555	2,138	583	A	61	A
Total Trust	**34,585**	**36,650**	**2,065**	**A**	**5,231**	**A**



Assurance report

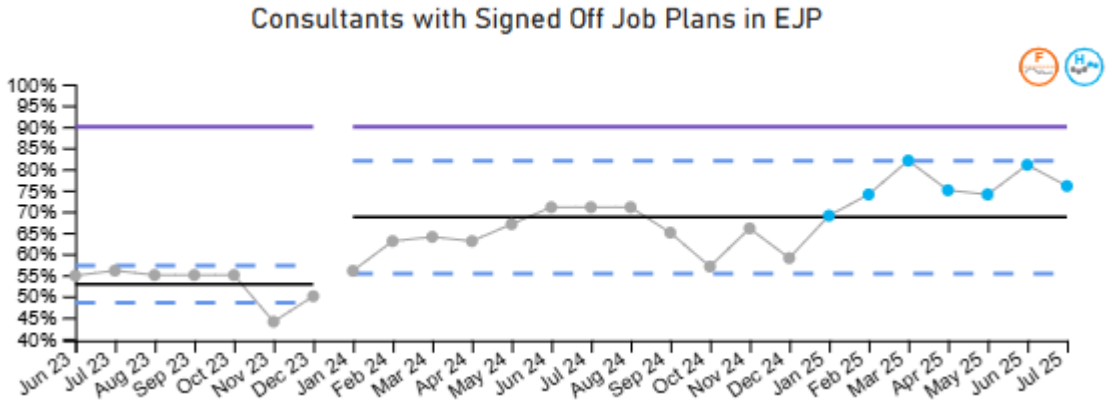
Pay spend against plan including substantive, additional sessions, bank and agency

Summary of challenge	Pay is overspent by £5.2m YTD
Actions to address	A. CIP Pay Efficiency Workstream in place for 25/26. Within the workstream there are x5 key projects supporting the reduction of agency and bank volumes and price:- (1) Medical Recruitment - Review recruitment activity and provide support through a series of initiatives to have more substantive colleagues in post and reduce reliance on temporary workers. This will include visibility that vacant roles are proactively recruited to, and plans are in place. (2) Medical Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. Identifying and managing escalation rates and out of policy bookings should be done through grip and control meetings. This should also include a review of the current controls in place e.g. sign off thresholds and that they are effective and proportionate. (3) Nursing, Midwifery & AHP Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. This includes a review of the current controls in place e.g. G&C, sign off thresholds and that they are effective and proportionate. (4) Sickness Absence - Support the reduction in sickness across the Trust through identification of hotspots and ensuring plans are in place to support increased attendance, monitor compliance with policies and through the wider health and wellbeing agenda. (5) Effective Rostering - Ensure our people are deployed as effectively as possible by monitoring compliance with rostering best practice e.g. roster sign off period, compliance with Annual Leave and Sick Leave thresholds, use of “additional bricks” and owed hours. Alongside these enabler projects the working groups are capturing divisional initiatives to reduce reliance on premium staff via rota changes and feedback for the VCF panel to recruit substantive posts. B. Additional Session funding is held centrally in reserves and only allocated once the COO has approved the sessions to be undertaken, this is considerable step change to previous years where funding was within divisional budgets with limited challenge. C. CIP Workforce Planning Workstream in place for 25/26. Within the workstream there are x3 key projects plus a number of ad hoc findings supporting the reduction of medical spend:- (1) Unpredictable on call emergency work - In line with the Consultant contract and recommendations from NHS Employers and BMA, during 2025/2026 the Medical Director’s office are planning to review the demands of unpredictable emergency work for those teams of senior medical staff who participate in an on-call rota. (2) Sessional Delivery Tracking - The aim of the sessional delivery tracking is to ensure that as far as possible clinical activity is being delivered as planned, for 25/26 the focus will be Outpatient and Theatres activity only. Most specialties have now been reviewed, meetings are underway with divisional colleagues to sense check initial outputs. Medical Director meeting timetabled for w/c 15/9/25 to review those in excess of tolerance and clear decisions will be made on reclaim actions and quantification of CIP and phasing. (3) Standardisation of Travel Time in Job Plans (4) Ad Hoc - RRP payments, review of annual and bank holiday entitlements for part time staff
Action timescale	UEC Rota review wef August 25 to reduce need for temporary staffing Sessional delivery pilot to commence July 25 then full roll out by Q3 Divisional action plans to address the pay overspends being discussed at PRMS and overall plans to 6.1% escalated to DBTHI Executive Accountability Meetings Detailed cash flow monitoring in place and being reviewed Detailed I&E forecasts including impact of efficiency plans discussed at PRMS DBTHi Executive Accountability Meetings reviewing CIP progress commenced 22/7/25

Assurance report

Consultants with signed off job plans in EJP

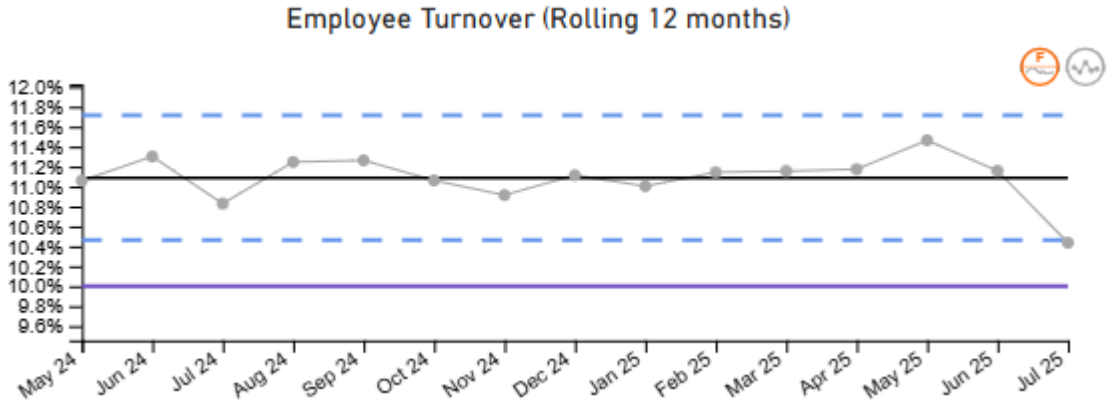
Summary of challenges & risks	For July 2025 76.0% of Consultants had a signed off job plan Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. Re-basing has taken place December 2023 as job planning completion was linked to CEA programme
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Job plan sign off rates fluctuate between the balance of those which become due and those signed off each month, with peaks in variation during August and April. Overall an improving position with 3 specialties to finalise job plan templates and sign off – 1 specialty in particular due to issues with eJP software. • sending reminders of job plan review due dates, contacting individual clinicians and their clinical managers, recording individual job plan sign off dates. Process in place for non compliance impacting on reduced APAs. • ensuring quality job plan documents are produced, through full completion of job plan templates which include all activities, SPA time, objectives and contract information. • testing a formula to measure delivered activity against job plan across all areas, along with monitoring of unpredictable on-call activity – to ensure compliance with job plan, transparency and fairness. • Glitches found in the eJP software causing issues with calculating some activity, L2P currently testing a resolution to this • Job Plan Policy developed, currently progressing through approval process
Action timescales and assurance group or committee	Aiming for achievement of target by the end of Quarter 2.
Risk register	No



Assurance report

Employee turnover

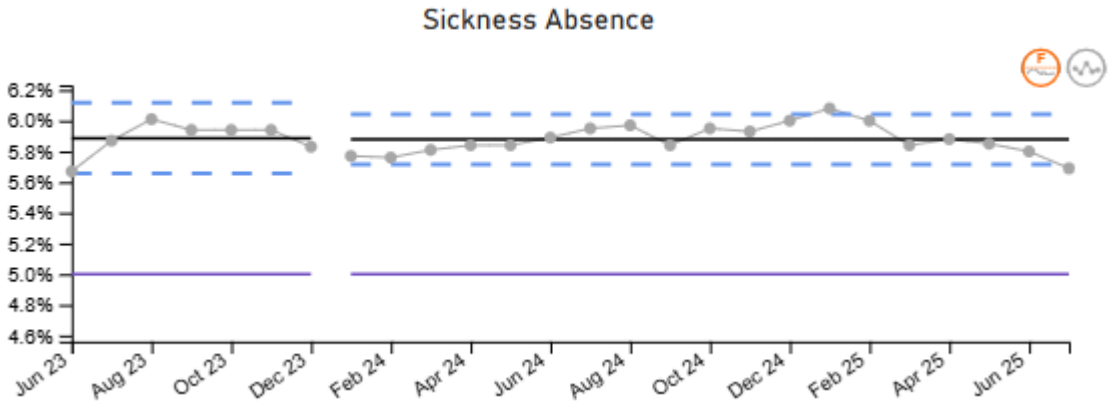
Summary of challenges & risks	For July 2025 Employee turnover was 10.4% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Learning from leavers project to improve the response rates of exit interviews and feedback from those leaving the Trust to enable improved thematic analysis • Leavers Policy approved by Policy Formulation Group in July 2025. To be communicated in Q2 with supporting guidance, as a new policy • Improved appraisal process complemented by Scope for Growth conversations and succession planning discussions. Recommunicated to support appraisal season 2025 (Q1/2)
Action timescales and assurance group or committee	• Leavers policy communication in Q2 • Monitor improvements in relation to learning from leavers project in Q2/3 – review at Workforce & Education Group
Risk register	16, 2554



Assurance report

Sickness absence

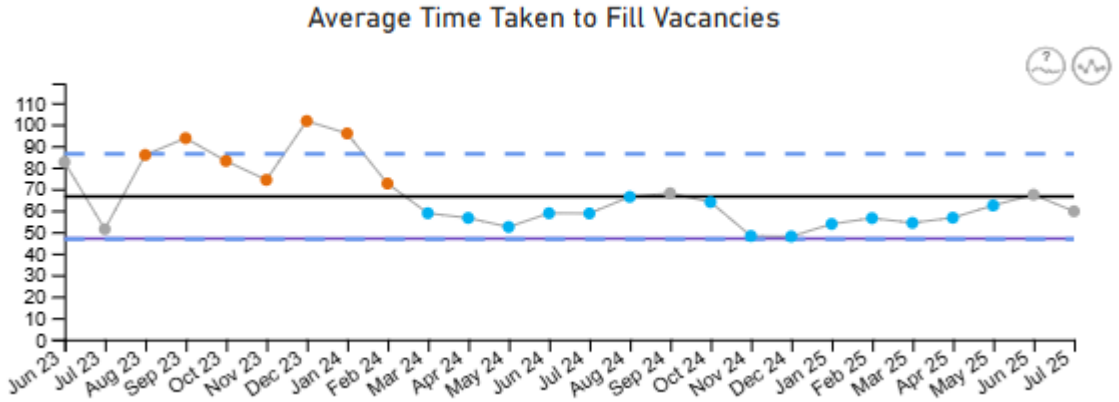
Summary of challenges & risks	In July 2025 the overall sickness was 5.7% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Sickness absence policy revised following policy implementation and learning from elsewhere, including refocusing as supporting attendance at work. Draft policy to be presented to Policy Formulation Group in Q2. • Focus and data analysis on further specific groups – Estates & Facilities and Admin & Clerical (Q1/2) • Offer of additional support and training from the People Business Partner Teams ongoing • Identification of patterns of absence and appropriate actions that can be taken in line with the policy • Improvement work ongoing supporting absence management for medical colleagues with feedback, input and support from Clinical Directors
Action timescales and assurance group or committee	• All actions in relation to improving attendance and sickness absence management are tracked on Monday.com and monitored through the Pay Efficiency workstream with monthly steering group meetings, chaired by the CPO • Actions have timeframes and deadlines throughout 2025/26
Risk register	2554



Assurance report

Time to hire (from TRAC authorisation - unconditional offer) A4C posts only

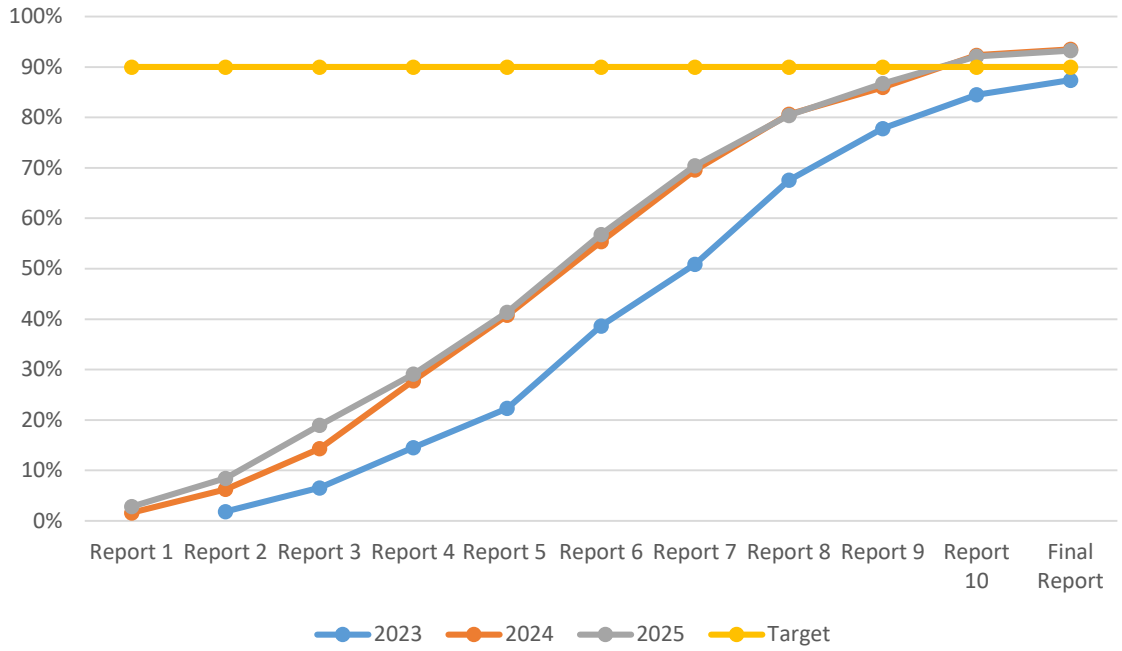
Summary of challenges & risks	The Trusts time to hire is 59.6 days for July 2025 Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Improvements made to the internal transfer register and plans to pilot the process for clinical admin and clerical roles (postponed until Q2 2025/26) – anticipated to have a positive impact on reduction of number of vacancies • Collaborative work with system trusts on improving time to hire continues, including reviewing processes for pre-employment checks • Recruitment administrative model to be reconsidered in 2025/26
Action timescales and assurance group or committee	• Support actions and recruitment training offer are ongoing • Collaborative work is ongoing throughout 2025/26 • Workforce & Education Group reports (bi-annual) • People Committee bi-annual reports (bi-annual) • Internal transfer for admin and clerical posts expected to be piloted in Q2/Q3
Risk register	16 (linked)



Assurance report

Completed Appraisals

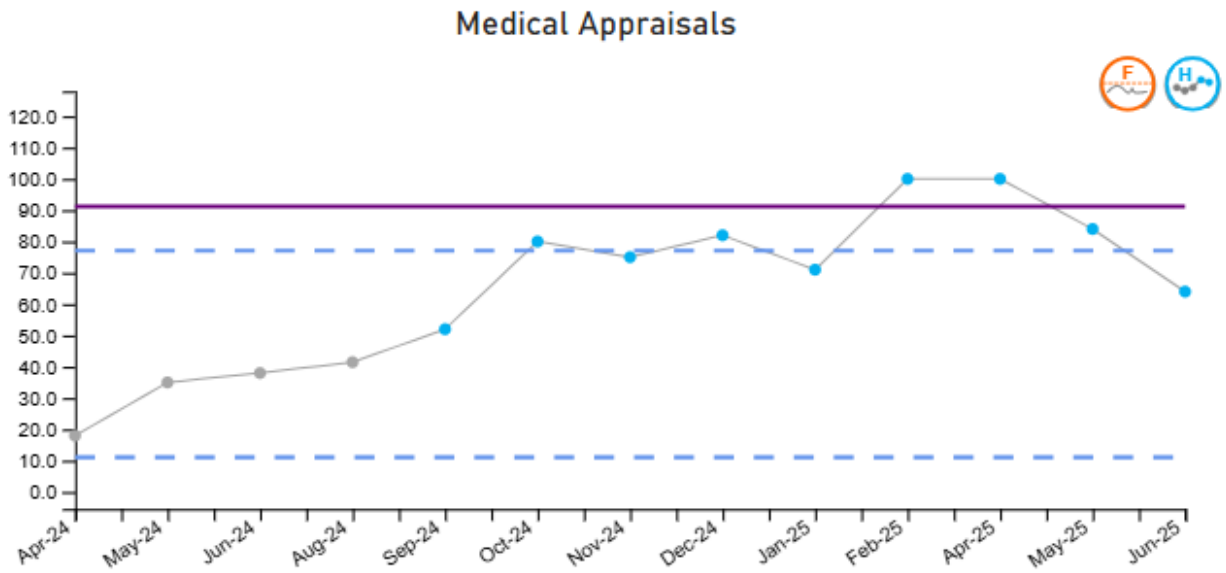
Summary of challenges & risks	Overall Trust Appraisal rate at end of appraisal season - 93.27% Appraisal season target of 90% exceeded for 2025.
Actions to address risks, issues and emerging concerns relating to performance and forecast	N/A
Action timescales and assurance group or committee	N/A
Risk register	N/A



Assurance report

Medical appraisals completed

Summary of challenges & risks	Medical appraisals completed for July 2025 was 64%. Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Medical appraisals were 100% compliant at the end of March 2025, and this position resets at the start of the new financial year. By the end of Quarter 1, the Trust achieved 80% compliance – of the 91 appraisals scheduled, 73 were completed. Each quarter will see a new set of appraisals scheduled, and compliance will be measured against the number scheduled versus the number completed for that quarter. This position will continue to fluctuate due to annual leave/study leave, sickness, operational pressures etc. Compliance is measured by NHS England at the end of the financial year.
Action timescales and assurance group or committee	Quarterly position monitored by the Associate Medical Director for Professional Standards Timescale for compliance in line with NHS England guidelines March 2026.
Risk register	



Metrics in development

- Medical Appraisals completed – *Back dated forms not yet completed*
- Duty of Candour (failure to undertake in its entirety) *Awaiting changes to be made in Datix*
- Vacancies (specific staff groups) – *Additional data required in extracts provided This is being investigated*
- Turnover – *reviewing logic*
- Severe harm falls per 1000 bed days – *Further development required following testing results*
- Combining of COHA & HOHA – *Further development required following testing results*

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2509 - D2 FINANCIAL & ACTIVITY REPORT - MONTH 3

Discussion Item

Yasmin Ahmed, Deputy Director of Finance & Denise Smith, Chief Operating Officer

10 minutes

REFERENCES

Only PDFs are attached

D2 - Finance and Activity Report - Month 3.pdf

D2 - Appendix A.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Finance and Activity Report - Month 3**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer Denise Smith, Chief Operating Officer			
Authors:	Yasmin Ahmed, Deputy Director of Finance Matthew Bancroft, Interim Associate Director of Finance Suzanne Stubbs, Deputy Chief Operating Officer			
Appendices:	Appendix A - Finance and Activity Report			
Purpose of the report	**Assurance**	~~Decision required~~	**Information**	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	BAF5 - If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term			

Executive Summary – Key messages and Issues

The Trust is reporting a £0.3m deficit in month bringing the year-to-date position to a £2.1m deficit. Surplus/deficit performance is essentially on plan in both the month and year to date. However, £0.8m of non-recurrent technical benefits have been made earlier than planned to support the position (an improvement from £1.2m last month).

Driven by further identification and progression of efficiency schemes, the overall net risk to delivery of the financial plan has continued to decrease (£8.2m at the end of month 2, £7.3m at the end of month 3). Whilst some finance risks have improved in month, none have shown sufficient improving to warrant a change in their risk scoring.

Activity in June exceeded plan in three of the four points of delivery. In the year-to-date activity exceeded plan in all four points of delivery.

In month 3 the Trust delivered £2.9m of in-year CIP savings bringing year-to-date delivery to £6.3m. Both in month and year-to-date delivery are in line with the plan submitted to NHSE. Non- recurrent technical benefits are contributing to this. The forecast outturn of £31.4m of in-year savings is in line with plan. Levels of high-risk CIP within the in-year programme have continued to decrease (£11.1m at the end of month 2, £6.5m at the end of month 3). The risk adjusted in-year forecast stands at £21.5m.

Analysis of the Recurrent Full Year Effect (FYE) of CIP savings has been added to the pack this month. On that basis, £16.7m of savings were committed in the plan, with £12.7m required to be delivered before savings started to eat into the Trust's underlying deficit. £9.9m has been delivered so far with £19.8m forecast to be delivered by the end of the year. The risk adjusted recurrent FYE forecast stands at £13.8m.

The cash balance of £20.3m exceeds the planned level of £13.8m, driven by lower levels of capital expenditure than had been planned at this point.

Year to date capital expenditure of £2.1m is £13.4m below plan with business cases being developed to ensure no slippage by year end.

Recommendations

The Board is asked to **NOTE** the financial and activity performance described in the report

<table>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td></td></tr>
<tr><td>People</td><td></td></tr>
<tr><td>Partnerships</td><td></td></tr>
<tr><td>Pounds</td><td>Paper outlines the financial and activity performance of the Trust</td></tr>
<tr><td>Health Inequalities</td><td></td></tr>
<tr><td>Legal/ Regulation:</td><td></td></tr>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Finance and Performance Committee on 14 August 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

NO</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Summary Finance And Activity Report

June 2025

Executive Summary

In month and YTD surplus/deficit (June 2025)

The Trust is reporting a £0.3m deficit in month, in line with plan. Year to date a deficit of £2.1m is reported also in line with plan. £0.8m of non-recurrent technical benefits have been made earlier than planned to support the position.

Annual Forecast Outturn (FOT)

FOT remains at breakeven in line with plan.

Activity

Activity in the month of June 2025 for New Outpatients, Elective and Daycase exceeded plan, however Outpatient Follow Ups were slightly behind. Year to date all points of delivery have exceeded plan.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
M03 June 2025

Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance				YTD Performance			
	Budget £'000	Actual £'000	Variance to budget £'000		YTD Budget £'000	Year To Date Actual £'000	Variance to budget £'000	
Income	(51,775)	(52,669)	(894)	F	(155,365)	(155,979)	(614)	F
Pay	33,848	35,180	1,332	A	102,655	105,821	3,166	A
Non Pay	17,443	17,210	(233)	F	52,487	50,983	(1,504)	F
Financing Costs	805	639	(166)	F	2,415	1,450	(965)	F
(Surplus)/Deficit for the period	**320**	**359**	**39**	**A**	**2,192**	**2,274**	**82**	**A**
Donated Asset Adjustment	(41)	(76)	(35)	F	(123)	(210)	(87)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**279**	**283**	**4**	**A**	**2,069**	**2,064**	**(5)**	**F**

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

Key
F = Favourable **A** = Adverse

Efficiencies

In month 3 the Trust has delivered £2.9m of savings in line with the plan submitted to NHSE. Year to date CIP delivery of £6.3m is also in line with plan. Non-recurrent technical benefits are supporting the year-to-date CIP delivery.

Cash

Cash balance is £20.3m against a plan of £13.8m, favourable due to slippage in the delivery of the capital plan.

Capital

Year to date expenditure of £2.1m, £13.4m below plan with business cases being developed and approved to deliver the full-year programme.

Key Risks and Mitigations

Key Risks	Risks (R) 25/26 Plan	M2	M3	Increase (Decrease)	Key Mitigations	Mitigations (M) 25/26 Plan	M1	M2	M3	Increase (Decrease)	Net (R/M)	Increase (Decrease)
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Additional cost risk	(2,000)	(2,000)	(2,000)	0	Additional cost control	2,000	2,000	2,000	2,000	0	0	0
Additional cost risk (inflation)	(6,178)	(3,707)	(3,707)	0	Additional cost control	6,178	3,707	3,707	3,707	0	0	0
Efficiency risk	(22,817)	(10,913)	(9,854)	1,059	Efficiency mitigation	2,322	4,793	2,750	2,520	(230)	(7,334)	829
Income risk	(1,000)	(1,000)	(700)	300	Contract negotiations	1,000	1,000	1,000	700	(300)	0	0
Total	**(31,995)**	**(17,620)**	**(16,261)**	**1,359**	**Total**	**11,500**	**11,500**	**9,457**	**8,927**	**(530)**	**(7,334)**	**829**

The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.

An improvement of £0.8m in net risk during month 3 driven by reduction in efficiency risk as further schemes have been identified and income risk following agreement of contracts with Commissioners.

There is a risk to the Trust if SYICB are unable to receive the deficit support funding and this has not been included in the above table.

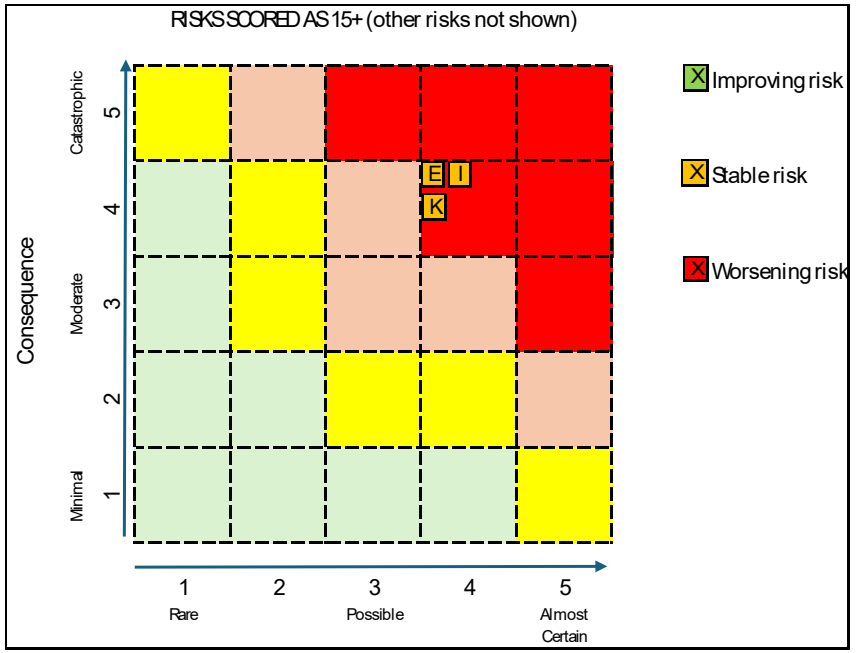
The Finance Department continues to formally review the Financial Risk Register on a routine basis.

Key Risks

- Failure to achieve compliance with financial performance and achieve 25/26 financial plan
- Failure to deliver 25/26 Cost Improvement Plan on a recurrent basis impacting on the Trust's delivery of financial targets
- Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital

Actions

- Divisions have been tasked to promptly identify schemes to the value of their 6.1%, a pipeline of multi-year ideas is being drafted and costed.
- Detailed cash monitoring and forecasting on monthly basis



Surplus/Deficit

In month/YTD

- In month £0.3m deficit, a £4k adverse variance to plan.
- Year to date a £2.1m deficit with a £5k favourable variance to plan. £0.8m of non-recurrent technical benefits have been made earlier than planned to support the position (improvement from £1.2m last month).

Income

- Income is £0.9m favourable to budget in month mainly due to ERF income.

Pay

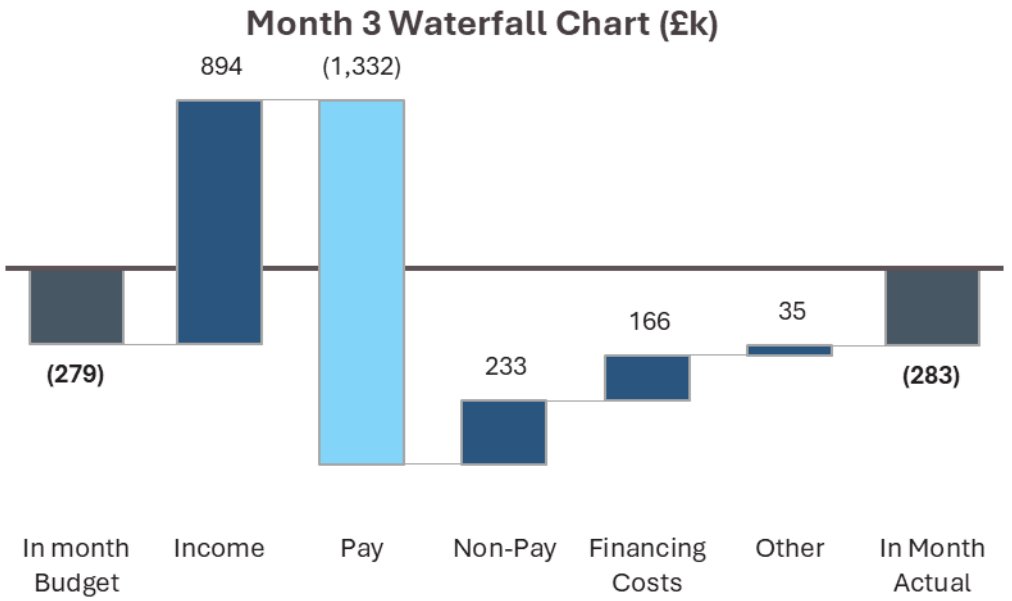
- Pay is £1.3m adverse to budget in month and £3.2m adverse YTD due to CIP delivery, operational pressures and premium costs.
- Bank/agency and additional medical sessions spend in month is £3.6m due to operational pressures, cover for vacant posts and sickness cover.

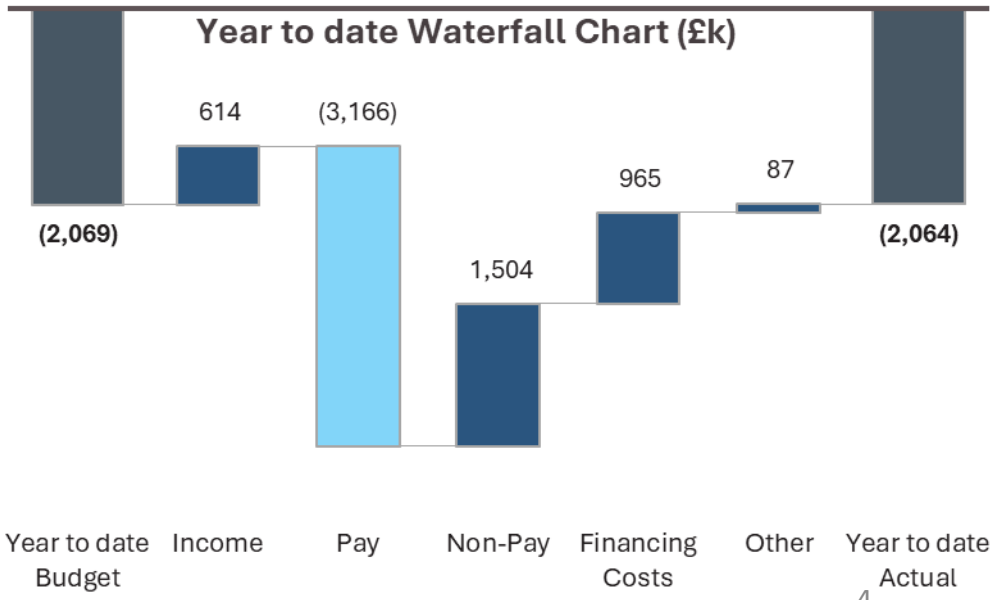
Non-Pay

- Non pay is £0.2m favourable to budget in month and £1.5m favourable YTD mainly due to non recurrent technical benefits.

Financing Costs

- Higher cash balance than planned has generated increased interest income.





Financial Performance – Income

Clinical Income Position Month 3

	Plan - M3 YTD	Actuals - M3 YTD	Variance
	£'000	£'000	£'000
ICB			
NHS South Yorkshire ICB	(98,009)	(98,017)	(9)
NHS Nott's and Nottinghamshire ICB	(27,356)	(27,439)	(83)
NHS Humber and North Yorkshire ICB	(2,173)	(2,087)	86
NHS Derby and Derbyshire ICB	(1,555)	(1,472)	84
NHS West Yorkshire ICB	(1,054)	(958)	96
NHS Lincolnshire ICB	(490)	(568)	(78)
LVA	(306)	(307)	(0)
ERF	0	(2,085)	(2,085)
API variable	113	113	0
ICB sub total	**(130,829)**	**(132,819)**	**(1,989)**
NHS England			
Specialised Commissioning	(16)	0	16
Public Health	(1,147)	(1,131)	16
Offender Health	(410)	(414)	(4)
Drugs and Devices	(2,864)	(2,864)	0
NHSE sub total	**(4,437)**	**(4,408)**	**28**
CDC	(2,471)	(1,886)	585
Clinical Income - misc	(297)	(381)	(83)
Road Traffic Accident, Private Pat. Oversea	(1,298)	(1,301)	(2)
ERF Provision	0	491	491
Reported Position	(139,332)	(140,303)	(971)

Contracts

The contracts with all Commissioners are agreed and signed for SYICB and NHSE. Associates will be varied into the contract at a later date.
The Trust is in the process of rebasing contracts for 26/27. This involves reviewing all block income as part of a system working group.

ERF Performance

The below shows the current estimated ERF performance. The activity has not been fully coded and includes estimates. MEOC, T&O and Ophthalmology specialties are the main over performers as at month 3.

ERF position by POD	M3 ERF Target	M3 ERF Actual	M3 variance to ERF Target
A & G	(579)	(537)	41
Daycase	(9,839)	(9,664)	175
Elective	(7,391)	(8,291)	(900)
Outpatient First	(6,537)	(7,063)	(526)
Outpatient Procedures	(4,174)	(5,050)	(876)
Total	(28,520)	(30,605)	(2,085)

The Clinical Income position is showing a favourable position YTD of £971k whilst Operating Income shows an adverse variance of £357k (due to HEE and research income) giving an overall year to date favourable income position of £614k. The main driver of the year to date favourable clinical income performance is ERF performance at £2.1m (baseline ERF income is included in the ICB income categories) partially offset by lower CDC activity of £0.6m. HEE income adverse variance is pending inflation increase and Research income is expected to recover in M4.

Activity Against Plan 25/26

Point of Delivery	Activity vs Plan (June 2025)
Outpatients New	107.9%
Outpatient Follow up	99.3%
Daycase, excluding MEOC	111.1%
Elective, excluding MEOC	118.4%

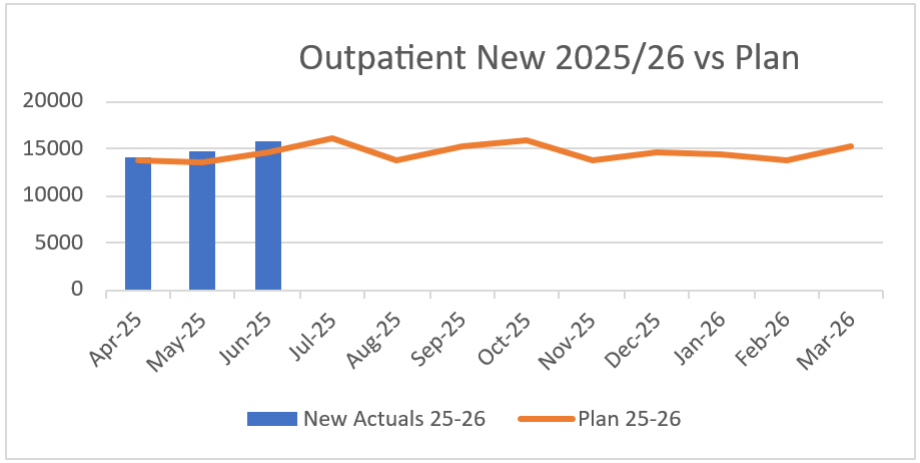
Outpatient New: 1,152 above plan in June (107%) and 2,731 above plan YTD (106.5%)

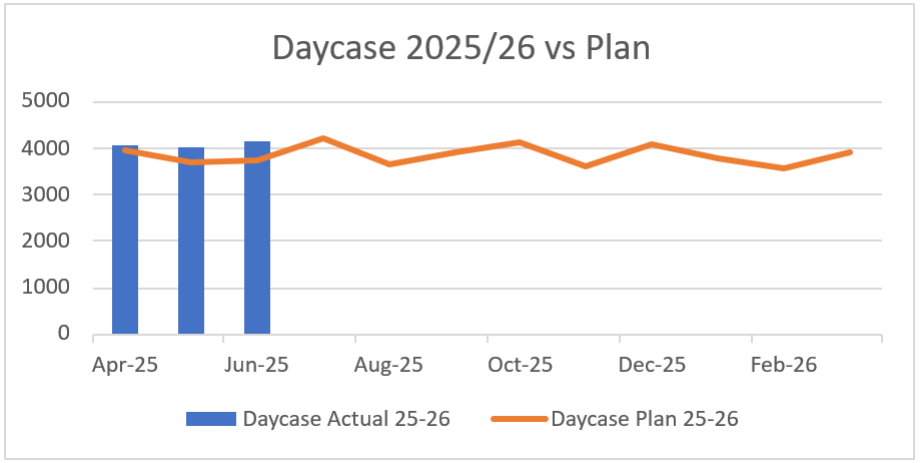
Outpatient Follow up: 222 below plan in June (99.3%) and 2,798 above plan YTD (103.2%)

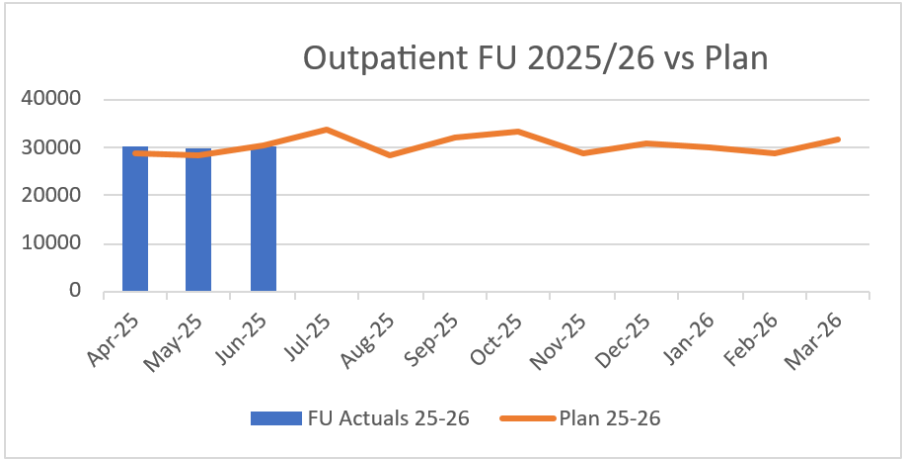
Diagnostics: 1,837 above plan in June (110.4%) and 3,188 above plan YTD. At individual diagnostic test level, all modalities are above plan in month and YTD apart from Echo and Dexa.

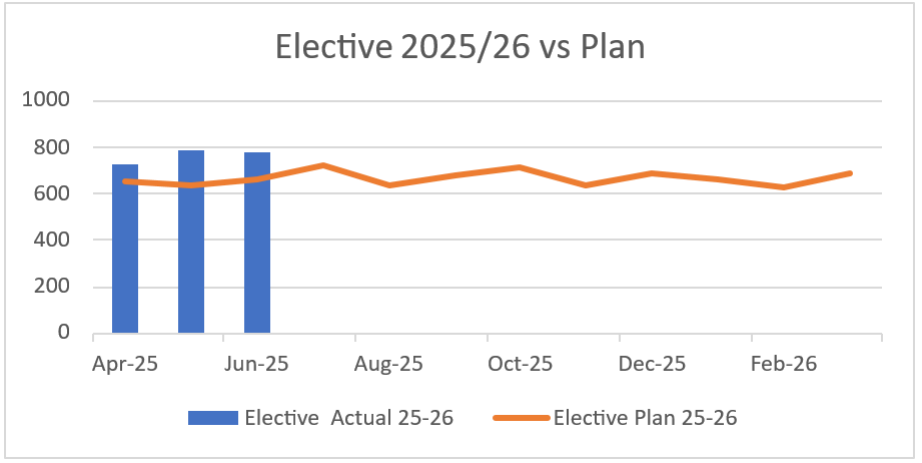
Day case: 416 above plan in June (111.1%) and 886 above plan YTD (107.8%). Ophthalmology, ENT and Urology are above plan in month and YTD. General Surgery and Trauma & Orthopaedics are slightly below plan in month and YTD.

Elective: 121 above plan in June (118.4%) and 343 above plan YTD (117.6%). General Surgery, Trauma & Orthopaedics and Urology are all above plan in month and YTD.







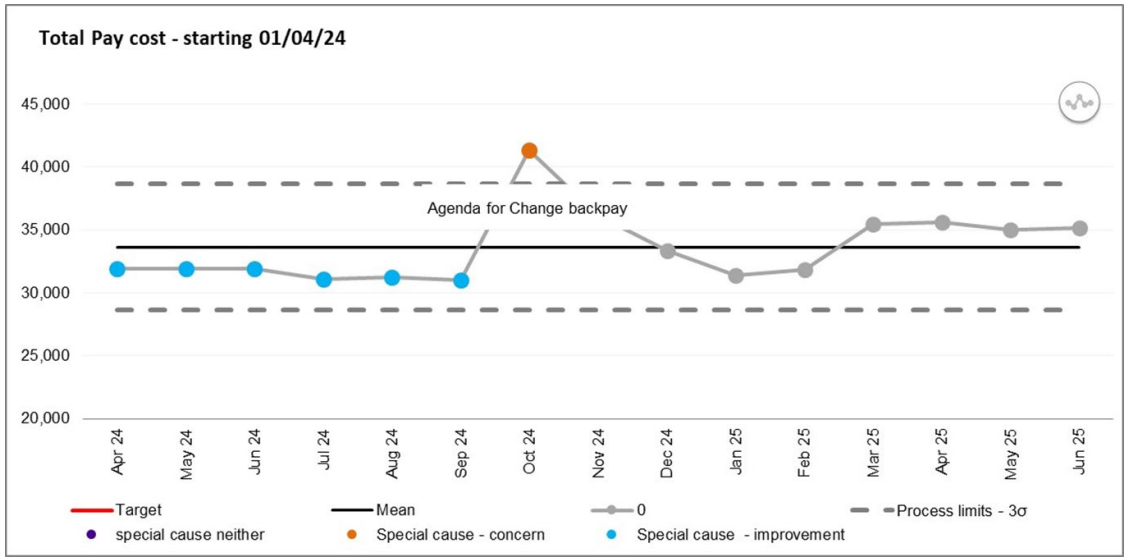


Financial Performance - Pay

In Month - £1.3m adverse to budget
Year to date - £3.2m adverse to budget

- Pay expenditure in month increased by £0.2m as a result of the one-off pension arrears credits from the prior month for medics and lead unit offset by additional income
- Substantive pay increased by £0.6m due to above offset by reductions in spend for additional sessions/bank/agency
- Bank/Agency spend has reduced by £0.4m in month, and additional sessions reduced by £0.1m.
- Adverse variance in month and year to date is mainly driven by unachieved CIP, operational pressures and premium costs of medics and nursing.

Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,138	6,091	-48	F	-277	F
Ambulance staff						
Apprenticeship Levy	131	125	-5	F	-14	F
Allied health professionals	2,959	2,838	-120	F	-244	F
Healthcare science staff	21	15	-6	F	-18	F
Medical and dental	10,650	11,328	679	A	2,247	A
Non Medical Non Clinical				A		A
Nursing & midwifery	12,940	12,872	-67	F	233	A
Comprising:						
Registered nursing	9,790	9,279	-510	F	-958	F
Unregistered nursing	3,150	3,593	443	A	1,191	A
Scientific, therapeutic and tech	837	851	14	A	125	A
Reserves	1,349	1,058	-291	F	-525	F
CIP Target	-1,177		1,177	A	1,638	A
Total Trust	**33,848**	**35,180**	**1,332**	A	**3,166**	A



Financial Performance – Non Pay

In Month - £0.3m favourable to budget

Year to date - £1.5m favourable to budget

The main reasons for the favourable variance is due to:

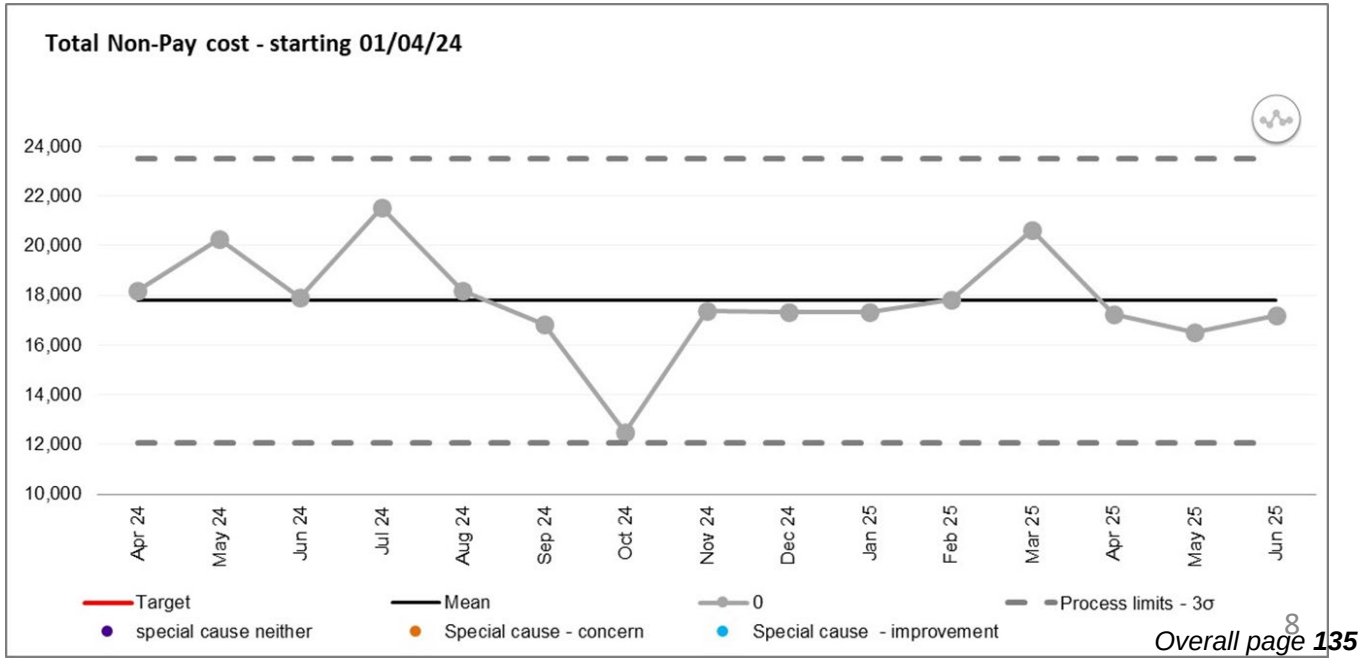
- Reserves

Offset by:

- Clinical supplies overspend due to increased activity

In month actual is £0.9m higher than the prior month as a result of month 2 non-recurrent benefits.

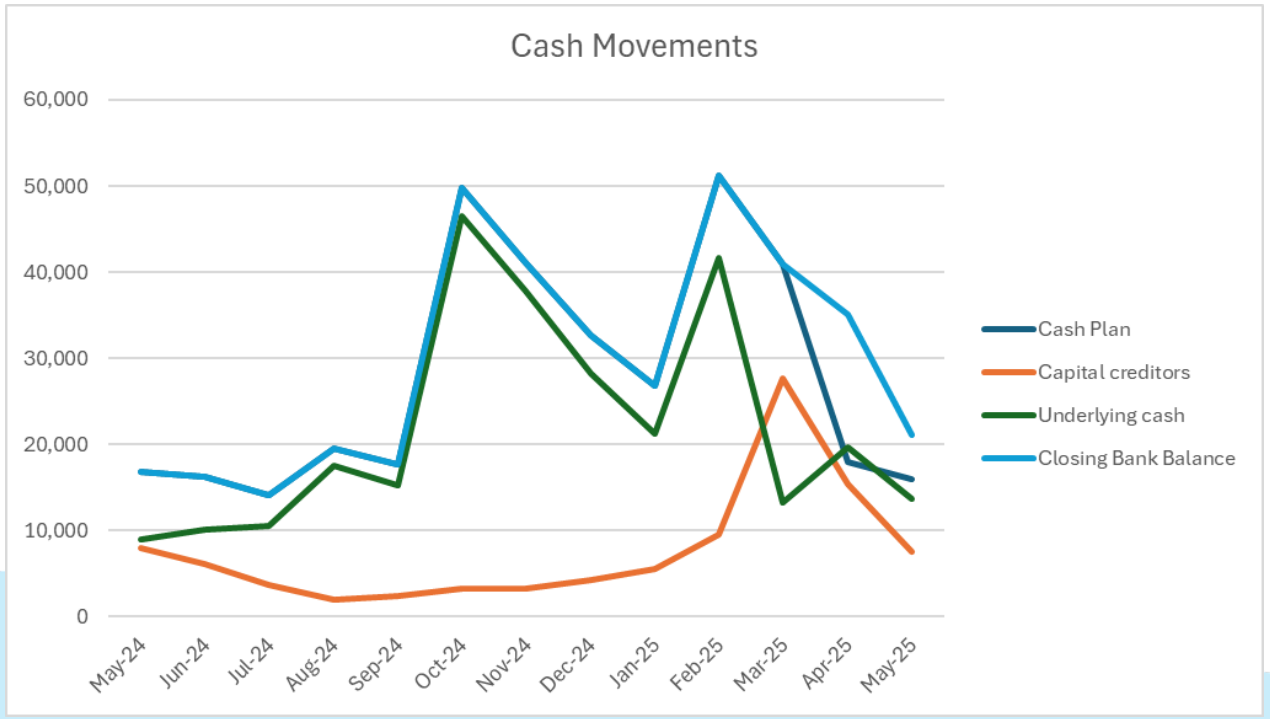
Non-pay trend by subjective	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Drugs (excluding non-PBR drugs)	1,424	1,250	-174	F	-192	F
Drugs (non PBR)	2,265	2,257	-9	F	-39	F
Clinical Supplies and Services	3,090	3,596	505	A	508	A
Other costs	6,376	6,955	579	A	-97	F
Non-Executive Directors	17	15	-2	F	-4	F
Depreciation	1,595	1,597	3	A	2	A
Reserves & Technical Adjustments	1,142		-1,142	F	-1,690	F
Recharges	1,499	1,499		A		A
Parkhill	35	42	7	A	7	A
Total Trust	**17,443**	**17,210**	**-233**	**F**	**-1,504**	**F**



Cash, Receivables and Payables

Cash reduced by £14.1m in the month to £20.9m but remains above plan. The reduction is mainly due to the level of year-end capital creditors being paid in the month (£8.5m) as well as timing of payment runs and the quarterly education income received in month 1. Underlying cash (cash less capital creditors) is £13.4m.

Better Payment Practice was relatively stable in the month.



Invoice Turnaround

Average days	Mar-25	Apr-25	May-25	YTD
Between date of invoice and date available on system	18.9	27	13.9	20.45
Between being available on system and approval	5.8	7	8.4	7.7
Between approved date and payment date	23.2	22.4	22.2	22.3
Total	47.9	56.4	44.5	50.45
Total that the Trust has control over	**29**	**29.4**	**30.6**	**30**
Number of invoices	*8,191*	*10,397*	*7,327*	*8,862*

Better Payment Practice Code (In month)

Average days	Mar-25	Apr-25	May-25	YTD
NHS - %age based on invoice count	82.25%	91.79%	86.34%	89.07%
NHS - %age based on invoice value	90.52%	89.85%	90.10%	89.98%
Non NHS - %age based on invoice count	36.84%	40.63%	36.93%	38.78%
Non NHS - %age based on invoice value	71.33%	77.48%	72.66%	75.07%
Overall - %age based on invoice count	39.06%	42.10%	38.00%	40.05%
Overall - %age based on invoice value	73.65%	74.69%	74.31%	74.50%

Efficiency Schemes

In addition to the 2025/26 in-year analysis that has been provided previously, additional analysis of the recurrent full year effect has been added to the pack this month. We are looking to add analysis of the Whole Time Equivalent (WTE) impact of efficiencies from next month.

In terms of 2052/26 in-year savings:

- In month 3 the Trust delivered £2.9m of savings in line with plan, bringing year to date delivery to £6.3m also in line with plan
- Further progress has been made in de-risking the plan with high-risk schemes falling from £11.1m last month to £6.5m this
- Forecast in-year savings are £31.4m in line with plan, the risk adjusted forecast now stands at £21.5m

In terms of recurrent full year effect:

- Savings beyond £12.7m will start to eat into the Trust's underlying deficit, planned delivery by the end of the year is £16.7m
- Schemes implemented in the year to date will yield a recurrent full year effect of £9.9m
- Forecast delivery by the end of the year is £19.8m which would exceed plan and address £7.1m of the Trust's underlying deficit
- The risk adjusted forecast stands at £13.8m, whilst still £3.9m short of plan this would address £1.3m of the Trust's underlying deficit

The DBTHi Team are undertaking Deep Dives into a number of cross cutting workstreams which scored inadequately in the assurance self-assessment, quick progress is expected and meetings are planned with SROs to repeat and improve the self-assessment which is to be monitored both internally and externally via ICB/NHSE.

Efficiency Schemes – 2025/26 In Year Savings

The tables below reflect the current status and plan risk of the CIP Programme as at month 3, in line with recent NHSE guidance we have eliminated the unidentified balance by the end of May 2025. All high-risk schemes were to be reduced by the end of June 2025, although improved this is yet to be achieved.

Efficiency Plan Status £000's	April Plan Submission	Month 1	Month 2	Month 3	Increase (Decrease)
Fully Developed	9,350	10,835	15,935	16,301	366
Plans in Progress	2,051	2,578	2,732	5,872	3,140
Opportunity	10,528	10,527	12,730	9,224	(3,506)
Unidentified	9,468	7,457	0		0
Total	**31,397**	**31,397**	**31,397**	**31,397**	**0**

Efficiency Plan Risk £000's	April Plan Submission	Month 1	Month 2	Month 3	Increase (Decrease)
High	23,450	19,739	11,104	6,512	(4,592)
Medium	5,968	7,674	10,707	11,257	550
Low	1,979	3,984	9,586	13,628	4,042
Total	**31,397**	**31,397**	**31,397**	**31,397**	**0**

The table highlights the key changes in month to the plan for the status and risk assessment

Workstream / Scheme	Movement	Value £000's	Risk as per Month 2	Risk as per Month 3	Status as per Month 2	Status as per Month 3
Digital First - Review of IT Contracts & AI	Plans being established	130	High	Low	Opportunity	Plans in Progress
Flow & LOS - Modular Ward	Modular Ward closure of x11 beds now counted	367	High	Low	Opportunity	Fully developed
Procurement - KPMG	Risk aligned to KPMG risk assessment	259	High	Medium	Plans in Progress	Plans in Progress
Procurement - KPMG	Risk aligned to KPMG risk assessment	1,127	High	Low	Plans in Progress	Plans in Progress
Workforce Planning - eJP	Review of Job plans	100	High	Medium	Opportunity	Plans in Progress
Workforce Planning - eJP	Review of Job plans	101	High	Low	Opportunity	Plans in Progress
Local	Identification of additional Divisional Schemes for PRMs yet to be processed within the CIP Database	2,488	High	Low	Opportunity	Plans in Progress

Efficiency Schemes – 2025/26 In Year Savings

All schemes are assigned a delivery risk within their respective trackers. This will be agreed by the SRO and updated by the PMO project support. The purpose of this risk rating is to allow the Trust to understand it's most likely outturn position in terms of CIP delivery. The annual forecast as at month 3 remains in line with plan at £31.4m, the risk adjusted view is £21.1m.

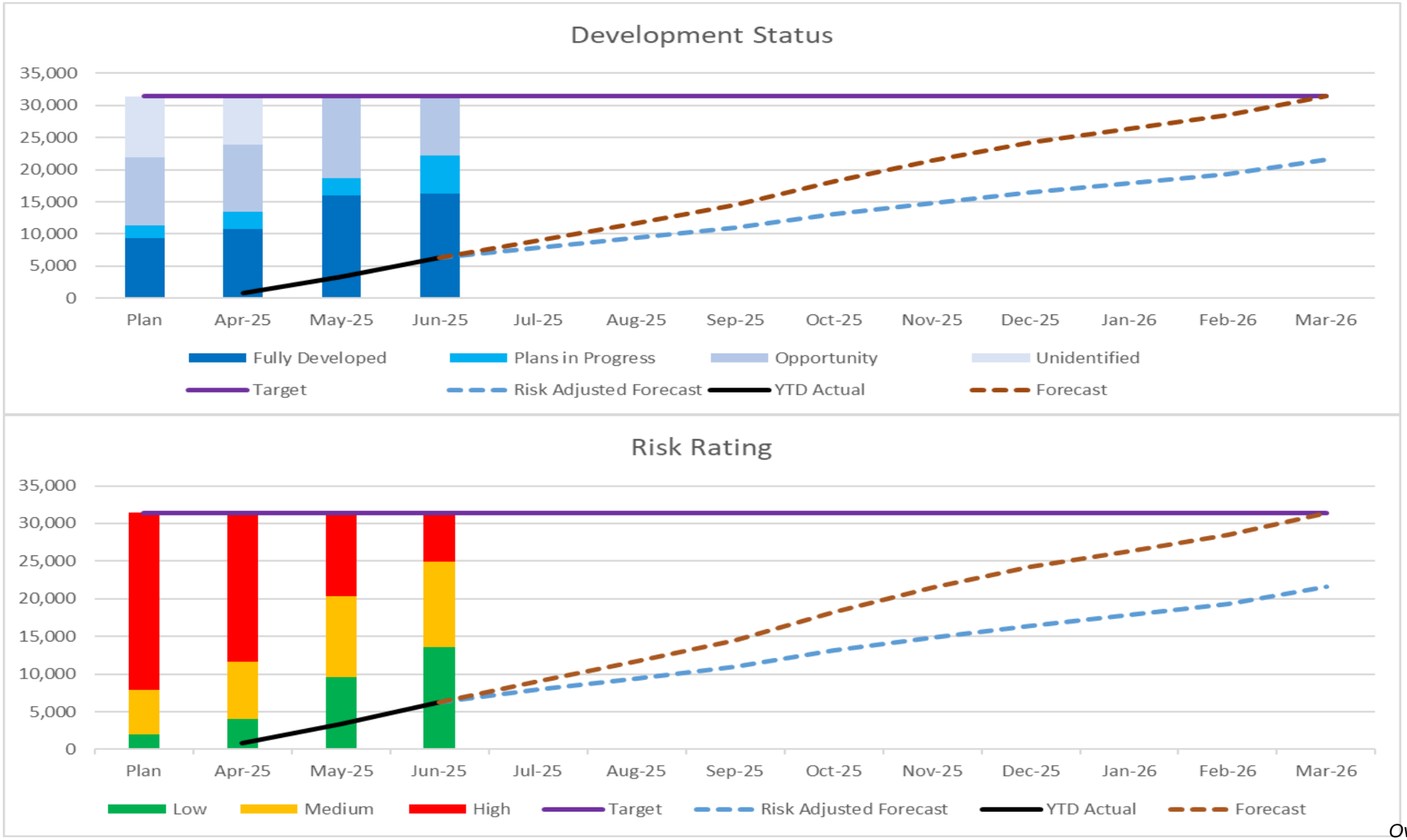
Actual Forecast £000's	April	May	June	July	August	September	October	November	December	January	February	March	Total
NHSE Plan	837	2,503	2,948	3,066	3,480	3,342	3,203	2,733	2,311	2,304	2,329	2,343	31,397
Actual / Forecast Delivery	838	2,503	2,948	2,731	2,641	2,792	3,779	3,195	2,826	2,083	2,124	2,938	31,397
Delivery/Forecast v NHSE Plan	0	0	(0)	(335)	(839)	(550)	576	462	515	(221)	(204)	595	(0)
Cumulative NHSE Plan	837	3,340	6,288	9,353	12,833	16,175	19,378	22,111	24,422	26,726	29,055	31,397	
Cumulative Actuals and Forecast	838	3,340	6,288	9,019	11,660	14,452	18,231	21,426	24,252	26,335	28,459	31,397	
Cumulative Delivery/Forecast v NHSE Plan	0	0	(0)	(335)	(1,173)	(1,723)	(1,147)	(685)	(170)	(391)	(595)	(0)	

Risk Adjusted Forecast £000's	April	May	June	July	August	September	October	November	December	January	February	March	Total
NHSE Plan	837	2,503	2,948	3,066	3,480	3,342	3,203	2,733	2,311	2,304	2,329	2,343	31,397
Actual / Risk Adjusted Forecast Delivery	838	2,503	2,948	1,634	1,521	1,555	2,121	1,741	1,588	1,399	1,442	2,255	21,543
Delivery/Forecast v NHSE Plan	0	0	(0)	(1,432)	(1,959)	(1,787)	(1,082)	(992)	(723)	(905)	(887)	(88)	(9,854)
Cumulative NHSE Plan	837	3,340	6,288	9,353	12,833	16,175	19,378	22,111	24,422	26,726	29,055	31,397	
Cumulative Actuals and Risk Adjusted Forecast	838	3,340	6,288	7,921	9,442	10,997	13,118	14,859	16,447	17,846	19,288	21,543	
Cumulative Delivery/ Risk Adj. Forecast v NHSE Plan	0	0	(0)	(1,432)	(3,391)	(5,178)	(6,260)	(7,252)	(7,975)	(8,880)	(9,767)	(9,854)	

Efficiency Category £000's	Forecast	Risk Adjusted Forecast
Income	599	468
Pay	16,810	12,335
Non-Pay	13,988	8,740
Total	**31,397**	**21,543**

Risk Adjustments £000's	Risk Adjusted Forecast
100% of Fully Developed	16,301
50% of Plans in Progress	2,936
25% of Opportunities	2,306
Total	**21,543**

Efficiency Schemes – 2025/26 In Year Savings



Efficiency Schemes – Recurrent FYE

The NHSE recurrent Plan (53% of the total target) is £16.7m, as at month 3 we are forecasting a recurrent FYE of £19.8m.

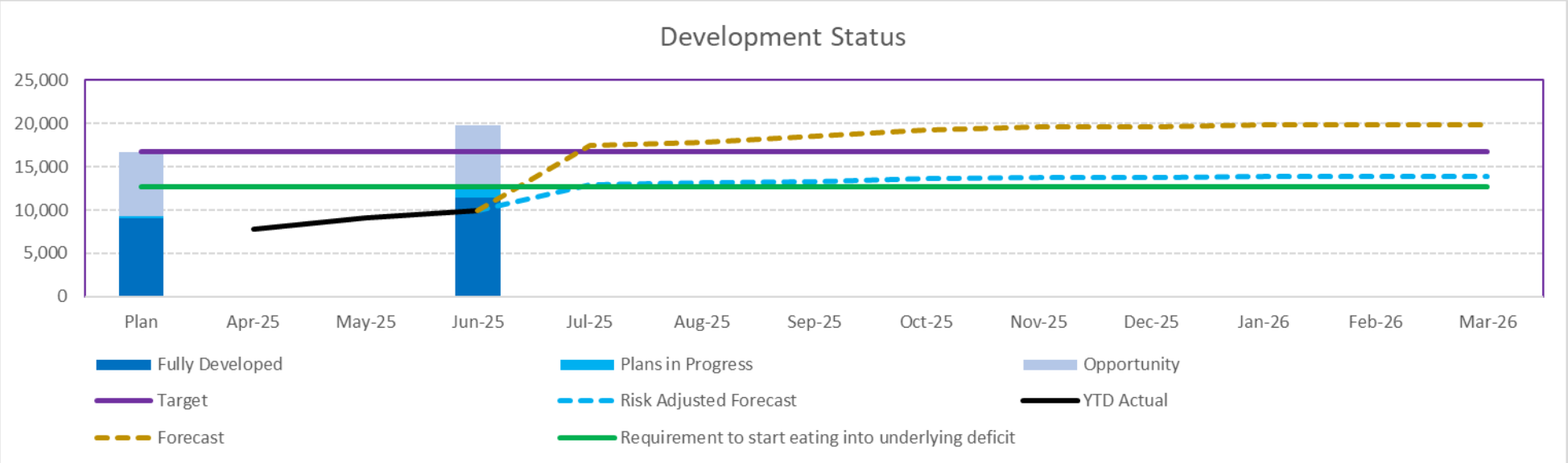
Recurrent FYE £000's	April Plan Submission	Month 1	Month 2	Month 3	Increase (Decrease)
Fully Developed	9,008			11,424	11,424
Plans in Progress	278			1,217	1,217
Opportunity	7,402			7,155	7,155
Unidentified	0			0	0
Total	**16,688**	**0**	**0**	**19,796**	**19,796**

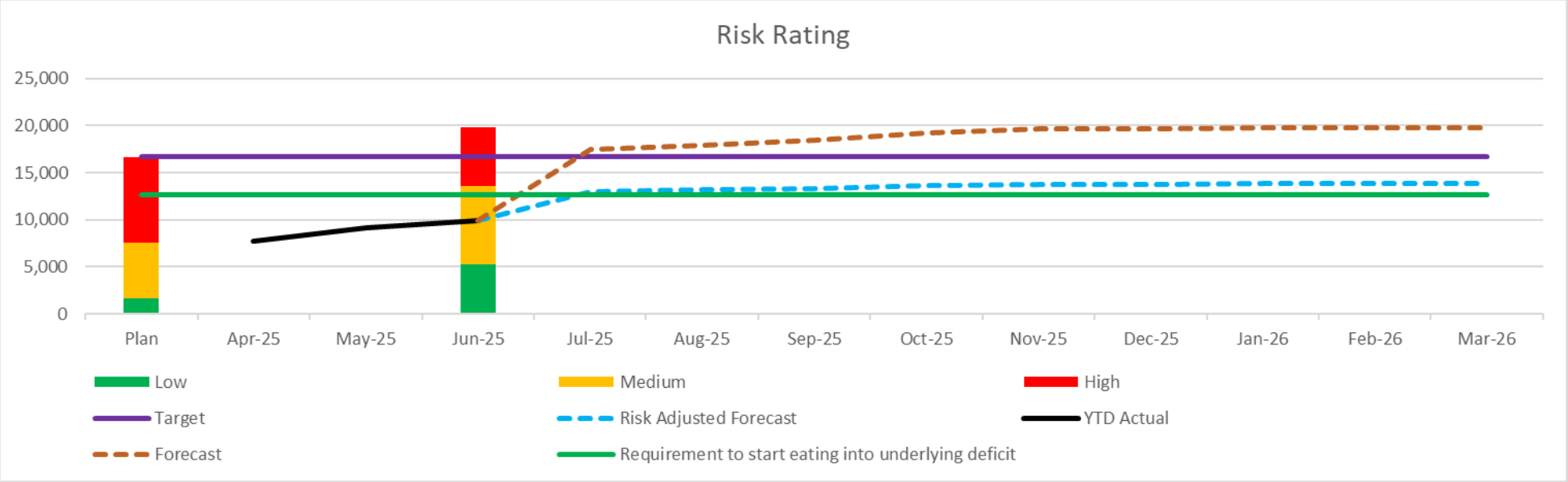
Recurrent FYE £000's	April Plan Submission	Month 1	Month 2	Month 3	Increase (Decrease)
High	9,083			6,189	6,189
Medium	5,973			8,320	8,320
Low	1,632			5,287	5,287
Total	**16,688**	**0**	**0**	**19,796**	**19,796**

Recurrent FYE has only been formally reported to NHSE from month 3, key changes in month are related to recurrent schemes commencing between months 2 and 3 as below.

Workstream / Scheme	Movement	Value £000's	Risk as per Month 2	Risk as per Month 3	Status as per Month 2	Status as per Month 3
Theatres - Utilisation	Recurrent scheme now delivering wef month 3	70		Medium		Fully Developed
Local - Surgery - IVT/Eylea	Recurrent scheme now delivering wef month 3	60		Low		Fully Developed
Corporate Services - Digital - Business Management B2 x3 reduction	Recurrent scheme now delivering wef month 3	90		Low		Fully Developed
Corporate Services - MD - B8b reduction in hours	Recurrent scheme now delivering wef month 3	28		Low		Fully Developed
Local - Medicine - Switch EPO Zeta	Recurrent scheme now delivering wef month 3	78		Low		Fully Developed
Flow & LOS - Surgery - Modular Ward	Recurrent scheme now delivering wef month 3	367		Low		Fully Developed
Local - Medicine - Tilt Chairs	Recurrent scheme now delivering wef month 3	49		Low		Fully Developed
Other Local x7 smaller schemes	Recurrent scheme now delivering wef month 3	60		Low		Fully Developed

Efficiency Schemes – Recurrent FYE





Cash Projections

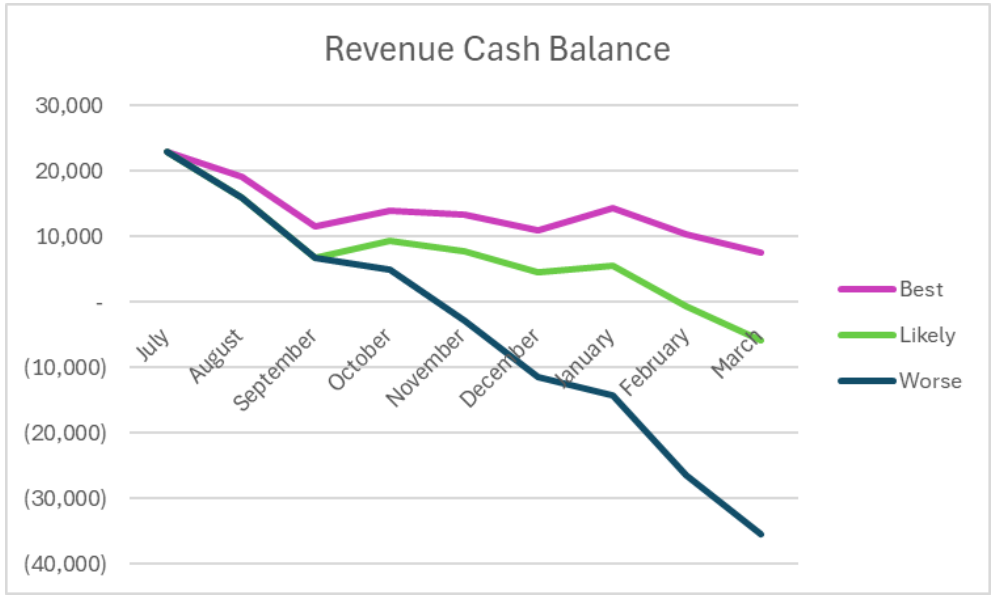
The graph shows a scenario analysis of cash movements between the end of Month 3 and Month 12.

An explanation of the key differences in each scenario is shown in the table.

The revenue cash balance will go below £5m at the particular month end:
Best – N/A
Likely – December (cash support will be required from ICB/NHSE)
Worse – October (cash support will be required from ICB/NHSE)

Due to the high levels of capital spend, the split between capital and revenue cash is important and use of the headline cash figure needs to be cautioned.

To mitigate this risk, cash releasing efficiency savings are required urgently.



Key variations in models	Best	Likely	Worse
Risks/Mitigations (See Slide 4)	Nil	Total risks of £16.2m, less mitigations of £8.9m Total risk £7.3m	Total risks of £16.2m
Deficit Support Funding	Trust to continue receiving funding steadily through the year	ICB recovers M4 funding in M5. No payment in M6. ICB pays Q2 & Q3 in Q3. Q4 is as per plan. Full income to be received in year, although timing differences	Clawback of 1/12th in August and then no further cash Total risk £12.7m

Capital

Capital spend in month is £0.9m, an underspend of £4.6m

The in month spend in Estates is linked to the completion of ongoing projects from 24/25, including the BDGH SDEC.

Capital allocations have been approved by the Executive Team and the sub-committees are working on the completion of business cases to CIG.

Capital expenditure is expected to deliver on plan by the end of the year, current underspend is linked to changes in the capital programme pre-commitments and timing of spend including DCC and Bassetlaw SDEC.

	In Month Budget (£'000)	In Month Spend (£'000)	In Month Variance (£'000)		YTD Budget (£'000)	YTD Spend (£'000)	YTD Revised Variance (£'000)		Revised Annual Plan (£'000)
Other Estates Projects	1,589	5	(1,584)		4,353	44	(4,310)		10,382
SDEC	284	144	(140)		778	148	(631)		1,338
SPECT CT	241	0	(241)		659	8	(651)		1,133
Pharmacy Robot	0	0	0		0	0	0		0
CT Scanner	0	0	0		0	0	0		0
DCC	1,061	6	(1,055)		3,182	17	(3,165)		9,827
Estates Safety	0	30	54		0	30	30		4,381
Return to Constitutional Standards Schemes	0	0	0		0	0	0		4,425
Solar Net Zero	0	0	0		0	0	0		55
Digital Transformation Projects	402	59	(343)		1,205	174	(1,031)		4,091
Electronic Patient Recording	15	(66)	(82)		46	175	129		17,805
Medical Equipment	676	723	47		2,028	1,492	(536)		4,758
Central Capital	1,002	(1)	(1,004)		2,708	6	(2,702)		3,062
IFRS16 Leases	205	0	(205)		561	0	(561)		964
Total Capital Spend	**5,474**	**898**	**(4,553)**		**15,521**	**2,093**	**(13,428)**		**62,221**
Charitable Funds/Donated Assets	0	(11)	(11)		0	6	6		0
Total Capital Spend inc Charitable Funds/Donated Assets	**5,474**	**886**	**(4,564)**		**15,521**	**2,099**	**(13,422)**		**62,221**

BREAK 11:40 - 11:55

2509 - D3 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

Discussion Item | Zara Jones, Deputy Chief Executive | 11:55

Executive Directors
10 minutes

REFERENCES

Only PDFs are attached

D3 - Board Assurance Framework including Trust Risk Register.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Board Assurance Framework including Trust Risk Register**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance Tracy Evans -Philips, Trust Risk Manager			
Appendices:	Appendix 1: Risk Report and Trust Risk Register Appendix 2: BAF Risk 1 - 7			
Purpose of the report	**Assurance**	**Decision required**	~~Information~~	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	Compliance to the Risk Policy and Board Assurance Framework impacts the effectiveness of the Board to monitor the Trusts Strategic risks			

Executive Summary – Key messages and Issues

This report presents the Board Assurance Framework (BAF) for 2025/26 up to and including reviews into August 2025. The Board Assurance Framework and Trust Risk Register are presented to the Board of Directors for further discussion and assurance.

Background and Summary

The Board Assurance Framework brings together the Trusts agreed strategic objectives and identifies and quantifies the risks to achieving those objectives. It is aligned to the Trust four priority areas – Patients, People, Partnerships and Pounds and the trusts risk register to ensure any emerging risks, either internally or externally are effectively managed. It summarises the controls in place to mitigate / manage the risks and sets out the assurance, including 3 lines of defence in line with the agreed risk appetite and tolerance levels for the Trust. Whilst risk cannot be eliminated completely, the Trust understands the importance of managing risk effectively to reduce any likelihood of a negative impact to the Trust, its people, and the patients we care for.

This is in line with best practice where reporting of the BAF to Board forms part of the Trust compliance with the Code of Governance 2023 which is also considered in the context of the risk register, financial & operational reporting, and other forums across the Trust.

2.7 The Board of Directors should carry out a robust assessment of the trust's emerging and principal risks.
2.8 The Board of Directors should monitor the trust's risk management and internal control systems.

The Partnership BAF Risk was discussed at length and agreement has been reached that this will be on each agenda for review at the Board Development Sessions, and amendments made there will be updated and agreed on the BAF at the next session. This has moved out of sync slightly as this was previously discussed through confidential board.

The BAF reflects the ongoing changes and updates to the strategic risks of the organisation. These are updated by the lead executive and monitored through the responsible committees. All risks and action plans are discussed in line with the risk policy. To note that following a discussion at the Finance and Performance Committee, the wording around EPRR has been amended to reflect that control focus on this risk which is the development of the DRI evacuation plans. The discussion on August on BAF risk 4 reflected the high risk of the current estate, which was recognised as being effectively managed by the systems and processes in place. However, in terms of reducing these risks, that is dependent on capital funding to address the underlying issue of the aging estate, and therefore managing through the controls in place is the only option for the Trust.

The BAF and risk report was presented and discussed at the Audit and Risk Committee in July which took assurance on the process of risk management, including its discussions at committee level and its proactive

management by the executive team. The new Risk Policy was approved at this committee and process monitoring will continue through ARC.

The 'clean version' of the Board Assurance Framework is enclosed in appendix 2 for Board review, discussion, and assurance, this has had all the changes updated that were shared within the committees and agreed. The BAF is a working document and will continue to change over time.

Operational risks that influence any strategic risk are documented within the corresponding BAF risk and are continuously managed through the monthly Risk Management Group. These are shown within the Trust Risk Register that is managed through the Datix System. The report is taken at a specific point in time and therefore any updates or amendments that happen after this time will not be reflected here.

Recommendations

The Board of Directors are asked to:

- Receive the report.
- Approve the current BAF risk content and take assurance this enables the Board to fulfil its duty to monitor its highest strategic risks.
- Note that the BAF and Trust Risk Register is a live document, which will be reviewed and updated regularly throughout the year.

Healthier together – delivering exceptional care for all

Patients	Regular review and assessment of the risks to patient care support the delivery of safe and effective services.
People	Regular review and assessment of strategic risks, support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships, however, may identify areas of risk as part of a triangulated approach to risk management.
Pounds	Regular review and assessment of the financial risks, support delivery of the strategic priority to be sustainable and spend money wisely. Regular review may identify areas of financial or resource risk as part of a triangulated approach to risk management.
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities
Legal/ Regulation	It is a regulatory requirement as part of the NHS Code of Governance for the Board of Directors to have mechanisms in place to manage and address risk throughout the organisation.
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies

Assurance Route

Previously considered by - including date:	Quality Committee People Committee Finance and Performance Committee Board of Directors Development Session
Any outcomes/next steps / time scales	To be approved by the Board of Directors on 2 September 2025 To be reviewed and updated in subsequent committees of the Board
In line with Current risk appetite **Yes**	**Risk Appetite levels: -** highlight only if this report is outside of Board Assessment

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Board Assurance Framework and Trust Risk Register Review

BAF Summary of Changes:

- Assurance levels on actions and controls have been agreed by respective lead committees – see highlight reports from each committee. These state the emerging risks as presented in the Trust Risk Register relevant to each committees' BAF risks, plus the assurance around the mitigating actions described therein.
- The Board of Directors will review the whole BAF within its public meeting as per the Trust Risk Management Policy and take a decision on the recommendations made by the relevant committees.

Trust Risk Register (Appendix 1)

Summary of data extracted from Datix Risk Management System 18 August 2025
Author: Tracy Evans-Phillips, Risk Manager.

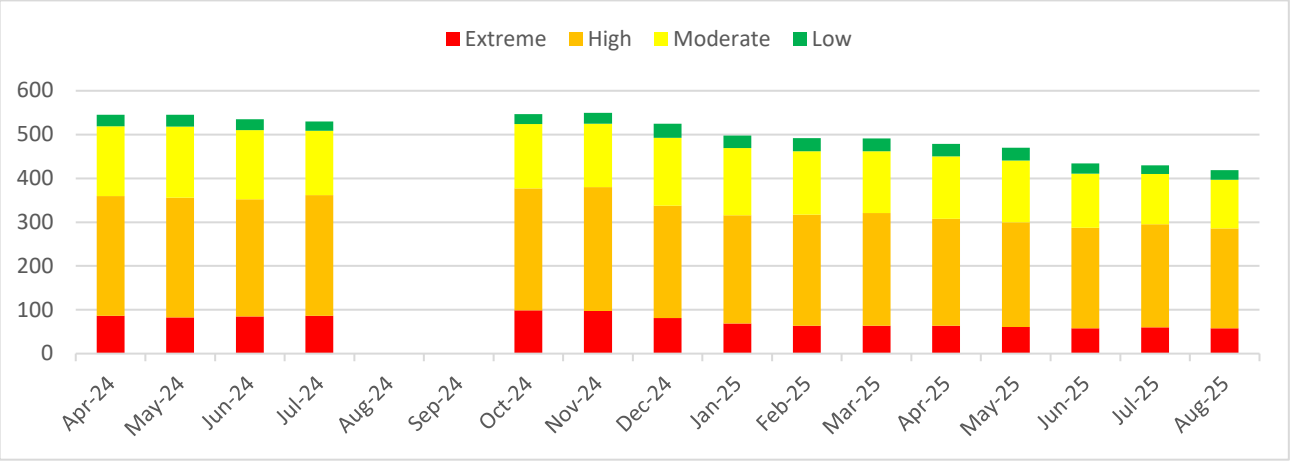
Introduction

This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the continued efforts of the Risk Management Group to assess and moderate risks, including escalations to the Trust Leadership Team and any new developments in risk management practices. The Trust Risk Management Policy has been revised to feature a more streamlined format, the addition of a "risk on a page" summary, and direct links to training resources. These policy amendments were agreed upon at the June meeting of the Risk Management Group and received approval from the Audit and Risk Committee in July.

Please note: The information provided is based on the date the reports were compiled. Specific figures are subject to change throughout the month as updates occur.

Risk Activity June to August 2025

From June to August 2025, the total number of risks on the register decreased from 434 to 419, marking a net reduction of 15 risks or 3.4%. This reduction is the result of active risk management, with risks being closed or downgraded as controls improved or issues were resolved. The overall risk profile for the Trust is moving in a positive direction, with fewer open risks compared to the previous period. The reduction in total risks signals that risk controls and mitigation actions are having a tangible impact and that the risk register is being actively maintained. The drop in overall risks does not stem from a single factor, but rather from a combination of risks being resolved, archived, and a number downgraded.



Overview of Risk Numbers and Changes

- Risks archived: 53
- New risks added: 38
- Risks escalated (risk rating increased): 2
- Risks downgraded (risk rating decreased): 29
- Risks with no change in rating: 350

A significant number of risks were downgraded, reflecting effective risk management across the Trust. Conversely, a small number were escalated, highlighting specific areas that require renewed attention and additional controls. Risks that have been archived represent those that have either been resolved, are deemed no longer relevant, or have been replaced by new risks. The addition of new risks illustrates emerging issues and shifts in the Trust's operating environment. Escalated risks indicate an increase in either likelihood or potential impact, necessitating further oversight, while downgraded risks demonstrate the positive impact of robust controls and an improved risk landscape.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	**5**	
Moderate	**29**	
High	**18**	
Extreme	**1**	Zillion Radiology Information System replaced; risk now closed
Total	**53**	

The majority of archived risks were moderate or high, indicating active management and resolution of significant issues. The closure of the extreme risk stands out as a key achievement, with the replacement of the Radiology Information System marking the Trust's successful resolution of a significant operational concern. This accomplishment reflects the Trust's dedication to investing in critical digital infrastructure and reducing high-level risks. Moving forward, it will be important for DBTH to ensure that the new Radiology Information System is fully embedded and that any lessons learned from the Zillion RIS risk are shared across both digital and clinical teams.

Risk Management Group Update

The Risk Management Group (RMG) undertook a comprehensive review of several key risks, paying particular attention to those that could be moderated or, where necessary, escalated. The group continues to work towards reducing risks wherever feasible, though some remain static due to factors beyond the Trust's control, such as financial and capital constraints that impact the ability to

remedy estates risks, especially on the Doncaster Royal Infirmary Site. In these instances, robust processes remain in place to effectively monitor and manage the risk. Recognising that certain risks cannot be mitigated further, the RMG ensures that all reasonable actions are considered, and any risks that exceed the Trust's risk appetite or require executive intervention are appropriately escalated to the Trust Leadership Team.

Risks escalated to Trust Leadership Team

Risk ID	Risk Title	Reason for Escalation
3632	Failure to achieve compliance with financial performance and plan	Extreme risk (finance) may require risk rating increasing

3634	Failure to deliver Cost Improvement Plans (CIP) for 25/26	Extreme risk (finance) may require risk rating increasing

New Risk Approval Form and Notifications

To strengthen risk management, a New Risk Approval Form has been introduced, ensuring every new risk is discussed and approved before being added to Datix. The form is designed to promote early discussion, confirm controls, and ensure RMG meetings can be managed more effectively by making sure risks are reviewed at Divisional and Directorate Senior Team meetings beforehand. Colleagues were informed about the form and its purpose via the Hive and Buzz platforms, emphasising the importance of using the correct process for risk management.

Appendix 1 Trust Risk Register

Subsequent to the review of the risks within the Board Assurance Framework, some of the risks no longer have an overarching status are directly linked to the relevant BAF Strategic Risk, resulting in a larger Trust Risk Register. The content of the risk register table has been updated to provide more clarity on each of the risks.

Risks with extended duration are reviewed through a scheduled Deep Dive at Risk Management Group on a rolling basis.

BAF	Risk ID	Risk Owner	Title	Review date	Regular Review	Rating (current)	Rating (Target)	Risk score requires review	Time at current risk rating (months)	Duration requires review	Number of Dependent Extreme Risks	Action Status
BAF 1	1517	Rachel Wilson	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	08/10/2025	✓	15	6	No	13 Months	No	0	✓
BAF 1	3209	Denise Smith	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	19/09/2025	✓	8	6	No	1 Months	No	0	✓
BAF 1	3246	Simon Brown	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	16/09/2025	✓	15	9	No	29 Months	RMG Deep Dive ✓	1	✓
BAF 1	3290	Karen Jessop	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	01/12/2025	✓	10	6	No	27 Months	RMG Deep Dive ✓	0	✓
BAF 1	3449	Simon Brown	Risk of harm to patients due to pressure ulcers due to numbers of patients on under prescribed mattress	01/09/2025	✓	6	6	No	1 Month	No	0	✓
BAF 1	3454	Nicholas Mallaband	Insufficient governance and service gaps risk failure to meet guidance, leading to harm, regulatory action, and reputational damage	30/09/2025	✓	16	8	No	17 Months	RMG Deep Dive ✓	4	✓
BAF 1	3627	David Harvey	EPRR non-compliance 2025/26 risks major disruption, legal breach, patient harm, and loss of trust	16/01/2026	✓	20	16	No	5 Months	No	5	✓
BAF 2	16	Zoe Lintin	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	30/09/2025	✓	12	9	No	14 Months	Yes	3	✓
BAF 2	19	Zoe Lintin	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	01/10/2025	✓	8	8	No	9 Months	No	0	✓
BAF 3	3434	Suzanne Stubbs	Timely access to diagnostic services - Demand, Capacity & Flow	30/09/2025	✓	12	12	No	18 Months	Yes	5	✓
BAF 3	3435	Suzanne Stubbs	Timely access to elective care - Demand, Capacity & Flow	30/09/2025	✓	12	12	No	18 Months	Yes	2	✓
BAF 3	3436	Lesley Barnett	Timely access to cancer services - Demand, Capacity & Flow	30/09/2025	✓	12	12	No	14 Months	Yes	0	✓
BAF 3	3437	Suzanne Stubbs	Timely access to emergency care - Demand, Capacity & Flow	30/09/2025	✓	16	12	No	18 Months	Yes	7	✓
BAF 4	12	Howard Timms	Failure to ensure that estates infra-structure is adequately maintained and upgraded in line with current legislation	28/11/2025	✓	25	10	No	5 Months	RMG Deep Dive ✓	11	✓
BAF 4	1083	Mathew Gleadall	Risk of electrical failure due to age and condition of HV/LV infrastructure	28/11/2025	✓	15	10	No	85 Months	Yes	1	✓
BAF 4	1412	Howard Timms	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	31/12/2025	✓	15	10	No	53 Months	Yes	7	✓

BAF 4	1807	Mathew Gleadall	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	31/12/2025	✓	16	8	No	5 Months	RMG Deep Dive ✓	2	✓
BAF 4	3348	Nicholas Mallaband	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/10/2025	✓	12	10	No	10 Months	No	1	✓
BAF 5	3628	Angela Lawson	25/26 PMO2 Financial services don't complete financial analysis of identified schemes within agreed timescales delaying schemes	14/10/2025	✓	6	6	No	5 Months	No	0	✓
BAF 5	3629	Sam Wilde	25/26 Risk of Fraud, Bribery and Corruption against the Trust through criminality by exploitation of control measures.	08/10/2025	✓	12	8	No	5 Months	No	0	✓
BAF 5	3630	Angela Lawson	25/26PMO1 Lack of engagement/capacity from operational services to deliver project objectives/CIP schemes not delivering savings	14/10/2025	✓	9	6	No	5 Months	No	0	✓
BAF 5	3631	Angela Lawson	25/26 PMO3 - Monday.com system failure resulting in the loss of project information	14/10/2025	✓	10	10	No	5 Months	No	0	✓
BAF 5	3632	Sam Wilde	Failure to achieve compliance with financial performance and achieve 2025/26 financial plan	11/09/2025	✓	16	8	No	5 Months	No	0	✓
BAF 5	3634	Yasmin Ahmed	Failure to deliver 25/26 Cost Improvement Plans impact on the Trust's deliver of financial targets	11/09/2025	✓	16	9	No	5 Months	No	0	✓
BAF 5	3635	Yasmin Ahmed	Failure to deliver 25/26 Capital Programme including inability to meet Trust's needs for capital investment	13/11/2025	✓	9	6	No	5 Months	No	0	✓
BAF 5	3636	Yasmin Ahmed	Non-delivery of 25/26 activity targets impacting on levels of income received by the Trust	13/11/2025	✓	9	6	No	5 Months	No	0	✓
BAF 5	3637	Yasmin Ahmed	Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital	11/09/2025	✓	16	8	No	5 Months	No	0	✓
BAF 5	3639	Yasmin Ahmed	Failure to capture all 25/26 NHS revenues may result in reduction in payments by commissioners	17/10/2025	✓	4	4	No	5 Months	No	0	✓
BAF 6	3507	Sam Debbage	Failure to meet MHRA research inspection standards	20/10/2025	✓	12	4	No	14 Months	Yes	0	✓
BAF 7	1410	David Linacre	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	30/10/2025	✓	10	10	No	2 Months	No	0	✓
BAF 7	1663	Dan Howard	Failure of the HSCN, Internet, or VOIP telephony external network connections	31/10/2025	✓	8	4	No	9 Months	No	0	✓
BAF 7	2727	Virendra Pandare	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	30/09/2025	✓	9	3	No	17 Months	Yes	0	✓
BAF 7	2736	David Linacre	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & DR	30/09/2025	✓	9	6	No	42 Months	Yes	0	✓
BAF 7	3184	Dan Howard	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	25/08/2025	✓	8	4	No	19 Months	Yes	0	✓
BAF 7	3384	Dan Howard	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	29/08/2025	✓	8	8	No	9 Months	No	1	✓

Appendix 2: Board Assurance Framework –

Strategic Risk 1	*If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH.*						**Strategic Objective: Patients**	**We deliver safe, exceptional, person-centred care**
Lead Committee	Quality Committee	Risk Rating	Current Exposure	Tolerable	Target (March 26)	Risk Type	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Chief Nurse / Executive Medical Director	Likelihood	4		4	Risk Appetite	Quality: Cautious Regulatory: Cautious	3209; 3454; 3627; 3449; 3290; 3246 1517
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Last reviewed (by on behalf of Lead Directors)	July 2025	Risk Rating	**16**		**12**			
Last Changed (By Lead Committee)	December 2024	Inherent Score	5x4=20					

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls and dates (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
Chief Nurse Oversight Framework – which includes ongoing monitoring of quality metrics, peer reviews, expert reviews, and the ward accreditation process.	**GC1** Quality Dashboard remains under development, ongoing issues with data quality and roll out of metrics	Divisional performance monitored at Performance Review Meetings with Exec oversight, (monthly) (1) CQC Action plan update to QC (August 25) (2) CQC Action plan assurance presentation to Integrated Quality Improvement Group (March & April 25) (3) CQC Quarterly Engagement Meetings (3) CARE Accreditation Process review oversight update to QC (Aug 25) (1) Maternity, Neonatal Quality and safety Group (1) IQPR (2) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3)		**Significant Assurance**
Compliance with Developing workforce safeguards including use of Safer Nursing Care Tool and biannual workforce reviews (BR+ for Midwifery) Establishment changes via Chief Nurse approval.	**GC2** Nursing skill mix of RN/Non-RN is not in line with national guidance **GC3** Limited national guidance/decision support tools and reporting for Allied Health Professionals	Biannual establishment review reporting for Nursing to People Committee (Feb 25) (2) Trust wide safe staffing meetings (1) Established use of safe care (1) Evidence of escalation in incident reporting (1) Monthly compliance with safe staffing care hours per patient day reporting via unify (2) Skill mix paper considered by Executive team and included in current annual planning (1) AHP Biannual workforce report presented to People Committee (Jun 25) (2) Biannual Midwifery Workforce report to Trust Board of Directors (Jul 25) (2)		**Significant Assurance** **Significant Assurance** **Significant Assurance**
Clinical Audit Programme and monitoring.		Report to Quality Committee June 2025 (2) Monday.com dashboards reports into Audit and effectiveness forum (1)	**GA2** Clinical Audit oversight not consistent across all areas.	**Significant Assurance**
Learning from deaths review process	**GC4** Insufficient structured judgement reviews (SJRs) completed to contribute to Learning From Deaths **GC5** No substantive Learning from Deaths manager in post	Mortality (and DQ) report to Quality Committee (2) Compliance with Quarterly reporting of perinatal mortality review tool outcomes (2) SANDS review of bereavement care (3)		**Significant Assurance**

Clinical policies, processes and clinical guidelines Risk Management Policy,	**GC7** Inconsistent use of complaints handling Policy **GC8** Application of the MCA not consistently applied across the Trust **GC9** High numbers of Clinical policies are out of date **GC10**: Antimicrobial Stewardship Procedures not consistently applied in all areas	Internal Audit Complaints Handling Policy (Oct 24) (3) (Moderate **Assurance**) Infection Prevention Control Steering Group (1) Internal Audit- Medicines Management **(Significant Assurance)** Risk Management Group (1) Actions completed and reported through to Audit and Risk committee (July 25)(2**)** Risk Management Board assesses and moderates significant risks and presence of valid action plans monthly (2)	**GA3** Lack of visibility of resuscitation activity and RESPECT compliance **GA4:** Implementation of recommendations for medicines management Internal Audit	**Moderate Assurance** **Significant Assurance** **Moderate Assurance**
Patient safety incident response plan	**GC11** Trust wide safety improvement plans under development and not embedded	Never event and PSII tracker at internal meetings (1) Patient experience Annual reports to Trust Board (sept 24) (2) Never Event Exception report to QC (Oct 24) (2) Divisional and Trust LFPSE panels (1) Trust Executive Patient Safety Oversight Group (2) Patient Safety report to QC (Aug 25) (2)		**Significant Assurance**
Clinical Negligence Scheme for Trusts monitoring and oversight (maternity and neonates)		LMNS-Local maternity and neonatal Annual system check & challenge, feedback received and shared at QC (Jun 25) (3) CNST divisional oversight group highlight reports (1) Maternity, Neonatal Quality and safety committee (2) Maternity safety champions visits and meeting (2) Maternity and Neonatal Board report (July 25) (2) Maternity and Neonatal Single delivery plan update to QC (June 25) (2) Received confirmation of achievement of Year 6 CNST from the Maternity incentive scheme (Jun 25) (3) Maternity and Neonatal report to QC under changed arrangements (Aug 25) (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	**Timescale**	**Lead**	**Progress update**
GA2) Effectiveness Group receive divisional highlight reports to check compliance with actions for clinical governance recommendations	March 26	EMD	All activities monitored through Monday.com and standardised templates for reporting through local governance, audit and effectiveness forum, and Effective Group. Continues to be reported through Quality Committee
GA3) Education Team working with EMD office to establish baseline for understanding required actions for RESPECT and resuscitation.	October 25	EMD	Audit review will come to Quality Committee once completed with next steps to address the gaps. Will be a priority area of focus in 2025/26, The Audit has been done at ward and service level. It was not possible to do through Tendable so will be done through Survey Monkey. Once the data capture form has been checked and signed off by the resus lead, it will be launched across the trust. Awaiting the launch date to close the action
GA4) Medicines management Implementation of Internal Audit 2 moderate recommendations.	October 2025	CN	Plans are in place to complete the recommendations; progress towards completion will be reported to Trust leadership team. Aug 25 – recommendations completed and submitted to Internal audit, await outcome of their assessment , verbal report to QC.
GC1) Quality dashboard implemented with phase 1 & 2 development complete overseen by IT (information services) Phase 3 development is underway. Further iterations included in annual plan for consideration in business planning processes.	September 25	CFO	Team met to review and adjust relevant metrics and issues with the timing of data capture inaccurately impacting on compliance.
GC2) Business case under development to embed required skill mix based on quality risks	August 25	CN	Once developed Business Case will be reviewed through Business Planning 25/26
GC4) SJR plan in place to address current gaps	July 25	EMD	Phase 3 is now ongoing training following identification of consultants once they come forward to be involved in the SJR process.

			2 x reports to August Quality Committee outlining the 'learning from deaths and structured judgment reviews' plus 'mortality surveillance systems and process compliance' providing evidence of closing the gap.
GC5) Recruitment to Learning From Deaths Manager	December 25	EMD	August 25 update: Interim manager remains in post working flexibly through the month and recruitment ongoing.
GC8) MCA steering group established with associated work plan	September 25	CN	Reported via Strategic Safeguarding Group, MCA advisor posts now recruited to
GC9) Implement and embed processes to ensure Trust wide clinical policies are reviewed in a timely fashion	September 25	DCEO	Process established for all policies on Monday.com for monitoring. Policy deadline reviews have now taken place and assigned to the correct executive portfolio. Individual executive teams are working through prioritisation of policies and also checking where these are guidelines and SOPs rather than policies.
GC10) Continue with ongoing processes of antimicrobial ward rounds, embed role of antimicrobial stewardship nurse	September 25	CN	Role recently recruited to, plan to undergo induction and review of workplan utilising fresh eyes.
GC11) Monitoring of Trust wide safety improvement plans	July 25	CN	Skin integrity, Falls, infection prevention and control, recognition of deterioration all complete and in the process of being implemented. Access, admission, assessment and transfer of care (COO office completing), recognising and responding to behaviours of concern(stakeholder group established) and documentation and communication under development. All improvement plans now received by Patient Safety Group and agreed process for monitoring in place (Aug 25)

Strategic Risk 2 (Cause – Event-impact)	***If DBTH do not listen, engage with and support colleagues, we will not create an open and inclusive culture, and risk being unable to recruit and retain a skilled workforce aligned to our DBTH way.***						**Strategic Objective: People**	**We are supportive, positive, and welcoming**
Lead Committee	People Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Chief People Officer	**Likelihood**	4		4	Risk Appetite	People: Seek Regulatory: Cautious	**16;19**
Initial Date of Risk Assessment	July 2023	**Impact**	3		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by on behalf of Lead Director)	July 2025	**Risk Rating**	**12**		**12**			
Score Last Changed (By Lead Committee)	October 2024	**Inherent Score (L x I)**	5x4=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) GA	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
The People Strategy Delivery Plans IA Bank and Agency processes	**GC1:** Additional actions identified to support return to work and reduce sickness absence.	Chief People Officer Senior Leadership meeting (1) Reports assurance at People Committee (2) IA Bank and Agency (3)All recommendations implemented. IA Pay and expenditure (3) Significant Assurance IQPR to Board (2)	**GA2:** IA Pay and Expenditure recommendations.	**Significant Assurance** **Significant Assurance** **Significant Assurance**
HR policies and support resources including Health and wellbeing resources.	**GC2:** Identified gap of capturing information from exit interviews.	Policy Formulation Group (1) Operational Delivery Groups (1) Reports to People Committee (2) Internal Audit eRostering (3) Moderate/Limited *Internal Audit Absence Management 2025 – 26 Audit plan (3)*	**GA3:** Internal Audit e rostering recommendations. Split assurance of Moderate and Limited	**Significant Assurance** **Limited Assurance** **Moderate Assurance**
Equality Diversity & Inclusion Improvement Plans		EDI Forum reports bimonthly (1) People Committee Biannually (2) WRES and WDES data reporting to Board (3) *Internal Audit Strategy 2023-2027 Equality Diversity and Inclusion 2025-*26 Audit Plan (3)*		**Significant Assurance**
Education Quality Framework		Operational Delivery Groups and Networks (1) People Committee reports (2) External Quality Visits (Various annual) (3) Learner Feedback and Surveys (various ongoing) (3)		**Significant Assurance**
People Engagement Strategic Approach		People Committee reports (2) Annual Staff Survey (3)		**Significant Assurance**
Speaking Up Process and Partnering Activities	**GC3:** Not all Staff Networks currently running as awaiting new volunteer Chair appointments.	Staff Networks (1) Operational Delivery Groups (1) Reports to EDI Forum (1) Reports to People Committee and Board (2)		**Significant Assurance**

Leadership Development Offer & Organisational Development Activities	**GC4:** Further work required to articulate the DBTH leadership framework for different levels of leadership role.	People Committee Report Annually (2) DBTH Way updates to People Committee (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	**Timescale**	**Lead**	**Progress update**
GA2: Implementation of IA Pay and Expenditure recommendations for people directorate	June 25	Chief People Officer	All remaining actions on track to complete
GA3: Implementation of Internal Audit e-rostering recommendations	September 2025	Chief People Officer	Progress report to be provided at June 2025 People Committee. All remaining actions on track to complete
GC1: The Workforce workstream reviewing identified actions for improvements, reporting Executive team	March 26	Chief People Officer	Policy implementation review of refreshed sickness absence policy completed. The recommendations and learning from this and benchmarking with another trust have now been collated and improvements agreed for implementation. The deep dive data analysis has been completed on additional groups. All actions are managed internally on Monday.com and monitored at steering group meetings.
GC2: Learning from Leavers Project in place to capture information from and ensure consistency of approach to the exit interviews process	March 26	Chief People Officer	Preferred option for data capture on exit interviews to be further detailed for implementation.
GC3: Network refresh and relaunch project	March 26	Chief People Officer	Progress monitoring and reporting will be through to EDI Forum. Executive Sponsorship of networks now in place for the two active networks as part of the refresh work over Feb and March 2025. Further networks are expected to launch in May and June 2025
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	The second annual DBTH Leadership Conference was held in April 2025, face-to-face in the education centre, with guest key-note speaker. Workshops were hosted by DBTH leads on a variety of topical subjects. Positive feedback received from attendees. Content can be used again and will be banked as resources going forward.

Strategic Risk 3 (Cause – Event-impact)	***If we do not address the post-pandemic elective care backlog, improve efficiency and manage demand, we are unable to deliver timely access to care resulting in long waiting times and potential patient harm.***						**Strategic Objective: Patients**	**We deliver safe, exceptional person-centred care**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Strategic / Financial	Links to Significant Risks on Trust Risk Register
Executive Lead	Chief Operating Officer	**Likelihood**	4		4	Risk Appetite	Quality: Cautious Regulatory: Cautious	**3434; 3435; 3436; 3437;**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by / on behalf of Lead Director)	July 2025	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)	November 2024	**Inherent Score (L x I)**	5x4=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Waiting time standards Access Policy Cancer Access policy Capacity and flow policy Trust validation Programme Patient Tracking List management Cancer Patient Tracking List management Clinical Prioritisation	**GC1)** No Current Trust Access Group **GC2)** Inconsistent use of the Urgent Emergency Care (UEC) escalation process **GC3)** Trust Validation Process to be aligned to current national best practice **GC4)** Consistent application of clinical prioritisation coding **GC5)** Delivery of the Elective Care improvement programme	Performance Review Meetings monthly report (1) National Data Submission of Trust performance (2) Access Standards Reports to F&P Committee (2) IQPR report to Board (2) Doncaster Place UEC board (monthly) (3) NHSE / ICB/ Place Tier 2 meeting (fortnightly) (3) Acute Federation Elective oversight Group (monthly) (3) Acute Federation Diagnostic Oversight Group (monthly) (3) Model Health reporting system (3) Internal Audit of Data Quality, Cancer metrics 25/26 Plan (3)	**GA1)** Operational Delivery Group (Monthly) to be set up **GA2)** Inconsistently applied Divisional Governance arrangements **GA5)** Internal Audit: Outpatients appointments	**Significant Assurance** **Limited Assurance**
Demand management Doncaster Place UEC improvement programme Patient initiated Follow-up (PIFU) policy Advice and Guidance policy Diagnostic improvement programme Virtual ward	**GC6)** Further develop SPA for ambulance crews to access **GC7)** A need to expand the use of PIFU **GC8)** A need to expand the use of Advice and Guidance **GC9)** Implement Urgent Treatment Centre First model **GC10)** Implement frailty and surgical SDEC	Performance Review Meetings monthly report (1 National Data Submission of Trust performance (2) Doncaster Place UEC board (monthly) (3) Outpatient improvement programme meeting (1) Diagnostic Improvement Programme meeting (1) Internal Audit of Patient Flow 25/26 Plan (3)	**GA3)** No current specific reporting on demand management	**Partial Assurance**
Efficiency GIRFT Programme Outpatient improvement programme Theatres improvement programme Urgent Emergency Care improvement programme	**GC11)** Review of impact of current GIRFT programme **GC12)** Improved reporting of the improvement programmes, using SPC charts as the standard	Performance Review Meetings monthly report (1 Doncaster Place UEC board (monthly) (3) Outpatient improvement programme meeting (1) Theatre improvement programme meeting (1) Model Health reporting system (3)	**GA4)** No current specific reporting on efficiency	**Partial Assurance**
Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)				

Actions: SMART Actions	**Timescale**	**Lead**	**Progress update**
GC1) Initiate and embed a Trust wide Access Group (executive led)	June 2025	COO	Operational Delivery Group established, first meeting 27 June 2025
GC2) Embed consistent use of Urgent Emergency Care (UEC) escalation process	April 2025	COO	Escalation process implemented. Further work in progress with YAS / EMAS to revise the ambulance handover process
GC3) Review Trust Validation Process with national best practice and initiate new process	September 2025	COO	Initial discussion with COO / CFO / COO taken place. The Trust is participating in the NHSE 'DQ Sprints' during 2025/26
GC4) Clinical prioritisation coding action plan	August 2025	COO	Initial scoping underway
GC5) Elective Care improvement programme	June 2025	COO	Initial focus on validation, action plan for the wider programme to be finalised
GC6) UEC Improvement programme to address ambulance conveyance rates and provide a single point of access (SPA) for ambulance crews to access advice and alternatives to conveyance	August 2025	COO	Work underway across the whole system to review the YAS protocols and support with improvements to reduce the conveyancing to DBTH's ED. Partnership discussions underway through the Doncaster Place UEC Board
GC7) Expansion of Patient Initiated Follow ups across all specialities Action plan	October 2025	COO	Using existing successful implementations as a blueprint - Initial scoping underway for remaining services to produce action plan and time scales
GC8) Expansion of the use of Advice and Guidance action plan	October 2025	COO	Using existing successful implementations as a blueprint - Initial scoping underway for remaining services to produce action plan and time scales
GC9) Urgent Treatment Centre First model to be implemented at all sites	October 2026	COO	Initial scoping underway, initial meeting with FCMS taken place and working group planned from April 2025
GC10) frailty and surgical SDEC implementation plan	March 2026	COO	Initial scoping underway and further discussion at the UEC workshop in March 2025 complete. Divisions of Medicine and Surgery developing the model of care in line with the national service specification
GC11) Current GIRFT programme review	June 2025	COO / EMD	Links to GA4) as part of a fundamental strategic decision and review. Discussion with the Elective Improvement Support Team took place in June to consider a support programme for the Trust for elective care / GIRFT improvement
GC12) SPC charts to be used as standard across all reporting for services	July 2025	COO	Working with Information team to scope what this will look like and how it can be used by managers. Implemented for some of the access standards.
GA1) Operational Delivery Group (Monthly) Chaired by the COO	July 2025	COO	Group established, first meeting 27 June 2025
GA2) Divisional Governance arrangements mapping exercise	June 2025	COO / DCEO	Part of a wider piece of work Trust wide. Currently led by the DCEO and Corporate Office
GA3) Demand management reporting plan	August 2025	COO	Elective Care Improvement Support Team to work with the Trust to develop the expertise internally
GA4) Efficiency reporting plan	June 2025	COO / EMD	Part of the wider Trust discussion on the GIRFT resources
GA5) Implementation of Internal Audit recommendations for Outpatients Appointments	March 2026	COO	

Strategic Risk 4 (Cause – Event-impact)	***If DBTH cannot maintain and improve the care environment in a timely way, this will lead to a poor-quality or unsafe environment, impacting the quality of care experienced by patients, colleagues and / or regulatory actions.***						**Strategic Objective:** **Patients** **People**	***We deliver safe, exceptional person-centred care** ***We are supportive, positive and welcoming**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Quality / Financial / Regulatory	Links to Significant strategic Risks on Trust Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	5		4	Risk Appetite	Finance: Open Quality: Cautious Regulatory: Cautious	**12; 1412; 1807; 3348; 1083**
Initial Date of Risk Assessment	July 2023	**Impact**	4		4	Risk Treatment Strategy	Manage	
Risk Last reviewed (by / on behalf of Lead Director)	August 2025	**Risk Rating**	**20**		**20**			
Score Last Changed (By Lead Committee)	July 2023	**Inherent Score (L x I)**	5x5=25					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
DRI Development Master Plan 2024 and long-term capital investment plan.		Review of incidents on Datix via Quality and Safety Group (1)		**Partial Assurance**
Planned Preventative Maintenance (PPM) program.	**GC1**: The Trust's current maintenance strategy focuses on statutory compliance and minimum essential maintenance requirements. An estates maintenance review indicates that circa £1m of additional resource (the majority at DRI) is required (£690kpay/£317k non-pay) to deliver an effective maintenance strategy that aims to improve preventative maintenance measures in line with industry guidance as a control against estates infrastructure risks.	Report to F&P Committee (2) Ongoing monitoring of maintenance reactive Programme of external audit for Authorising Engineers (AE) and enforcing authorities. (3) PAM Assurance Model self-Assessment (1)		**Significant Assurance**
Doncaster Royal Infirmary Site Evacuation Plans	**GC2**: Work is currently in progress to establish effective site evacuation plans for DRI, supported by a regional response.	EPRR response approved by Board of Directors (2) Review through Capital Monitoring Committee (2) EPRR Self-Assessment extended review (1) Report to Audit and Risk Committee (2)	**GA2:** Gaps in assurance in relation to EPRR core standards.	**Partial Assurance**
5 year Annual Capital Investment Programme CDEL – focus on backlog eradication Trust wide	**GC3:** Site Development Master Plans required for Bassetlaw and Montague sites. **GC4:** Annual CDEL investment alone is unable to keep up with level of backlog within the Trust, as evidenced in annual ERIC returns	Annual report to Board of Directors (2) ERIC return (3) Annual 6 facet surveys to monitor risk profile changes (1)		**Partial Assurance**
Policies, procedures and Standard operating procedures		Monitored through incident and risk in Datix at divisional management meetings (1) Health and Safety reports to F&P committee (2) HSE Audit Outcomes (3)		**Significant Assurance**

		ROSPA accreditation (3)		

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	Timescale	Lead	Progress update
GC1a: Confirm the funding availability for estates maintenance based on the findings of the estates review and associated business case by the end of quarter 1 of FY2025/26	June 2025	CFO	Cost pressure not funded for 25/26 due to the financial position of the Trust. As a result we will not yet be able to move to have preventative maintenance in line with industry guidance and estates infrastructure risks will remain higher than otherwise would have been the case.
GC1b : Once funding is confirmed, align the estates maintenance strategy to funding availability, adopting an approach that mitigates risk and regulatory non-compliance as far as reasonably practicable within any funding constraints that may remain.	November 2025	Head of Estates	Maintenance strategy under review by Head of Estates in line with funding decision to confirm risk and regulatory non-compliance mitigated as far as reasonably practicable within current budget constraints.
GC1c : Assess remaining gaps in compliance after the maintenance strategy is reviewed, complete a risk assessment and record the findings on the E&F risk register.	December 2025	Head of Estates	To be completed once GC1b complete
GC2: Complete site evacuation plans for DRI	May 2026	COO	Initial Draft Site evacuation plans nearing completion and about to be issued to colleagues, further work continuing to provide greater detail and refinement of the plans and also test with partners.
GC3: Draft site development plans for BH and MH	March 2026	Director of Infrastructure	Ongoing annual investment plans for F&P Quotes obtained for site development plan. Director of Infrastructure drafting proposal for consideration by the Trust Executive Team.
GC4: Review risk register and updated 6 facet survey data annually to inform capital planning process	March 2026	Director of Infrastructure	Annual investment plans for F&P to be brought to committee and reviewed ahead of the following year Action completed for 25/26 – action is an ongoing annual requirement – updated target completion date to reflect requirement to complete for 26/27
GA2: Address any outstanding gaps in compliance with EPRR core standards	November 2025	COO	Part of a wider piece of work regarding meeting EPRR core standards, directly monitored through the Audit and Risk Committee and Board.

Strategic Risk 5 (Cause – Event-impact)	***If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.***						**Strategic Objective: Pounds**	**We are efficient and spend public money wisely**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 26)**	**Risk Type**	Reputational / Financial	Links to Significant Risks on Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	4		4	Risk Appetite	Finance: Open Regulatory: Cautious	**3629; 3630;3628; 3681; 3632;3634; 3635; 3636; 3637; 3639**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risk Last reviewed (by / on behalf of Lead Director)	August 2025	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)		**Inherent Score (L x I)**	4x5=20					

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Annual , Medium- & Long-Term Planning	**GC1:** Medium Term Finance Plan requires review and updating	Annual Plan reviewed by the F&P Committee (2) Trust Board Approve the Annual Plan (2)		**Partial Assurance**
Cost Improvement Plans		CIP reported to F&P committee (2) HFMA Checklist Action Plan complete in April 2023. (3) CIP plans reviewed at Performance Review Meetings at divisional level monthly (2)	**GA1**: HFMA checklist compliance check is now out of date	**Partial Assurance**
BAU Financial Operating policies, procedures Estates procurement and Contract management	**GC5**: Embedding of Medical rostering **GC7:** Completion of actions from IA of Accounts Payable	Bank and Agency Spend Control Follow Up Audit Review (2) Reports to Audit and Risk Committee (2) Counter fraud reports (2), Internal Audit work plan (3) NHSE monthly finance and workforce submissions (3) External Auditors Annual Audit Letter (Clean Opinion) Internal Audit of Accounts Payable (3) [Significant Assurance] Internal Audit of Estates Procurement and Contract Management 25/26 plan(3)		**Significant Assurance** **Significant Assurance** **Significant Assurance**
Specific Financial expenditure control measures: • Executive vacancy approval Panel Weekly (1) • Capital Investment Group and linked operational Control environments • DCN review of Nursing Agency and temp • Off framework protocol • Nursing rosters review • Weekly Non-pay review		Reports to Executive team (1) Reports to F&P Committee (2) Confirm and Support meetings with each division (1)		**Partial Assurance**
Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)				

Actions SMART (specific, measurable, achievable, relevant, and time-bound) actions.	**Timescale**	**Lead**	**Progress update**
GC1: Medium Term Finance Plan will be refreshed, reviewed by new CFO, aligned to capital plans and allocation of resources.	December 2025	CFO	24/25 underlying exit rate confirmed as £41.2M. Delivery of the 25/26 plan would reduce this to £37.2M by year end. National medium term financial planning process confirmed as running to December 2025 which the Trust will align with
GC2: Don't currently have a rolling 3-year CIP programme	TBC	DCEO	New DBTHi approach to improvement under leadership of Deputy CEO has been implemented. Rolling 3-year improvement programme to follow
GC5: Medical rostering project, measured via reduction in locum medical use and expenditure	September 2025	CFO / MD	Key project as part of the Pay Efficiency Workstream. Pay Efficiency Workstream Charter has now been signed off. UEC are fully live with the new system. Medicine and Women & Childrens are partial. Anaesthetics are next with go-live planned at the end of September.
GC7: Implementation of all Internal Audit recommendations for Accounts Payable	August 2025	CFO	3 of the 4 actions have now been completed and reported to the Internal Auditor. The remaining action is due at the end of August and is on track.
GA1: Review of current compliance against the HFMA checklist	August 2025	CFO	Refreshed assessment to be made by new CFO and Deputy Director of Finance

Strategic Risk 6	to insufficient resource and focus on key partners, we will not maximise the opportunities of collaboration, impacting our ability to transform and enhance services						**Strategic Objective: Partnerships**	**We work together to enhance our services with clear goals for our communities**
Lead Committee	Board of Directors – development session	Risk Rating	Current Exposure	Tolerable	Target	Risk Type	Strategic / reputational	Links to Significant Risks on Risk Register
Executive Lead	Deputy Chief Executive Officer	Likelihood	2		2	Risk Appetite	Seek	
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Manage	3507
Risk Last reviewed (by on behalf of Lead Director)	July 2025	Risk Rating	**8**		**6**			
Score Last Changed (By Lead Committee)	March 2025	Inherent Score	4x4=16					

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance (**Insufficient evidence as to effectiveness of the controls or negative assurance) GA	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
CEO Is partner member of South Yorkshire Integrated Care Board. Chair and DCEO attendance at key South Yorkshire and Nottinghamshire strategic forums. Full DBTH engagement in any emerging Collaborative Opportunities in the South Yorkshire and Bassetlaw areas	**GC1:**Collaborative Opportunities and impact on DBTH being assessed for priorities to talk forward **GC4:** Not all partner governor positions are filled or actively engaged	Reporting through to each Board on activities from the CEO report (1) The DGH Collaboration Opportunities Report (3) Board of Directors (2) Board to Board meetings (3) Partner Governor arrangements (2)		**Partial Assurance**
Executive attendance at South Yorkshire Acute Federation professional groups, leading on key services and pathways. Partnership governance arrangements for Acute Federation	**GC2:** Traction on some of the key identified workstreams has yet to be demonstrated	DBTH involvement with Acute Federation Clinical Sustainability Review report. (2) Professional Partnerships Company Secretary Network reviews governance arrangements including ToR review.(2) *Acute Federation Commissioned Audit of Partnership arrangements due in 2025* (3)	**GA1** Reporting arrangements through the individual organisations are not fully embedded.	**Partial Assurance** **Partial Assurance**
Tacking Health Inequalities Ambition Trust and Place level HI Activities. Health Inequalities considered on each Board and Committee paper explicitly		Health Inequalities reported through to Finance and Performance Committee on progress(2) Presentation to Board Development Session Due November 2025 (2) Internal Audit of Partnership arrangements 24/25 Audit plan(3)	**GA2**) Implementation of IA recommendations	**Significant Assurance** **Moderate Assurance**
Pathology Partnership		Pathology Partnership Board (2) *Internal Audit of Partnership governance arrangements - Pathology 25/26 Audit plan* (3)		*To review*
Strategic Partnership Teaching Hospital Forum	**GC3:** Full Partner engagement on some of the key identified workstreams to achieve University Teaching Hospital status.	Reports to People Committee (2) Updates to DBTH Board (2)		**Significant Assurance**
Research Innovation Strategy delivery plans		Reports to People Committee (2) Updates to DBTH Board (July 2025) (2)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions	**Timescale**	**Lead**	**Progress update**
GC1: Assessment of the Opportunities / risks for DBTH as part of this report's conclusions.	September 25	CEO	DGH opportunities report received and shared at Board of Directors of all DGHs. Working through the options to increase collaboration for delivery of strategic aims.
GC2: Engagement in Acute Federation workstreams to drive change and improvements.	March 26	DCEO	Clinical Sustainability Review workstreams established. Outcomes to be delivered by defined timescales in programme mandates.
GC3: Increased Partnership engagement around University Hospital Status	March 27	CPO	Update: The research team are planning an extra-ordinary engagement event in December 2025 with our key partners in relation to the role of the Strategic Partnership Teaching Hospital Forum. This will support the group to remain focused, maximise partnership opportunities and support our ambition to be a UTH.
GC4: Increase the range of Partner Governors and review the engagement as part of the wider membership project	Dec 25	DCEO	July update Membership project commenced in June 25 with Civica and this is now in train to support electronic communication routes. Awaiting outcome from the 10 year plan and FT status with Governors position
GA1: Mapping of the partnership governance arrangements. 360 Assurance reviewing partnership arrangements across the ICB, will feed into these recommendations	June 25	DCEO	DBTH will review any recommendations from the wider audit review Mapping of meetings and reporting has been completed
GA2: Implementation of Internal Audit recommendations	December 25	DCEO	July 2025: Update of the Partnership mapping. Recommendations on the Board reporting communicated to report writers

Strategic Risk 7 (Cause – Event-impact)	***If we fail to develop essential digital, data and technology that prioritises cyber resilience, we will prevent our people from delivering efficient, safe patient care and increase the risk of key system failure and disruption to services***						**Strategic Objective:** **Patients** **People**	***We deliver safe, exceptional, person-centred care.** ***We are supportive, positive and welcoming**
Lead Committee	Finance and Performance Committee	**Risk Rating**	**Current Exposure**	**Tolerable**	**Target (March 28)**	**Risk Type**	Reputational / Quality	Links to Significant Risks on Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	3		3	Risk Appetite	Regulatory: Cautious Quality: Cautious	1410; 3384; 2727; 3184; 1663;2736
Initial Date of Risk Assessment	January 2025	**Impact**	5		4	Risk Treatment Strategy	Treat	
Last reviewed (by / on behalf of Lead Director)	July 2025	**Risk Rating**	**15**		**12**			
Last Changed (By Lead Committee)		**Inherent Score (L x I)**	4 x 5 = 20		3 x 5 = 15			

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of Assurance relating to effectiveness of the controls and associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Digital Strategy (including Analytics) Digital Business Plan (versions to be updated)	**GC1**: 24/25 funding confirmed. Agreement of funding for all routine business as usual priority areas for 25/26 and onwards. **GC2**: Universal digital performance reporting not yet fully in place (such as system monitoring and desktop support tickets) **GC3:** New Digital Strategy and Delivery Plan not yet completed	Report to F&P Committee (2) Digital Data and Technology (DDaT) Meeting(1) Report to Trust Leadership team (a regular digital update is preferred) (1)		**Partial Assurance**
Electronic Patient Record (EPR) Programme Board, overseeing EPR FBC and programme delivery.	**GC4:** Frontline Digitisation funding approval for EPR not yet secured	DSPT Audit reports, external cyber security assessments such as penetration testing, ad testing of information sharing agreements. (3)		**Partial Assurance**
Digital policies and procedures and Standard Operating Policies and Procedures for all digital activities	**GC5:** Unsupported end user hardware (such as Windows 10 which is end of life mid-October 25)	Data Security and Protection Toolkit assessment (achieved standards met assessment in 24/25) and *Internal Audit of Data Security and Protection Toolkit 2025-26 Audit Plan (3)*	**GA1**: DSPT Action Plan	**Significant Assurance**
Data quality improvement plan.	**GC6:** Unsupported and out of data core systems or systems running unsupported versions of Microsoft Server	Digital Maturity Assessment (3)		**Partial Assurance**
Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware),		NHS Cyber Assurance Framework results(3) Results of business continuity / EPRR testing (1) Reporting into DDaT (1) Report to Audit and Risk Committee (2) Data Security and Protection Toolkit (3) Audit plan (internal audit) (3) Counter Fraud arrangements (3) *Internal Audit of Cyber Security Governance 2025-26 Audit Plan (3)*	**GA2**: Cyber Assurance Framework Action Plan	**Partial Assurance**
EPRR and business continuity arrangements	**GC7**: Check resilience of EPRR disaster recovery and business continuity plans	Reported to Audit and Risk Committee (2)		**Partial Assurance**

Information Asset Management Framework		Reviewed by IG committee and SIRO (1)		*For review*

Actions to Address Gaps in Controls and Assurance **(specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)**

Actions	**Timescale**	**Lead**	**Progress update**
GC1: Agree Digital Delivery plan for 25/26	March 25	CIO	Complete: 25/26 digital plan has been shared and agreed. Plan subject to onward monitoring and review by TLT and F&P.
GC2: Universal digital performance reporting action plan	August 2025	CIO	Draft KPIs are in place and were reported on at the last Digital Performance Group (March 25). They were further refined ~~by~~ in June 25.
GC3: Agree Digital Strategy 2025-2030	October 25	CIO	Early planning has started and draft themes shared. Workshop sessions to build digital strategy to be set up. To be approved by relevant committee and Trust Board in due course. Deadline updated to October to allow full engagement with all relevant internal and external stakeholders.
GC4:NHSE Frontline Digitisation approval of the full business case for EPR	June 25	CIO	Draft FBC was reviewed by F&P in February 2025. Final FBC was reviewed by F&P in March and F&P recommended its approval to Trust Board, Trust Board (private) approved the FBC in March 2025. It has since been submitted onwards for regional and national approval by NHSE and then Cabinet Office. The Change Control Notice is being finalised and the FBC is proceeding through its approval route in parallel, and as expected with no delays. The forward timeline is a) CCN approval by STH, DBTH and FD – June 2025 b) Fundamental Criteria Review by FD team – July 2025 c) EPRIB sign off, final FD FBC approval and Order Generation – August 2025 No concerns or delays to escalate.
GC5: Replace all end of Windows 10 life desktop hardware (desktops, laptops)	September 25	CIO	Orders have been placed for devices and the replacement programme is underway.
GC6: Core System review project	September 25	CIO	Terms of reference and scope agreed.
GC7: Complete Digital Disaster Recovery and Business Continuity review	August 25	CIO	On track for completion by end of July 25. Actions will be monitored thereafter and progress reviewed by relevant committee. Tabletop business continuity exercise took place in June 25 which was a simulated exercise of multiple core systems being unavailable. Lessons learnt and feedback from the session will be incorporated into BC procedures.
GA1: DSPT Action plan recommendations	March 25	CIO	The audit ahead of our 2025 DSPT submission has taken place. While we are yet to receive the formal management report, the verbal feedback was very positive and suggested only a small number of minor recommendations will be made in the audit report.
GA2: Agree Cyber Assurance Framework Action Plan and complete actions	May 25	CIO	Monitored by Audit and Risk Committee. All actions to mid-June 2025 complete with the exception of CS3 (device compliance for third party remote connections) and CS5 (device hardening – making more resilience to an attempted cyber security attack). Both outstanding actions will be complete by end of June 25.

Three Lines of Defence		
First Line of Defence – operational management, examples include:		
	Budgets; Risk assessments; Work programmes of groups / committees;	Planning exercises when, who, relevance; Training needs assessments.
Second Line of Defence – Corporate oversight, examples include:		
	Performance/Quality monitoring in place and at what level, how and when; Action monitoring reports Complaints and Compliments / Incident monitoring;	National returns; Training compliance monitoring; Routine reporting of key targets together with any necessary contingency plans.
Third Line of Defence - Independence assurances example include:		
	External audit; External inspection bodies, such as the Care Quality Commission and Royal Colleges; Systems of accreditation	Mandatory reporting systems; Internal Audit; Health and Safety Executive.

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified management actions are not considered vital to achievement of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions have been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operational weaknesses have been recognised. Existing performance presents an unacceptable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accepted as urgently required.
External - Third Line of Defence - Internal Audit (360 Assurance)	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2509 - D4 PREMISES ASSURANCE MODEL ASSESSMENT REPORT 2024/25

Decision Item | Kirsty Edmondson-Jones, Director of Infrastructure | 12:05

Sean Tyler, Head of Compliance
10 minutes

REFERENCES

Only PDFs are attached

D4 - Premises Assurance Model Assessment Report 2024-2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Cover Page				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Premises Assurance Model (NHS PAM) Assessment Report 2024/2025**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Sean Tyler, Head of Compliance (Estates and Facilities)			
Appendices:	Appendix 1: Facilities Management Standard (FMS) Maturity Tool 001 2024/2025 Appendix 2: Facilities Management Standard (FMS) Maturity Tool 002 2024/2025			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**BAF1:** If DBTH is not a safe trust, which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action. **BAF2:** If DBTH is unable to recruit, motivate, retain and develop a sufficiently skilled workforce to deliver services then patient and colleague experience and service delivery would be negatively impacted and we would not embed an inclusive culture in line with our DBTH Way. **BAF4:** If DBTH's estate is not fit for purpose, then DBTH cannot deliver services and this impacts on outcomes & experience for patients and colleagues.			

Executive Summary – Key Messages and Issues

The NHS Premises Assurance Model (PAM) provides a nationally consistent basis for assurance for Trust Boards on Regulatory and Statutory requirements relating to their estate and related services, and the NHS constitution right:

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

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

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

This report provides information from the PAM assessment for 2024/2025, covering all five mandated PAM domains and the Cabinet Office Facilities Management Standard (FMS) Maturity Framework results for FMS 001: Management and Services and FMS: 002 Asset and Data Maturity.

The Trust Overall Summary Position for 2024/2025 for the domain Self-Assessment Questions (SAQ's) is:

- 'Good' in 162 (48.5%) elements;

- 'Requires Minimal Improvement' in 141 (42.2%) elements;

- 'Requires Moderate Improvement' in 28 (8.4%) elements;

- ‘Inadequate’ in 3 (0.9%) elements

NB 46 elements were scored as ‘Not Applicable’ (N/A).

The report outlines areas that require further improvement (and in some cases investment) to achieve compliance with Legislation, Approved Codes of Practice (ACOP’s) and Guidance, to bring the Trust up to an all-round good rating.

Estates and Facilities Management (EFM) Strategic objectives and identified goals which are directly aligned to improving the elements rated as ‘Inadequate’, ‘Requires Moderate and Minimal Improvement’ within the Efficiency, Effectiveness and Organisational Governance PAM assessment are explained in detail within the report, identifying three main Strategic Objectives:

- Board approved Green Plan;

- E&F Operational Performance; and

- Emergency Preparedness Resilience and Response (EPRR).

The report confirms positive progress over the last period, with an increase in the number of SAQ’s achieving a rating ‘Good’ from 133 in 2023/2024 to 162 in 2024/2025. There has been a reduction in the elements requiring both minimal and moderate improvement from 151 to 141 and 31 to 28 respectively. Further reductions have also been achieved in the number elements deemed to be inadequate from 5 to 3 relating to a requirement for an air pollution policy, and two elements of the National Standard of Healthcare Cleanliness, currently being rolled out. The assessment also saw the introduction of a further 17 new elements for this year’s assessment.

It should also be noted that foundations are now firmly in place within E&F to deliver further continued improvements in domains requiring moderate and minimal improvement, including the development of improvement action plans and designated subject leads for each area, which should be reflected in the 2025/2026 assessment.

Where improvement is required to achieve compliance, estimated capital and revenue costs are provided, identifying a need for approximately £1.1M (£670,500 FY23/24) in additional revenue funding and £119M (£120M FY23/24) capital investment to address high and significant risk (critical infrastructure) backlog maintenance as defined by the Estates returns information collection (ERIC). The assessment provides a breakdown of where these costs sit against each element, providing the granular detail of where investment is required to enable the Trust to successfully achieve an overall rating of ‘Good’, which then informs the Capital investment programme.

To note the ERIC figures are exclusive of on costs such as; prelims (initial costs and activities required to set up and manage a construction project, including site setup, temporary works, project management, health & safety provisions, and utilities before the main build begins), decant (temporary relocation of people, equipment, or services from a site to allow construction or refurbishment to take place), profit, contingency, fees, expenses and VAT, so do not reflect the full investment figure required to address the critical infrastructure risk.

In conjunction to the revenue and capital funding identified above, the report also highlights the Estates Workforce business case which cannot currently be supported due to a requirement for the Trust to make 6.1% savings in Financial Year (FY) 25/26. The business case confirmed the need for additional resource to close identified gaps so that a preventative maintenance regime more reflective of the known and foreseeable risks present within the estate could be implemented. The business case recommended a phased approach, which would allow progressive recruitment into new roles and embedding of new ways of working. To note affordability of the case will be reviewed again as part of budget setting for FY26/27.

The FMS maturity framework assessments FMS 001: Management and Services and FMS 002: Asset and Data Maturity for 2024/2025 were completed by the Trust E&F management team following the FMS standard self-assessment guidance documentation and peer reviewed with a local Trust South West Yorkshire Partnership FT (SWYFT) for consistency. Requirements from both FMS 001 and FMS 002 have

also been incorporated into the annual E&F business planning process, which contains a strategic objective to attain a 'Good' maturity standard for all elements. Currently the Trust maturity status ratings are: FMS 001: Developing/improving in four of the five maturity dimensions. Good within the strategic reporting dimension. FMS 002: Developing/basic within the data assurance quality dimension, developing/improving in the team capacity and capability dimension , good (attaining the standard) in data structure and data usage and best (best practice) in data ownership and data systems.
Recommendations
The Board of Directors to **APPROVE** the information enclosed in the PAM 2024/2025 submission which is required to be submitted through the NHSE on-line reporting system before the deadline of 30th September 2025.

Healthier together – delivering exceptional care for all	
Patients	Effective Estates and Facilities management directly supports the Trust strategic focus on patients by ensuring a safe environment for care delivery, minimising risks to patients, colleagues and visitors. This alignment enhances patient outcomes by fostering an environment where effective care can be consistently provided without compromise due to safety concerns.
People	Estates and Facilities management underpins our strategic focus on people by protecting the wellbeing of our workforce, enabling staff to deliver high-quality care confidently and consistently. A safe, supported working environment is fundamental to staff engagement, retention, and overall organisational performance.
Partnerships	Continual improvement in Estates and Facilities policies, processes and procedures is evidenced through partnership working with colleagues from external agencies including: South Yorkshire Fire and Rescue Service (SYFRS), Nottinghamshire Fire and Rescue Service (NFRS), the Health and Safety Executive (HSE), and other Regional NHS Trusts and health care providers.
Pounds	Estates and Facilities management contributes to the Trust strategic focus on finance by reducing the financial impact of accidents, incidents, and associated liabilities. Proactive measures within Estates and Facilities lower costs related to staff absence, legal claims, and service disruption, ensuring more efficient use of resources and better value for public funds.
Health Inequalities	By improving Estates and Facilities management systems, processes and procedures the Trust can directly contribute to reducing the unequal burden of adverse health events experienced by vulnerable communities, ethnic minorities, and other disadvantaged groups, therefore addressing a critical dimension of health inequalities, improving patient safety and clinical outcomes.

<table>
<tr><td>Legal/ Regulation:</td><td>

The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
Developing an Estate Strategy document
Health Building Note 00-08
Health building Note 00-08: Land and Property Appraisal
Strategic Health Asset Planning & Evaluation (SHAPE) tool
Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services
Monitor: Strategy development: a toolkit for NHS providers
Monitor: Developing strategy - What every Trust board member should know.
Health and Safety at Work Act 1974 (HASAWA)
Management of Health and Safety at Work Regulations 1999
The Workplace (Health, Safety and Welfare) Regulations 1992
The Health and Safety (Display Screen Equipment) Regulations 1992
The Manual Handling Operations Regulations 1992 (as amended) (MHOR)
The Personal Protective Equipment at Work Regulations 1992
The Provision and Use of Work Equipment Regulations 1998
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
The Control of Substances Hazardous to Health Regulations 2002
Safety Representatives and Safety Committees Regulations 1977
Health and Safety (Consultation with Employees) Regulations 1996.

</td></tr>
<tr><td>Partner ICB strategies</td><td>N/A</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>None</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Continual Annual reporting the PAM to Board. Annual reporting to Finance and Performance and quarterly reporting to the Trust Health and Safety Committee.</td></tr>
<tr><td>Is this in line with Current risk appetite

YES/~~NO~~</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table>
</td></tr>
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1. Introduction

The assessment of the DBTH Premises Assurance Model (PAM) has been undertaken using the revised and updated PAM 2024 model and reflects the Trust's position as at the end of 2024/2025. The methodology utilised adopts the NHS England (NHSE) PAM format and approach through the 5 identified Domains, integrated PAM Self-Assessment Questions (SAQ's) and Cabinet Office Facilities Management Standard (FMS) Maturity Framework Standards FMS 001: management services and 002: asset data maturity, in conjunction with the responsible DBTH Estates, Facilities and Clinical Trust management PAM leads.

Evidence for each PAM domain rating is provided by the named responsible Trust lead for each SAQ. Examples of evidence include Approved Policy and Procedural Documents (APD), other procedures and protocols, evidence of appointments and competencies, and any other supporting information that justifies that rating attributed to the SAQ. An electronic assurance system (Concerto) is used to store evidence and track approval, review and expiry dates for auditing purposes.

The rationale and rating of each SAQ is scrutinised and challenged by an ongoing review process, which includes open and challenging discussions with SAQ leads to ensure that the assessment is robust, accurate and transparent, as well as ensuring that evidence is provided and verified for each rating.

Once the evidence is considered to be complete, each SAQ element is rated in accordance with one of the following categories; 'Not Applicable', 'Inadequate', 'Requires Moderate Improvement', 'Requires Minimal Improvement', 'Good' or 'Outstanding'. Once complete, this allows an assessment of all evidence to determine an overall summary rating for the Trust.

The Trust's overall summary position for 2024/2025:

- Good in 162 elements,
- Requires Minimal Improvement in 141 elements
- Requires Moderate Improvement in 28 elements,
- Inadequate in 3 elements,
- Not Applicable in 46 elements

Figure 1 provides the overall summary comparison from the previous reporting period 2023/2024, against the position for 2024/2025, confirming positive progress in a number of areas. It should be noted that the 2024/2025 assessment also included the addition of two new safety domain SAQ's; SH20: Mortuaries, which added 14 additional elements and SAQ: SS10 Terrorism, which added 3 additional elements.

Figure 2 provides the distribution of SAQ ratings for each of the 5 domains, Safety (Hard FM/Soft FM), Patient Experience, Efficiency, Effectiveness and Organisational Governance. Note that for the purpose of the report, Hard and Soft FM safety domain elements are reported separately.

There has been an increase in the number of SAQ's achieving a rating 'Good' in the reporting period, increasing from 133 in 2023/2024 to 162 in 2024/2025. There has also been a reduction in

the number elements deemed to be inadequate from 5 to 3, and a reduction in the elements requiring both minimal and moderate improvement from 151 to 141 and 31 to 28 respectively.

An overview of the PAM Safety domain is presented to the Trust H&S Committee quarterly and the Finance and Performance (F&P) Committee bi-annually. A summary is also presented to F&P within the annual Estates & Facilities performance report for further assurance.

The Patient Experience domain results are presented annually to the Patient Experience & Involvement Committee (PEIC) for information and assurance.

Figure 1: Overall Summary Position of Self-Assessment Question (SAQ) Scores 2023/2024 v 2024/2025

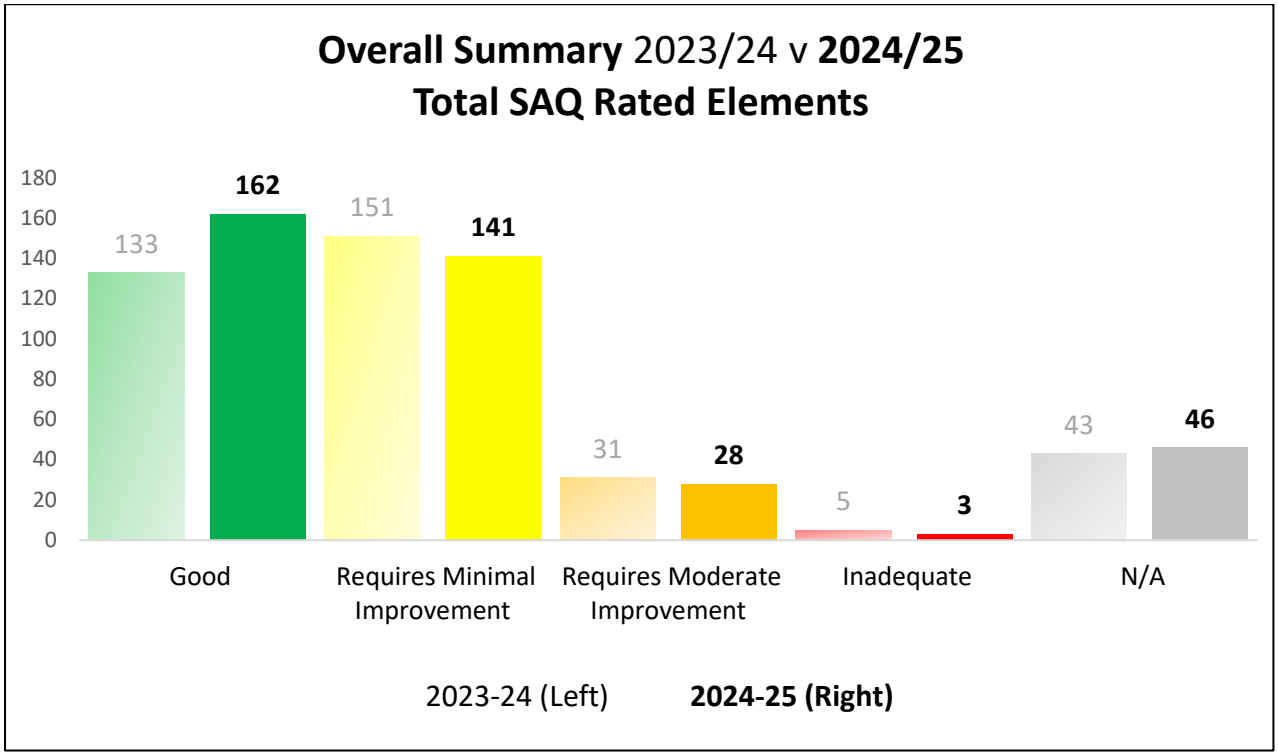
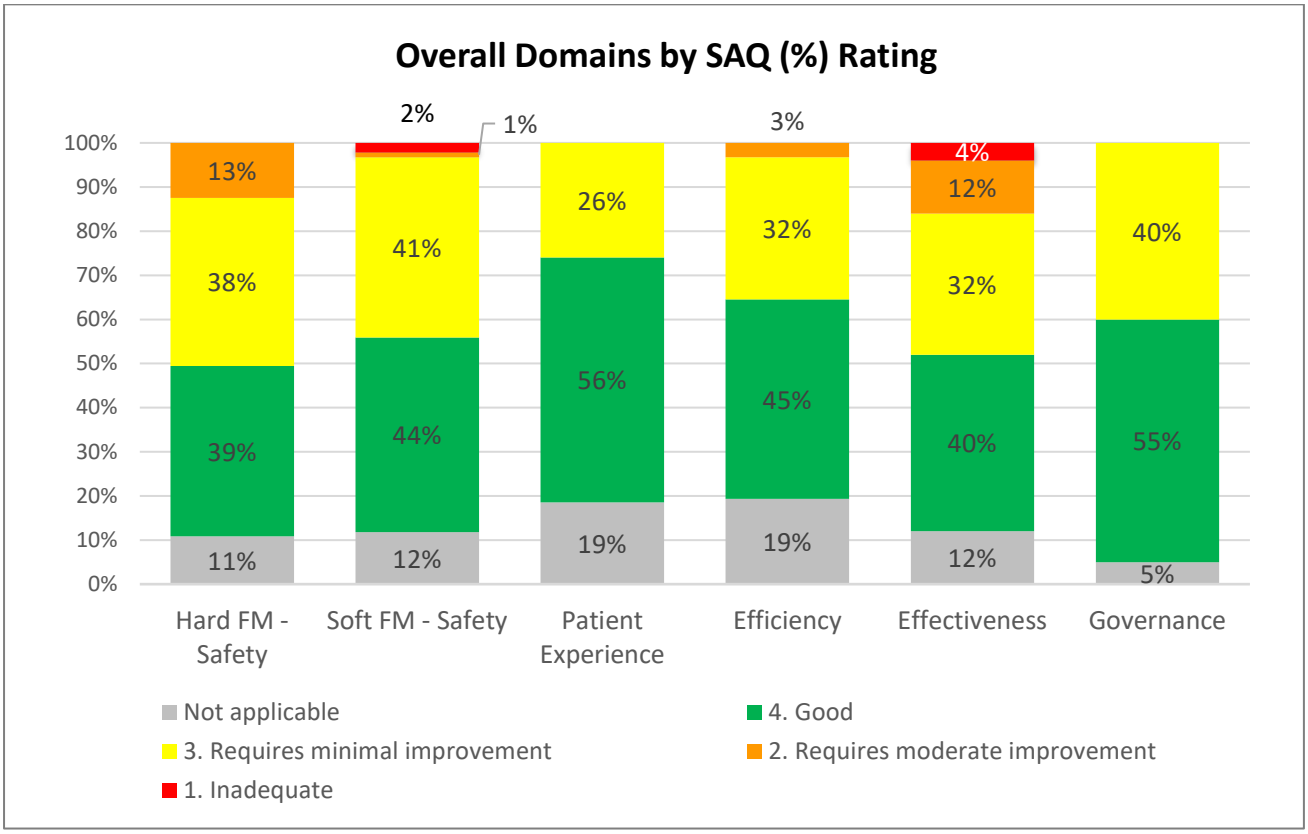


Figure 2: Overall, Distribution of Self-Assessment Questions (SAQ) Ratings (%) for 2024/2025



2. Safety Domain

This domain contains SAQ's related to both Hard FM and Soft FM, but for reporting purposes sections 2.1 and 2.2 provides a breakdown of each area separately.

The combined safety domain scores (Figures 3 and 5) show the Trust is 'Good' in 112 elements, 'Requires Minimal Improvement' in 108 elements, 'Requires Moderate Improvement' in 24 elements and is 'Inadequate' in 2 elements. A further 31 elements were deemed 'Not Applicable'. The evidence suggests therefore that the majority of the SAQ's within this domain are either good or require minimal improvement.

Continual progress is being made to the majority of SAQ elements, with a solid foundation to continually deliver anticipated overall reductions in 'Requires Minimal Improvement', 'Requires Moderate Improvement' and 'Inadequate' scores within the following 2025/2026 PAM assessment reporting year.

2.1 Safety (Hard FM)

Figure 3 presents the PAM summary position of Hard FM SAQ ratings for 2024/2025 with figure 4 providing the DBTH PAM Distribution of SAQ Ratings for 2024/2025. Table 1 provides a legend listing the Hard FM SAQ's individual elements.

Figure 3: Hard FM Safety Domain Summary Position for 2024/2025

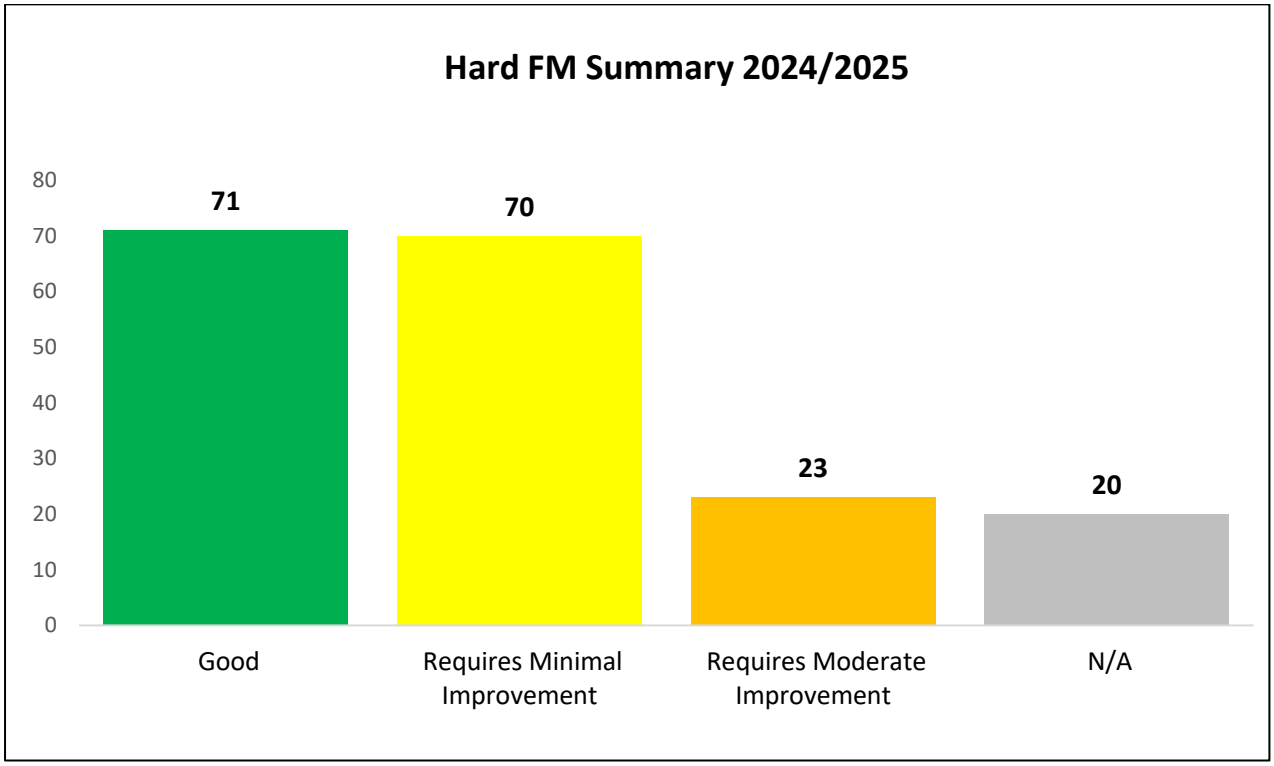


Figure 4: Distribution of SAQ Ratings (%) for Safety Hard 2024/2025

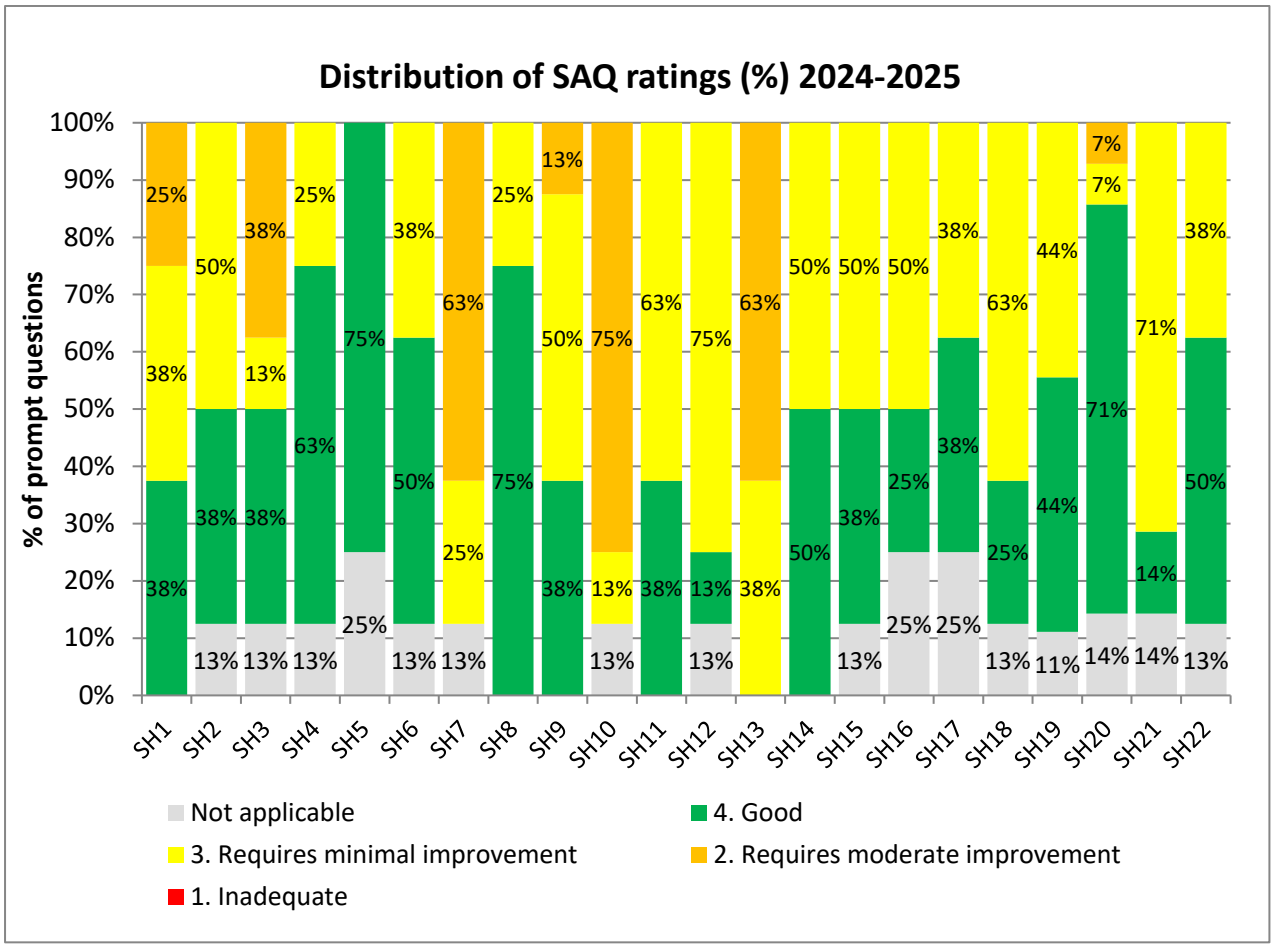


Table 1: Safety Domain Hard FM Individual SAQ Element Legend 2024/2025

Legend	
SAQ Code	**Self-Assessment Question – Is the Organisation/site safe and compliant with well managed systems in relation to:**
SH1	Estates and Facilities Operational Management
SH2	Design, Layout and Use of Premises
SH3	Estates and Facilities Document Management
SH4	Health & Safety at Work
SH5	Asbestos
SH6	Medical Gas Systems
SH7	Natural Gas and specialist piped systems
SH8	Water Systems
SH9	Electrical Systems
SH10	Mechanical Systems e.g. Lifting Equipment
SH11	Ventilation, Air Conditioning and Refrigeration Systems
SH12	Lifts, Hoists and Conveyance Systems
SH13	Pressure Systems
SH14	Fire Safety
SH15	Medical Devices and Equipment
SH16	Resilience, Emergency and Business Continuity Planning
SH17	Safety Alerts
SH18	Externally Supplied Estate
SH19	Contractor Management
SH20	**Mortuaries (new SAQ)**
SH21	The Built Environment: Reducing Harm by Ligature Practice
SH22	Estates IT and Building Information Management (BIM) Systems

Taking into consideration the introduction of the new Mortuaries SAQ with 14 associated elements, there has been an increase in 'Good' ratings in 23 elements, a reduction of 4 areas 'Requiring Minimal Improvement', 1 'Requiring Moderate Improvement' and an increase in 4 'Not Applicable' ratings, delivering and an overall improvement within the domain for the reporting period.

The majority of elements 'Requiring Minimal and Moderate Improvement' relate to Policies and Procedures, Roles and Responsibilities, Training and Development and Business Continuity.

Improvements within the Business Continuity element are anticipated as a result of the continued Trust Emergency Preparedness, Resilience and Response (EPRR) work to develop internal evacuation plans across all inpatient areas and external multi-agency incident exercises in preparation for a potential major critical infrastructure issue.

The Estates review business case produced from the Granger report recommendation actions confirming the need for additional resource was re-submitted to Corporate Investment Group (CIG) at December's (2024) meeting. The business case identified the resource required to deliver a preventative maintenance regime more reflective of the known and foreseeable risks present within the estate. Whilst the Trust was unable to support the case in FY25/26 due to a requirement to make 6.1% savings, the cost of the business case will be considered again as part of budget setting for FY26/27.

Actions relating directly to the Estates review business case, particularly around Roles and Responsibilities, have also been identified during Authorising Engineer (AE) audits regarding ongoing requirements to appoint a greater number of Authorised Persons (AP's) and Competent Persons (CP's), along with work to review maintenance schedules in line with industry best practice (SFG20).

All deficiencies within this SAQ will continue to be reviewed through the PAM review process for 2025/2026, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

2.2 Safety (Soft FM)

Figure 5 presents the PAM summary position for Safety Soft SAQ ratings for 2024/25, with figure 6 providing the DBTH PAM distribution of SAQ Ratings for 2024/2025. Table 2 provides a legend listing the Soft FM SAQ's individual elements.

Figure 5: Safety Domain Soft FM Summary Position for 2024/2025

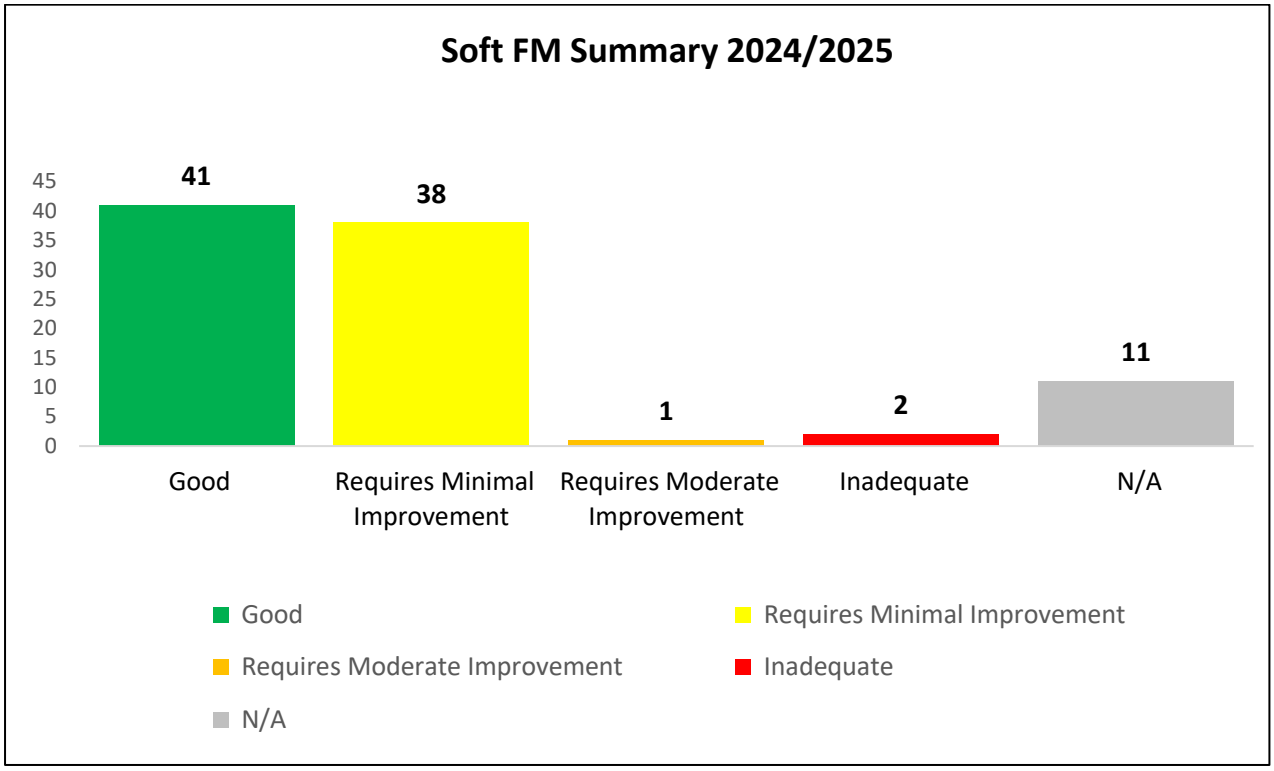


Figure 6: Distribution of SAQ Ratings (%) for Safety Domain Soft FM 2024/2025

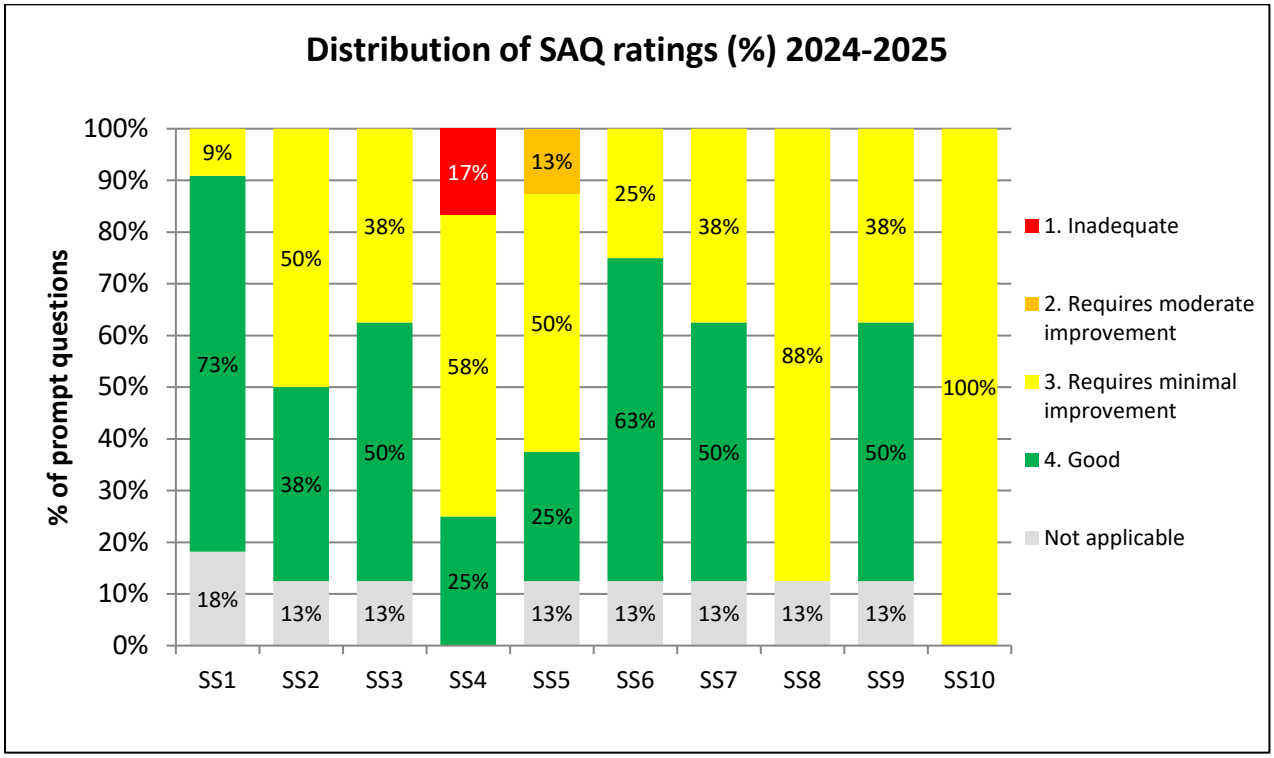


Table 2: Safety Domain Soft FM Individual SAQ Element Legend 2024/2025

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

Taking into consideration the introduction of the new Terrorism SAQ with 3 additional elements, there has been a positive improvement in the Soft FM Safety domain, with an increase in 3 'Good' element ratings, a reduction of 4 elements 'Requiring Minimal Improvement', a reduction of 1 element 'Requiring Moderate Improvement' and a reduction of 2 'Inadequate' ratings, providing an encouraging indication of progress.

The key Soft FM elements requiring improvement for the reporting period are cleaning and infection control, mainly owing to the Trust currently not achieving full compliance against the 2021 National Standards of Healthcare Cleanliness. This is due to a requirement for additional

resource, although the previous 2007 Cleanliness Standards are being achieved as identified within the Facilities cleanliness audits.

Following a previous derogation agreed with NHS England in recognition of the need for additional resource, a business case to bridge the gap between the current service model & compliance with the standards was submitted for consideration by the CIG and approved in Q3 FY24/25 securing the additional funding required to achieve compliance. The operational delivery plan was agreed and recruitment to posts initiated, with the plan to deliver full compliance by the end of Q2 FY25/26.

The majority of all other elements 'Requiring Minimal and Moderate Improvement' within this domain again relate to Policies and Procedures, Roles and Responsibilities, Training and Development and Business Continuity. Areas for improvement will continue to be reviewed through the PAM review process for 2025/2026, with action and review dates including clearly defined timescales presented to the individual responsible managers to improve progress in the overall PAM SAQ scores.

3. Patient Experience Domain

The PAM Patient Experience summary position ratings for 2024/2025 is illustrated in figure 7, figure 8 provides the distribution of Patient Experience SAQ ratings, and Table 3 provides a legend listing the Patient Experience SAQ's individual elements.

The summary of SAQ Ratings for Patient Experience shows DBTH to be 'Good' in 15 elements and 'Requiring Minimal Improvement' in 7 elements, with 5 elements assessed to be 'Not Applicable. The domain good rating has increased from 14 to 15 elements as a result of 1 element previously assessed as 'Requiring Minimal Improvement' now being rated as good due to positive work undertaken during the reporting period

A full Patient Led Assessment of the Care Environment (PLACE) programme led by the Trust's Patient Engagement, Experience & Involvement team with support from E&F was successfully undertaken during the reporting period, supporting the attainment of a 'Good' rating within this domain.

SAQ's identified as requiring minimal improvement include the requirement for improved internal assessment and improved staff and patient engagement through the introduction of patient participation focus groups. These areas form part of the work of the Patient Environment Group (PEG) and progress will be monitored via the PAM management process for 2025/2026.

Figure 7: Patient Experience Domain Summary Position for 2024/2025

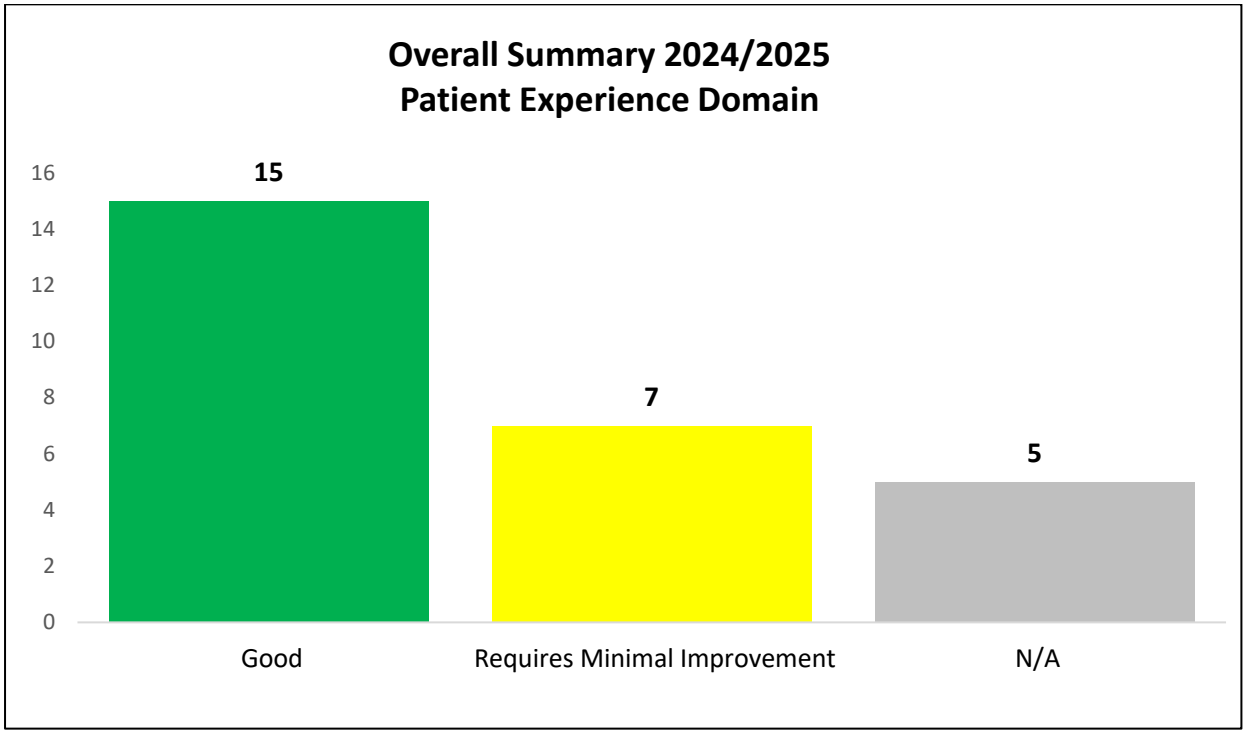


Figure 8: Distribution of SAQ Ratings (%) for Patient Experience Domain 2024/2025

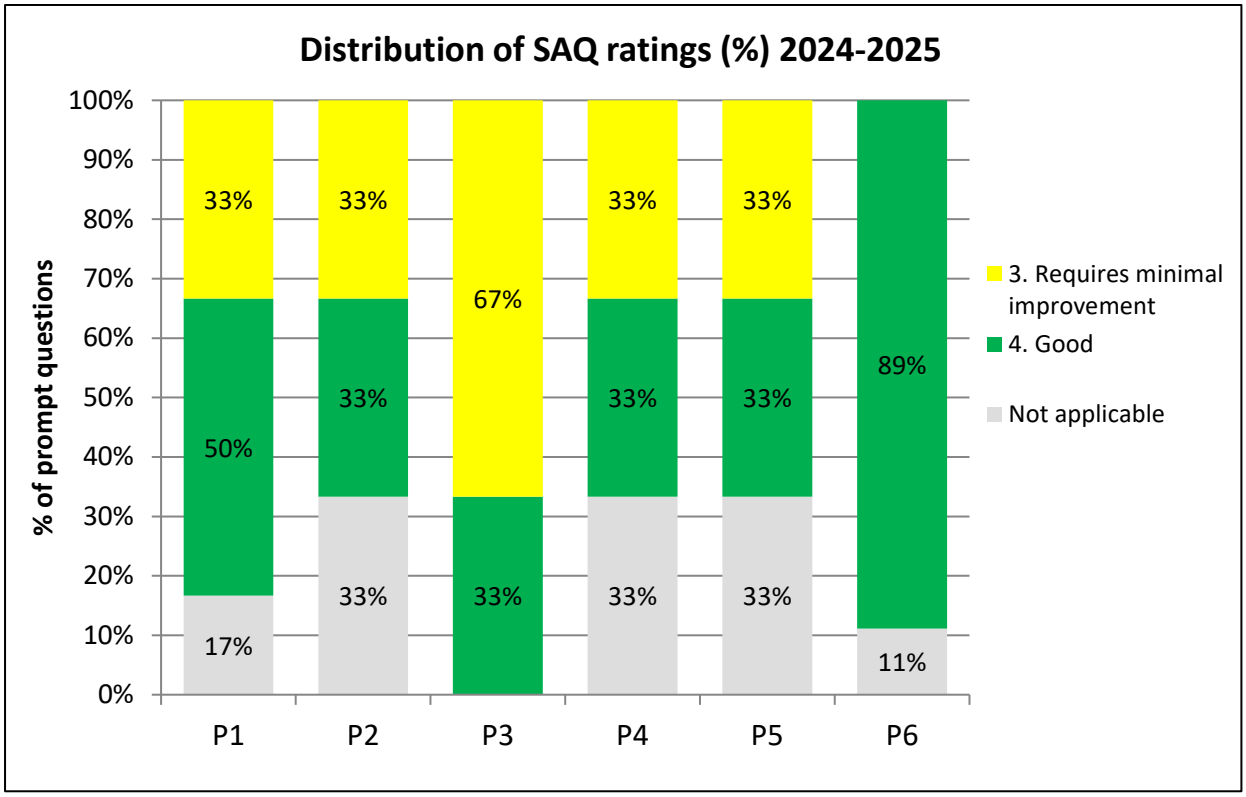


Table 3: Patient Experience Domain Individual SAQ Element Legend 2024/2025

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

4. Efficiency, Effectiveness and Organisational Governance Domains

Figure 9 presents the summary position of Efficiency, Effectiveness and Organisational Governance SAQ ratings for 2024/2025, with figure 10 providing the distribution of SAQ Ratings for 2024/2025. Table 4 provides a legend listing the Efficiency, Effectiveness and Organisational Governance SAQ's individual elements.

The summary of SAQ ratings shows continued improvement against the previous reporting period, with an increase in 'Good' from 33 to 35 elements. As a consequence of these improvements the 'Requires Minimal and Moderate improvement' elements have both reduced by 1 element. There still remains 1 'Inadequate' element, relating to Policies and Procedures for air pollution control, with a further 10 elements in the 'Not Applicable' category.

Following this year's assessment process, the objectives for the Efficiency, Effectiveness and Organisational Governance domains is to continue to prioritise the 'Inadequate' and 'Requires Moderate Improvement' elements. Elements 'Requiring Minimal Improvement' will also be targeted via the PAM review process for 2025/2026, with the aim of increasing elements rated as 'Good' where possible.

Evidence reviewed during the assessment confirms the long term key strategic objectives included within the E&F annual business plan (listed and explained below), which directly align to the Efficiency, Effectiveness and Organisational Governance PAM assessment SAQ action plans aim to deliver sustained improvement within this reporting period through:

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

    a) Update the Board approved Green Plan in line with NHS England guidance.

b) Continue to manage the Green Plan and Green Action Plan through the Trust Sustainability Group.
c) Complete the Trust climate change risk assessment and climate change adaption plan.
d) Introduce a Trust sustainable active travel and transport plan.
e) Complete a decarbonisation strategy for DBTH explaining how the organisation will move away from the use of fossil fuels on the lead up to 2045.
f) Develop sustainability objectives for 2025 in conjunction with the sustainability steering group / anchor strategy group.
g) Agree sustainability targets with the ICB Estates group.

2. E&F operational performance continues to be managed through use of the Balanced Scorecard (BSC) model to promote continuous improvement across the following four strategic domains:

1. Operational Performance
2. Financial Control
3. Departmental Learning & Development
4. Customer/Stakeholder Perception

Guided by the Trust's vision **'Healthier together – delivering exceptional care for all'** and the E&F mission to **'provide sustainable services and environments that are safe, effective and resilient'**, the Strategy map developed as part of the BSC approach outlines the E&F long term strategic objectives:

- Enhanced workforce engagement aligned with DBTH's People Strategy, the DBTH Way, and National workforce plans
- Strengthened accountability and communication across the department
- Review and refinement of KPI data to identify opportunities for improved performance and efficiency
- Continued delivery of Performance Overview and Support Meeting (POSM) meetings chaired by E&F leadership
- Embedding of the performance oversight framework
- Ongoing development of financial management structures, including grip and control mechanisms
- Service reviews in multiple areas including:
    - Estates maintenance workforce
    - Cleaning services in line with NHS Standards of Healthcare Cleanliness 2021
    - Catering services (in collaboration with Sodexo) under NHS Food and Drink Standards 2022
    - Staff accommodation and policy update
    - Medical technical services
    - Internal transport services

    - Waste management including waste segregation and point of use recycling
- Increased stakeholder engagement to better understand and respond to service needs
- Taking an active role in multi-disciplinary projects targeting improved safety, improved sustainability, and a reduction in incidences of violence and aggression against staff within the organisation
- Continue to drive transformational change within the organisation in relation to improved health and safety management and culture

3. DBTH's Estate continues to present a number of foreseeable critical infrastructure risks, particularly at the Doncaster Royal Infirmary (DRI) site where the risk of major failure remains significant. Robust business continuity plans therefore remain essential to mitigate potential infrastructure failures and risk to service delivery.

   E&F will continue work with the Trust Emergency Preparedness Resilience and Response (EPRR) to develop internal evacuation plans across all inpatient areas. E&F will also form part of regional mass evacuation planning and multi-agency incident exercises in preparation for a major critical infrastructure issue (both locally and regionally). Finally a continued improvement approach to EPRR generally via the E&F 10 point plan following the NHS National EPRR Framework guidance ensuring:

   a) Continued work alongside DBTH EPRR, ICB partners and NHSE to further develop business continuity plans for major foreseeable infrastructure failures leading to full or partial closure of DRI. Plans to include internal evacuation and potential temporary relocation of service to regional partners.
   b) Application of E&F's '10 point plan to continually improve EPRR' internally within E&F and as a support service organisationally.

Figure 9: Overall Summary Position - Efficiency, Effectiveness, Organisational Governance Domains 2024/2025

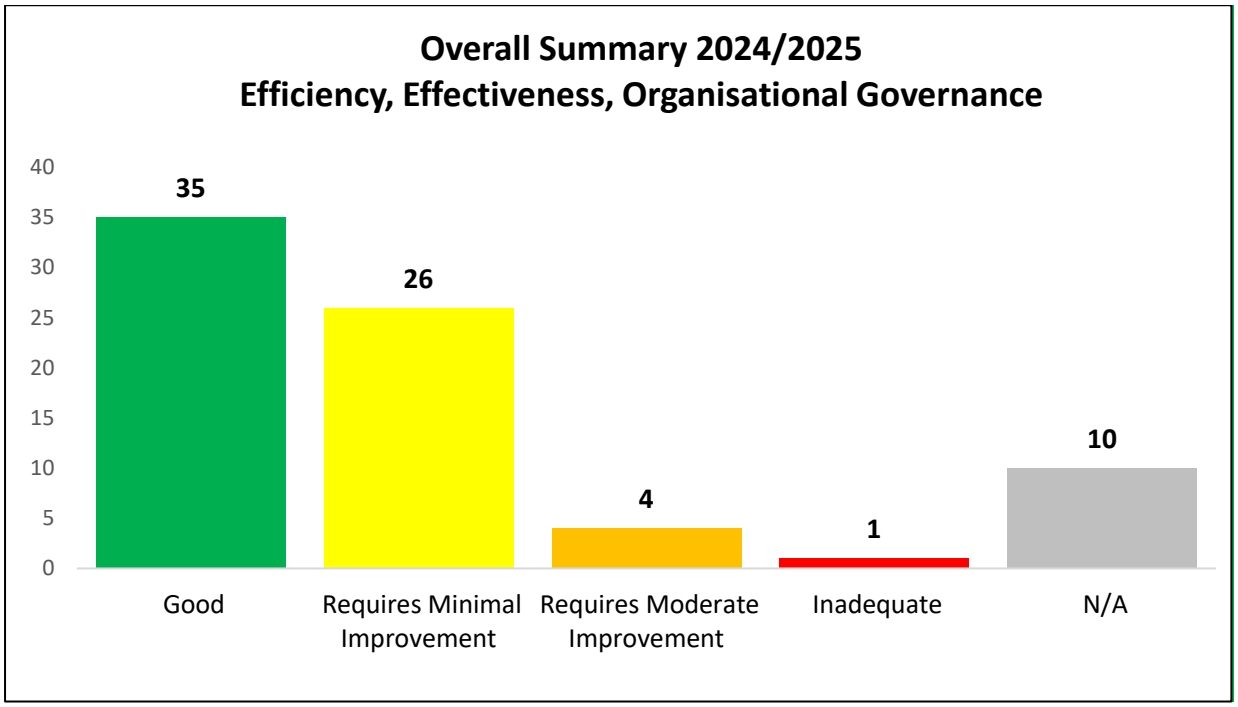


Figure 10: Overall Distribution of SAQ Ratings (%) for Efficiency, Effectiveness, Organisational Governance Domains 2024/2025

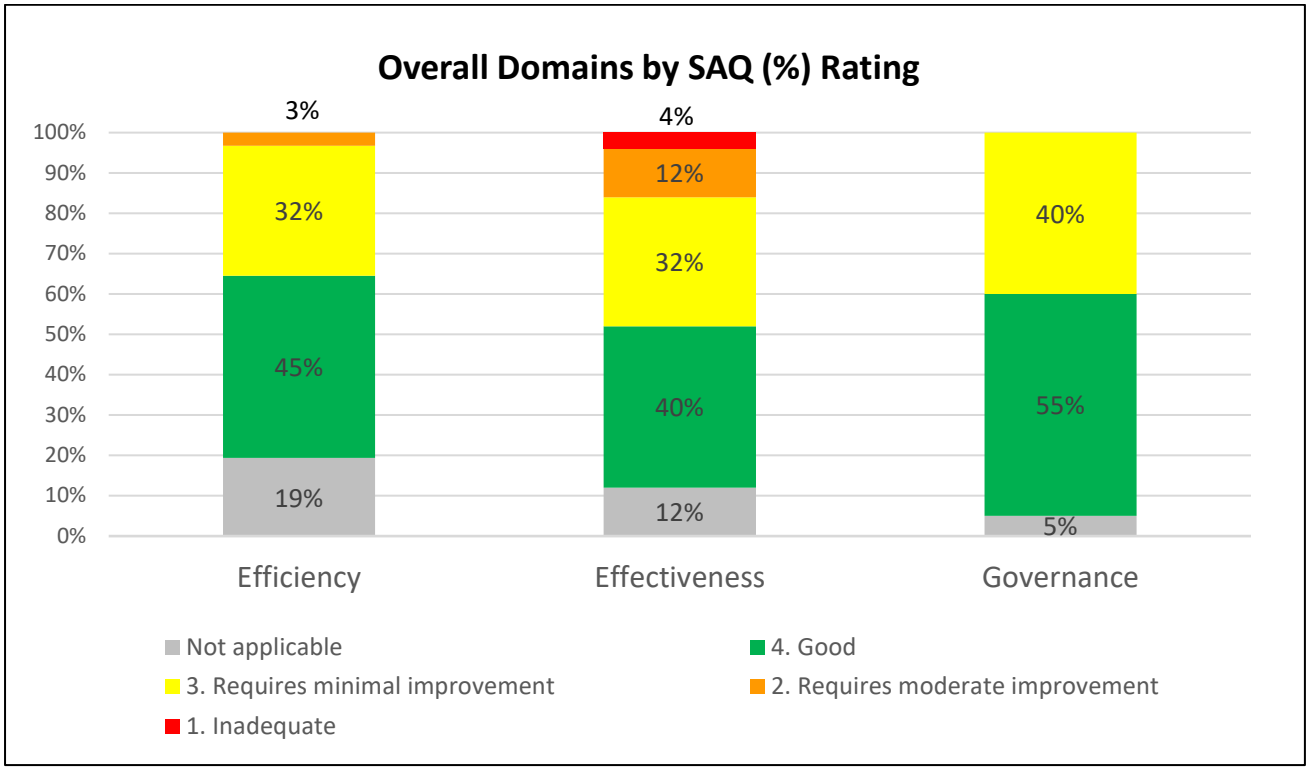


Table 4: Efficiency, Effectiveness and Organisational Governance Domain SAQ Element Legend 2024/2025

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

5. Capital Costs for Compliance and Revenue Consequences

Table 5 below provides a breakdown of the capital and revenue costs required to address gaps in compliance identified during the 2024/2025 PAM assessment, with comparative costs from the previous reporting year (2023/2024) included.

The Capital costs associated with SH1, Operational Management (maintenance SAQ element), have been provided from the annual 6 facet survey undertaken by external surveying consultancy Oakleaf for Critical Infrastructure Risk (High and Significant risk) reported through the ERIC returns.

To note the ERIC figures are exclusive of on costs including such as; prelims (initial costs and activities required to set up and manage a construction project, including site setup, temporary works, project management, health & safety provisions, and utilities before the main build begins), decant (temporary relocation of people, equipment, or services from a site to allow construction or refurbishment to take place),, profit, contingency, fees, expenses and VAT, so do not reflect the full investment figure required to address the critical infrastructure risk.

Revenue costs include those associated with the resource required to close gaps in compliance identified during the PAM assessment process.

The business case associated with the Estates workforce review to deliver a phased approach allowing progressive recruitment into new roles and embedding of new ways of working will be considered again in budget setting for FY26/27 as the trust was unable to support the case in FY25/26 due to the requirement to make 6.1% savings.

Table 5: Capital Costs for Compliance and Revenue Consequence 2023/2024 v 2024/2025

SAQ	Capital Cost for Compliance	2023/2024	2024/2025
SH1: E&F Operational Management	Trust Critical Infrastructure Risk (For information Only)	£120,138,820	£119,901,370
SAQ Revenue Consequence			
SH1: E&F Operational Management	Estates Workforce Review	TBC	£1,007,451
S4: Health and Safety at Work	Emergency First Aid at Work Training	£4,500	£5,500
SH8: Water Safety	Water Safety Healthcare Technician Training	£8,000	£12,000
SH9: Electrical Systems	Electrical Low Voltage (LV) Approved Person (AP) and Competent Person Training (CP)	£8,000	£12,000
SH11: Ventilation, Air Conditioning and Refrigeration Systems	CP Heating, Ventilation and Air Conditioning (HVAC) training (HTM03)	£8,000	£12,000
SH12: Lifts, Hoists and Conveyance Systems	Passenger Lift Training	£10,000	£14,000
SH13: Pressure Systems	AP and CP Pressure Systems Training	£0	£12,000
SH14: Fire Safety	Fire Risk Assessment Training	£3,000	£7,000
SH14: Fire Safety	Firecode for healthcare premises (HTM 05-02 & HTM 05-03)	£0	£15,000
SS4: Cleanliness and Infection Control	Compliance with NHS Cleaning Standards	£629,000	£0

6. Facilities Management Standard (FMS) Maturity Framework 001 and 002

The Facilities Management Standard (FMS) maturity framework assessment now forms part of the PAM submission requirements following its phased inclusion over the last two reporting periods, following requests by the Cabinet Office. The framework assessment supports organisations in evaluating their performance against core Facilities Management (FM) service and asset data standards.

The framework comprises two key assessment tools—FMS 001 and FMS 002—each designed around a structured five-stage maturity scale (Developing – Basic, Developing – Improving, Good, Better,

Best). The tools facilitate robust self-assessment, helping the Trust evidence current capabilities identify areas for development and validate investment required to meet standard requirements.

The overarching Cabinet Office goal remains to foster greater alignment and quality assurance across the public sector FM landscape, creating a consistent and integrated approach to service delivery and asset management across the Government Estate.

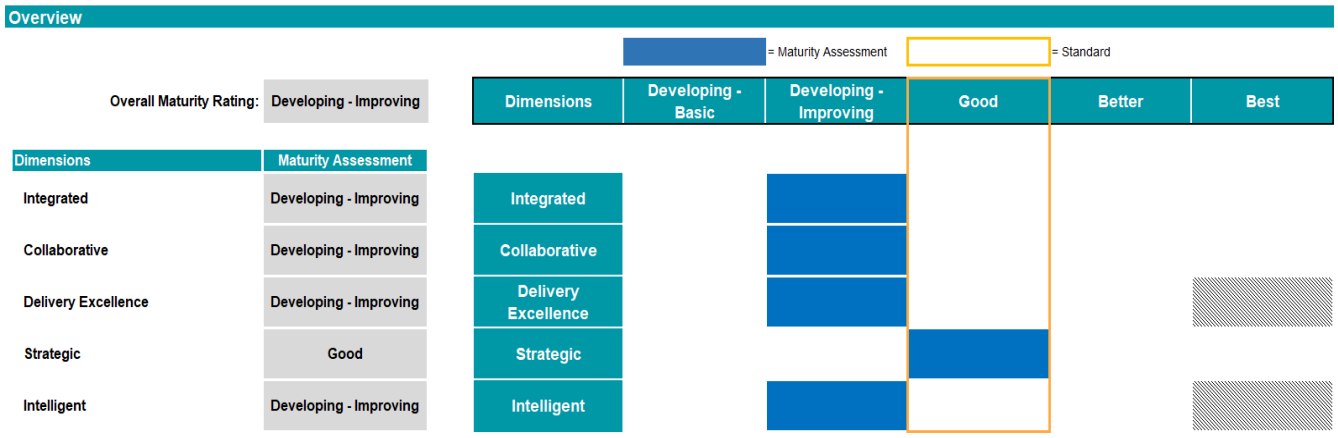
6.1 FMS 001: Management and Services Maturity

Introduced in the last reporting period, FMS 001 focuses on FM governance, leadership, operational strategy, and service excellence. This year's self-assessment reiterates the importance of embedding robust FM management principles to support the Trust wider organisational goals. Key maturity dimensions within FMS 001 include:

- Strategic: Alignment of FM strategy with organisational goals, effective governance frameworks, and value-adding practices.
- Integrated: Coordination across service domains to ensure unified leadership and data representation.
- Intelligent: Building capacity to act as a knowledgeable FM client, with the planning and insight needed to drive continuous improvement.
- Collaborative: Fostering transparent partnerships with FM service providers, underpinned by trust and shared objectives.
- Delivery Excellence: Demonstrating best practice through compliance, defined roles, and evidence-based service validation.

This year's assessment (Appendix 1) places the Trust at a Developing/Improving level across four dimensions, with a Good rating retained in the strategic category. This reflects the ongoing progress being made to align the FM services with the Trust Organisational Strategy and Objectives and is illustrated in Figure 11.

Figure 11: Facilities Management (FM) Standard Maturity 001 - Summary Overview 2024/2025



6.2 FMS 002: Asset Data Maturity

FMS 002 remains the foundation for assessing the quality and reliability of FM asset information within the Government estate. The assessment ensures that the Trusts maintain comprehensive asset registers, understand asset condition and maintenance requirements, which are essential for informed decision-making and risk management.

The six dimensions of the FMS 002 maturity framework are:

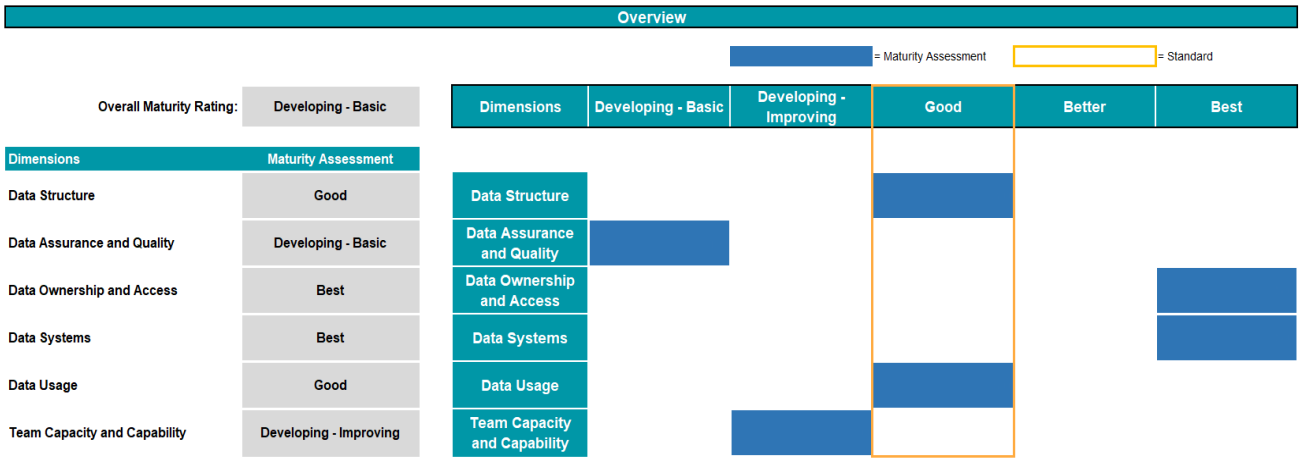
1. Data Structure: Robust configuration of asset registers to support long-term assurance.
2. Data Quality and Assurance: Processes that underpin data completeness, accuracy, and regular validation.
3. Data Ownership and Access: Defined roles and protocols for data stewardship, accessibility, and security.
4. Data Systems: Technology infrastructure that enables portable and interoperable asset data.
5. Data Usage: Application of data in operational and strategic decision-making.
6. Team Capacity and Capability: Equipping FM teams with the skills and resources to use data effectively.

The submission for this reporting period illustrated in Figure 12 confirms the following Trust ratings:

- Developing/Basic in Data Quality and Assurance
- Developing/Improving in Team Capacity and Capability
- Good in Data Structure and Data Usage
- Best Practice attained in Data Ownership and Data Systems

These scores remain broadly consistent with the previous year's asset data management reporting and have been incorporated into in the annual E&F business plans alongside FM 001. The strategic priority objectives for FM 001 and 002 are to attain at a minimum 'Good 'maturity standard level across all dimensions in subsequent reporting periods.

Figure 12: Facilities Management (FM) Standard Maturity 002 - Summary Overview 2024/2025



The FMS maturity framework assessments continue to follow the same process and have been completed by the Trust E&F management team following the FMS standard self-assessment guidance

documentation, with an additional peer review undertaken with a local Trust South West Yorkshire Partnership FT (SWYFT) for accuracy and consistency.

7. Conclusion and Recommendations

The report provides a comprehensive overview of the processes followed by DBTH during the implementation of the Premises Assurance Model (PAM) for 2024/2025. It demonstrates clear, positive progress across all five domains, resulting in an overall improvement when compared to the 2023/2024 assessment.

While the positive progress made is encouraging, the report also highlights that solid foundations have been established to support further improvements within 2025/2026 which are anticipated to be reflected within next year's assessment. However, it is important to recognise that certain areas will require targeted investment to resolve outstanding compliance issues. This is particularly relevant to SAQs associated with elements of the Hard FM safety domain, such as the appointment of Authorised Persons (APs) and the adoption of maintenance practices aligned with identified and foreseeable estate risks.

Encouragingly, the alignment of strategic objectives within the E&F business plans with SAQs across the Effectiveness, Efficiency and Organisational Governance domains evidences the directorate's strategic direction is consistent with the Trust organisational strategy and strategic priorities. This alignment reinforces the expectation that continued delivery of the business plan will lead to further improvements within the PAM ratings.

Furthermore, the integration of the Cabinet Office's FMS maturity assessments into the PAM framework has introduced further insight into key areas needing development. The data from both FMS 001 and FMS 002 is now being incorporated into the E&F business planning for 2025/2026 as part of strategic objectives for the coming year.

In summary, the report reflects meaningful progress at DBTH during 2024/2025 and outlines a robust review and assessment process that ensures the accuracy and validity of self-assessment ratings. It further indicates that the foundation for future improvement is firmly in place, though continued progression will depend in part on securing future funding to address compliance gaps.

Appendix 1: Facilities Management Standard (FMS) Maturity Tool 001 - 2024/2025

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Integrated					
Integrated	Integrated Leadership	Q1	How integrated is facilities management - Soft Services?	3+	
		1	Soft services is devolved around the organisation without a central "controlling mind".		
		2	A central team exists that manage a range of core buildings directly but are not fully integrated		
		3+	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
		Q2	How integrated is facilities management - Hard Services?	3+	
		1	Hard services is devolved around the organisation without a central "controlling mind".		
		2	A central team exists that manage a range of core buildings directly but are not fully integrated		
		3+	Hard services is integrated with a clear centre of expertise with delivery coordinated centrally		
		Q3	How integrated is Property Leadership?	2	
		1	FM works in a silo, reactive to demand with little engagement with wider property leadership		
		2	FM links in some what with construction, design and asset management teams, but gaps remain.		
		3+	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM	Q4	How integrated are your FM Management IT Systems?	2	
		1	No CAFM, basic spreadsheets or similar used to monitor and manage FM.		
		2	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.		
		3	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.		
		4	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.		
		5	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Collaborative					
Collaborative	**Partnership & Transparency**	**Q5**	**How closely does FM management work with the FM delivery organisation(s)?**	3	
		1	Minimal, adversarial relationship		
		2	Weekly or monthly meetings, focused on performance and reporting		
		3	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes		
		4	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.		
		5	A fully open and trusting relationship, working both ways to improve performance and value		
		Q6	**How strategic and effective are supplier relationships?**	2	
		1	Supplier relationships are transactional only.		
		2	A supplier relationship model (SRM) is in place (See CCS)		
		3+	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.		
		Q7	**How transparent is FM delivery between the management organisation and delivery organisation?**	2	
		1	No transparency regarding performance or cost.		
		2	Data held by supplier but regularly validated and shared at monthly meetings.		
		3+	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
		Q8	**Does the FM team collaborate outside of the management organisation?**	2	
		1	Little engagement with wider government departments, occasional attendance at events or key meetings.		
		2	Actively involved in cross government forums, such as those driven by CCS, GPA.		
		3+	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Delivery Excellence					
Delivery Excellence	**Compliance**	**Q9**	**How effective is your hard compliance management approach?**	3	
		1	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.		
		2	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.		
		3	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.		
		4+	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.		
		Q10	**How effective is your soft compliance management approach?**	3	
		1	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.		
		2	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.		
		3	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.		
		4+	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.		
	Standards and Best Practice	**Q11**	**How well standardised is FM management in line with industry best practice? (E.g. ISO)**	2	
		1	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.		
		2	Use of some industry standards, such as ISO9001 but less maturity on other aspects		
		3+	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Delivery Excellence	Standards and Best Practice	**Q12**	**How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)**	2	
		1	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.		
		2	Use of some industry standards, such as SFG20 but less maturity on other aspects.		
		3+	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
	Defined Roles	**Q13**	**How well defined are FM roles and responsibilities within Hard Services?**	3+	
		1	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).		
		2	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.		
		3+	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
		Q14	**How well defined are FM roles and responsibilities within Soft Services?**	3+	
		1	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).		
		2	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.		
		3+	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension	Questions		Self-Assessment Score	Comment
Strategic					
Strategic	**Enabling**	**Q15**	**How flexible is FM to changing business needs?**	3	
		1	FM works on fixed price or square meter rate with complex or costly variation process.		
		2	Part fixed, part variable arrangement with clear and simple change control mechanisms .		
		3	Work in partnership with suppliers to continually improve support for changing business objectives.		
		4+	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.		
	FM Strategy	**Q16**	**How strategic is FM?**	3	
		1	No FM strategy or service plan. FM is delivered in a reactive way.		
		2	Basic FM strategy and service plan in place, but not fully integrated with wider business priorities.		
		3	FM Strategy in place, considering 5 year + horizon, service plan refreshed annually.		
		4+	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/		
	Governance	**Q17**	**Do you have effective FM governance in place?**	3	
		1	No management/minimal management. Risk poorly allocated.		
		3	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.		
		5	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		

Assessment - FM Standard-FMS 001-Maturity Tool

Please enter the department / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Comment
Intelligent					
Intelligent	**Intelligent Client**	**Q18**	**Do you have a clear definition and recognised Intelligent client function?**	3	
		1	The ICF is dispersed without a clear, recognised function.		
		3	A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.		
		4+	A highly effective ICF is in place with it's value recognised at an organisational level.		
		Q20	**Is an effective client department in place?**	3+	
		1	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects		
		2	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.		
		3+	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
	Control Levers	**Q19**	**How well do you understand the levers to improve performance?**	3+	
		1	A basic understanding of levers available in the contract, primarily performance failure driven		
		2	A good understanding of commercial, financial and quality control levers and their impact of performance		
		3+	Regular, demonstrable use of all types of control levers to drive continuous improvement		
	Management Structures	**Q21**	**Is there sufficient management, capability and capacity to be effective? Are roles clear?**	2	
		1	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".		
		2	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.		
		3+	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
	Forward Planning	**Q22**	**How proactive is FM service delivery in your organisation?**	3+	
		1	Reactive works only, failure driven.		
		2	Short term planning - next financial year only.		
		3+	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Questions completed: 22

Appendix 2: Facilities Management Standard (FMS) Maturity Tool 002 - 2024/2025

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Structure					
Data Structure	Hierarchy	Q1	What level of location hierarchy is asset data captured against?	3+	
		1	Asset level data is captured against the site and building it is in.		
		2	Asset level data is captured against the site, building, floor and location it is in.		
		3+	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification	Q2	Is there a consistent data specification aligned to the FM asset data standards (4.2)?	3	
		1	No defined data specification for FM asset data.		
		2	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).		
		3	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).		
		4	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).		
		5	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).		
		Q3	How consistently is the data specification applied across the estate?	3+	
		1	No defined data specification for FM asset data.		
		2	The data specification is inconsistently applied across the estate.		
		3+	The data specification is consistently applied across the estate.		
Data Assurance and Quality					
Data Assurance and Quality	Coverage and Completeness	Q4	What is the level of coverage of assets in the asset register data?	3+	
		1	The asset data covers some assets in some estates.		
		2	The asset data covers all assets in some estates but only some assets in other estates.		
		3+	The asset data covers all assets in all estates.		
		Q5	How complete is the data captured against assets in the asset register?	4	
		1	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).		
		2	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).		
		3	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).		
		4	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).		
		5	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).		
	Audit	Q6	Is a full asset verification exercise required to update the asset register (5.1)?	3+	
		1	Data is out of date or incomplete and requires a full asset verification exercise.		
		2	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.		
		3+	Data is up to date and complete. An asset verification exercise is not currently required.		
		Q7	What regular sample surveys exist for on-going asset verification (5.2)?	3	
		1	No / limited sample surveys.		
		2	Inconsistent and ad-hoc sample surveys for some of the estates.		
		3	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.		
		4	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.		
		5	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Assurance and Quality	Data Quality Control	Q8	What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	3	
		1	No / limited processes in place.		
		2	Inconsistent processes exist covering some parts of the estate.		
		3	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.		
		4	Partially automated processes with frequent updates to change log.		
		5	Automated processes across all estates with close to real-time updates to change log.		
		Q9	What processes are in place for data quality checks (5.4)?	2	
		1	No / limited processes in place.		
		2	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.		
		3	Consistent and regular processes exist using checks based on business rules covering all estates.		
		4	Partially automated processes using data quality check algorithms and data quality dashboards.		
		5	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.		
		Q10	What processes are in place for data update assurance (5.5)?	3	
		1	No / limited processes in place.		
		2	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.		
		3	Consistent and regular processes exist using verification tools and update logs covering all estates.		
		4	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.		
		5	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.		
	Governance	Q11	What governance is in place to support data assurance and quality (5.6)?	1	
		1	No / limited governance / informal group for asset data quality.		
		2	A dedicated asset data-quality governance board exists but meets on an irregular basis or without the required attendees.		
		3	A dedicated asset data-quality governance board exists, which meets regularly with all the relevant attendees.		
		4	Along with the dedicated asset data quality governance board, there are additional sub-working groups with the suppliers.		
		5	Along with the dedicated asset data quality governance board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.		
		Q12	What level of documentation exists for the these data quality processes and governance (5.7)?	1	
		1	No / limited documented items for processes and governance.		
		2	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.		
		3+	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Ownership and Access					
Data Ownership and Access	Ownership	Q13	Is the data contractually owned by the organisation (6.1)?	3+	
		1	The organisation does not contractually own the data.		
		2	The organisation contractually owns the data for some data stores/parts of estate.		
		3+	The organisation contractually owns the data for all estates.		
	Accessibility	Q14	What level of access does the organisation have to the data in the asset management systems (6.2)?	5	
		1	No / limited access to the data (e.g. data extracts requested via email to FM provider).		
		2	Access to some data tables/extracts across some data stores/parts of the estate.		
		3	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.		
		4	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.		
		5	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.		
		Q15	What level of access management exists for controlling user privileges (6.3)?	3+	
		1	No / limited access management privileges.		
		2	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.		
		3+	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
Data Systems					
Data Systems	Flexibility	Q16	Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	3+	
		1	Systems with limited flexibility to accommodate the data standards.		
		2	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.		
		3+	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		
	Interoperability	Q17	Do the asset management systems allow interoperability of asset data (7.2)?	3+	
		1	Systems with limited interoperability between systems.		
		2	Systems with some interoperability between some systems and data is not transferable in COBie format.		
		3+	Systems with interoperability between all systems and data is transferable in COBie format.		
		Q18	Does the asset management systems sync to a common data platform (7.3)?	5	
		1	No common data platform exist.		
		2	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.		
		3	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.		
		4	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.		
		5	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.		
Data Systems	Management	Q19	Do the systems meet data security requirements (7.4)?	3+	
		1	No systems meet minimum requirements across any estate.		
		2	Some of the systems meet data security requirements across some data stores/parts of the estate.		
		3+	All systems meet data security requirements across all estates.		
		Q20	Do the systems meet data backup management requirements (7.5)?	3+	
		1	No systems meet minimum requirements across any estate.		
		2	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.		
		3+	All systems meet data backup management requirements. Backup processes are on a regular basis.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Data Usage					
Data Usage	Management Information	Q21	What types of management information reports and dashboards are used for FM asset data (8.1)?	5	
		1	No / ad hoc reporting and dashboarding to support the use of FM asset data.		
		2	Inaccurate reports generated from data gathered point in time.		
		3	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.		
		4	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.		
		5	Ability to create bespoke customisable reports to answer the latest business questions.		
	Insights	Q22	How does asset data inform decisions relating to contract management (8.2)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q23	How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q24	How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		
		Q25	How does asset data inform decisions relating to Investment Prioritisation (8.5)?	3	
		1	None / limited insights available to inform decision making.		
		2	Some insights generated but with limitations that impact decision making.		
		3	Data insights are generated and used to make informed decisions.		
		4	Robust and repeatable processes for generating insights and acting upon these.		
		5	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.		

Assessment - FM Standard-FMS 002-Asset Data-Maturity Tool

Please enter the organisation / portfolio: Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dimension	Sub-Dimension		Questions	Self-Assessment Score	Rationale
Team Capacity and Capability					
Team Capacity and Capability	Capacity	Q26	What is the capacity of the teams working with asset data (9.1)?	3	
		1	No dedicated teams/informal teams.		
		2	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.		
		3	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.		
		4	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.		
		5	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.		
	Capability	Q27	What is the capability of the teams working with asset data (9.2)?	3	
		1	No dedicated personnel/informal teams.		
		2	Team with some FM and data/technical understanding.		
		3	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.		
		4	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.		
		5	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.		
	Training	Q28	What training is provided for teams working with asset data (9.3)?	2	
		1	No / limited training provided.		
		2	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.		
		3	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.		
		4	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.		
		5	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.		
		Q29	What training materials exists relating to asset data (9.4)?	2	
		1	No training and guidance material for asset data and processes.		
		2	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.		
		3+	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
		Q30	What knowledge sharing exists relating to asset data (9.5)?	3	
		1	No / limited knowledge sharing in place.		
		2	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.		
		3	Consistent knowledge sharing exists between different organisations on a regular basis.		
		4	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.		
		5	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.		

Questions completed: 30

2509 - D5 GREEN PLAN REFRESH 2025

Decision Item | Kirsty Edmondson-Jones, Director of Infrastructure | 12:15

10 minutes

REFERENCES

Only PDFs are attached

D5 - Green Plan Refresh 2025.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	Green Plan Refresh 2025			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Mathew Gleadall, Operational Director of Estates and Facilities			
Appendices:	N/A			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**BAF 4:** Objectives within the Green Plan are directly linked to improvements within the care environment. **BAF 5:** Improved environmental sustainability is linked to financial sustainability. By improving energy efficiency, maximising opportunities for on-site renewable energy generation, reducing waste, and mitigating the impact of disruptive climatic weather events, delivery of the Green Plan contributes to the financial security of DBTH. **BAF 6:** If the NHS is to achieve its national net zero ambitions, a coordinated approach aligned with our partners is required. The Green Plan is therefore closely aligned with key stakeholders across our region. **BAF 7:** Innovation through digital transformation offers one of the greatest opportunities for emission reduction, this is therefore a key area of focus within the plan.			

Executive Summary – Key messages and Issues

The NHS has an ambitious aim to become the world's first net zero national health system, targeting net zero for the emissions it directly controls (NHS Carbon Footprint) by 2040, and net zero for the emissions it can influence (NHS Carbon Footprint Plus) by 2045.

To help achieve this goal, all NHS organisations have been required to have a Board approved 'Green Plan' outlining their path to net zero since 2022. Earlier this year, guidance was published from NHS England requiring trusts to 'refresh' their Green Plans in line with latest guidance, placing an increased emphasis on clear objective setting, performance measurement, and oversight mechanisms to ensure delivery.

This refreshed Green Plan provides an updated roadmap for delivering sustainable healthcare services at Doncaster and Bassetlaw Teaching Hospitals (DBTH) for the period covering 2025 -2028.

Significant progress has been made since the Trust's first Green Plan launched in 2022, including a transition to the procurement of clean renewable electricity, phasing out the environmentally damaging anaesthetic agent desflurane, decommissioning nitrous oxide infrastructure, and investing in low carbon technology and on-site renewables.

Building on this progress, the refreshed Green Plan provides objectives spanning nine mandated areas of focus:

- **Workforce and Leadership**
- **Medicines**
- **Estates and Facilities**
- **Digital Transformation**
- **Climate Adaptation**
- **Net Zero Clinical Transformation**
- **Travel and Transport**
- **Procurement and Supply Chain**
- **Food and Nutrition**

Aligned with the guidance from NHS England, the South Yorkshire Integrated Care Board's Green Plan, and the Government's Fit for the Future: 10 Year Health Plan for England, the plan contains clear SMART objectives, measurable performance indicators, and robust governance arrangements to ensure delivery.

Once the Green Plan is formally ratified, an associated delivery plan will be developed in conjunction with leads for each area of focus, providing a more detailed description of the anticipated improvement trajectory over the period covered by the plan.

The aim of the Green Plan is to ensure that environmental sustainability is embedded across all services at DBTH, not only to reduce our carbon footprint, but also help tackle wider social and environmental factors that impact health inequalities in our local communities, contributing to our vision to be **Healthier Together: Delivering Exceptional Care for All.**

Recommendations
The Board of Directors are asked to review the proposed Green Plan refresh and provide formal **RATIFICATION** for its approval.

Healthier together – delivering exceptional care for all	
Patients	The Green Plan aims to reduce environmental impacts that can affect patient health, such as air pollution and climate-related risks
People	Various objectives within the Green Plan, particularly under the Workforce and Leadership section, aim to engage, inform and educate our people to empower them to contribute towards a more sustainable future for DBTH.
Partnerships	The Green Plan details the importance of partnership working in the successful delivery of the plan's objectives, particularly across the South Yorkshire ICB.
Pounds	Energy efficiency, waste reduction, and a smarter use of resources as detailed within the plan all contribute to a sustainable financial future.
Health Inequalities	The Green Plan aligns closely with Health Inequalities, addressing environmental determinants of health such as air quality and climate resilience.
Legal/ Regulation:	The plan directly supports DBTH's obligations under the Health and Care Act 2022 and NHS England's Net Zero requirements.
Partner ICB strategies	The plan is closely aligned with the South Yorkshire ICB's Green Plan.

Assurance Route	
Previously considered by - including date:	Finance and Performance Committee - 14 August 2025.
Any outcomes/next steps / time scales	Approved for submission to the Board of Directors for ratification on 2nd September 2025
Is this in line with Current risk appetite **YES/~~NO~~**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

DBTH Green Plan
2025 - 2028

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Foreword

As a Trust, we recognise the impact of climate change and the effect it has on the lives of people across the world. As one of the largest employers in our region, Doncaster and Bassetlaw Teaching Hospitals (DBTH) acknowledges its responsibility to act to reduce our environmental impact and protect the health and wellbeing of our communities.

This refreshed Green Plan sets out our strategic approach to delivering a more sustainable, efficient, and resilient health service over the next three years. It builds on the significant progress we have made so far, which includes the phasing out of desflurane, removing piped nitrous oxide infrastructure, investing in digital technology to support a more sustainable approach to care, and increasing the use of low-carbon technology and on-site renewables. Together, these actions provide a clear roadmap for further progress across all areas of our organisation.

The NHS is the first health system in the world to commit to reaching Net Zero, and we are proud to contribute to this nationally coordinated effort. Our plan is fully aligned with the ambitions of NHS England and the South Yorkshire Integrated Care Board, ensuring we continue to work in partnership to deliver greener, fairer healthcare at a system level. It also supports the vision set out in the Government's Fit for the Future: 10-Year Health Plan for England, which emphasises more resilient, digitally enabled and sustainable services that protect health today and for future generations.

The measures in this plan will also help us to meet our legal duties under the Health and Care Act 2022 and to do so in a way that supports better outcomes, more efficient use of resources, and care that is fairer for all.

At DBTH, our vision is clear: **Healthier together—delivering exceptional care for all**. This includes care for our environment. Through strong leadership, robust governance, and the commitment of our people, we will ensure sustainability becomes an integral part of how we plan, deliver, and improve services. We thank all colleagues who have contributed to this work so far, and we look forward to building on this progress together in the years ahead.

Richard Parker OBE

Chief Executive

Sam Wilde

Chief Finance Officer
(Board-Level Net Zero Lead)

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Executive Summary

Climate change poses an escalating threat to the health, wellbeing, and long term sustainability of the NHS. As one of the largest public sector organisations in the UK, the NHS is responsible for around 4% - 5% of the nation's carbon emissions. In response, the NHS aims to become the first national health system in the world to reach net zero, with targets to eliminate direct emissions by 2040 and indirect emissions by 2045.

This Green Plan sets out Doncaster and Bassetlaw Teaching Hospitals' refreshed strategy for contributing to this ambition. It builds on the foundations laid by our first Green Plan (2022 - 2025), which led to significant improvements within the Trust including:

- Phasing out the use of desflurane and removing piped nitrous oxide infrastructure.
- Transitioning to 100% renewable electricity across our sites.
- Expanding virtual wards and digital care models.
- Achieving a cumulative reduction of 6,550 tCO_2e across our estate and operations.
- Securing Green Flag Awards for our memorial gardens at DRI and BH.

The refreshed plan is aligned with NHS England's national guidance, the South Yorkshire Integrated Care Board's (SY ICB) Green Plan, and our Trust's vision: **Healthier together – delivering exceptional care for all**. It is structured around the nine nationally mandated areas of focus, each supported by a clear set of objectives, key performance indicators, and defined governance arrangements.

Workforce and System Leadership: We will develop knowledge, skills and leadership across all levels of the organisation, including a Green Champion network and executive-level accountability.

Net Zero Clinical Transformation: We will continue to assess and redesign high-emission clinical pathways, supporting new technologies and early intervention to reduce the environmental impact of our services, as well as embedding sustainability into our quality improvement programmes.

Digital Transformation: We will maximise the role of digital technology in reducing our environmental impact, scaling virtual consultations, enabling agile working, and improving digital infrastructure efficiency.

Travel and Transport: We will reduce emissions from travel by promoting sustainable and active travel options, supporting staff to switch to lower carbon commuting options, and transitioning our fleet to electric vehicles.

Estates and Facilities: We will improve energy efficiency, develop plans to decarbonise our heat production, invest in smart building technologies to reduce energy and water consumption, and introduce measures to reduce waste generated across our estate.

Medicines: We will maintain our progress in phasing out high carbon volatile anaesthetic agents, reduce our use of nitrous oxide and associated products, and integrate sustainability into medicines optimisation.

Supply Chain and Procurement: We will ensure that our key suppliers are meeting sustainable supplier expectations, embed sustainability into our tender processes, and minimise waste by reducing our reliance on single use items.

Food and Nutrition: We will promote healthier and more sustainable food options for patients, staff and visitors, reduce food waste, and comply with national catering and nutrition standards.

Adaptation: We will assess and respond to the risks posed by climate change, including higher temperatures, increased rainfall, and a rising number of extreme weather events, developing adaptation plans that improve the resilience of our infrastructure, services and emergency planning.

Strong governance is essential to delivering this plan. The Trust's Chief Finance Officer acts as our board level Net Zero Lead, supported by operational leads and a dedicated Green Plan Delivery Board. Progress will be monitored routinely and reported periodically to the Trust Board, with annual summaries published publicly.

Sustainability is not the responsibility of one team, it is a shared endeavour that requires coordinated, visible action from every part of the organisation. Through this Green Plan, DBTH reaffirms its commitment to leading on environmental responsibility, supporting better health outcomes, and playing our part in creating a greener, fairer and more resilient NHS.

Introduction

This Green Plan sets out Doncaster and Bassetlaw Teaching Hospitals' (DBTH) refreshed strategy for delivering high-quality and environmentally sustainable healthcare from 2025 to 2028. It builds on the foundations of our 2022–2025 Green Plan and reflects updated national guidance from NHS England, as well as our shared commitments under the South Yorkshire Integrated Care Board's (ICB) Green Plan.

As a large acute provider serving a diverse population across Doncaster, Bassetlaw and surrounding areas, we recognise that the health and wellbeing of our patients is directly influenced by the quality of the environment in which they live. The growing effects of climate change, such as rising temperatures, air pollution, and extreme weather, pose a serious and increasing risk to the NHS, particularly for the most vulnerable in our communities. At the same time, our services contribute to those environmental pressures. The NHS is responsible for approximately 4%-5% of the UK's total carbon emissions, with healthcare activity across clinical, estates, transport and supply chain systems all playing a role.

This plan reaffirms our commitment to being part of the solution. It sets out how we will align with the NHS's ambition to achieve net zero for direct emissions by 2040, and for emissions we can influence by 2045. It also outlines how we will embed sustainability into our decision making, reduce the environmental impact of the care we provide, and improve the resilience of our estate and services. We have framed this plan around nine nationally mandated areas of focus, each supported by a clear set of SMART objectives, measurable performance indicators, and local actions tailored to the needs of our organisation and the people we serve.

This Green Plan also reinforces our commitment to national and regional collaboration. It has been developed in close alignment with the South Yorkshire ICB Green Plan and reflects our wider role as a system partner and anchor institution within our community. It integrates sustainability into our broader corporate strategy and supports the Trust's vision of being **Healthier together—delivering exceptional care for all**.

Delivering sustainable healthcare requires coordinated and sustained effort from all parts of the organisation. Through strong leadership, clear governance, and the continued commitment of our people, we will ensure that DBTH plays a leading role in delivering a greener, fairer and more resilient health system for the future.

About us

We are an acute NHS Foundation Trust and teaching hospital, serving a diverse population of over 440,000 people across South Yorkshire, North Nottinghamshire, and surrounding areas.

Figure 1: Our Trust

We provide a wide range of high quality healthcare services throughout our three main hospitals - Doncaster Royal Infirmary (DRI), Bassetlaw Hospital (BH), and Montagu Hospital (MH) - as well as additional services at smaller sites like Retford Hospital.

As a teaching hospital, we proudly work closely with local universities, contributing to the development of future healthcare professionals while advancing research and innovation. Our links with Integrated Care Partnerships and system partners, spanning South Yorkshire and Nottinghamshire, enable us to deliver seamless, person-centred care in collaboration with other health and social care organisations.

We are also home to some of the busiest emergency departments in the region, offering essential services ranging from emergency care to specialist tertiary care, such as vascular surgery.

Our vision, **Healthier together – delivering exceptional care for all**, underpins everything that we do, reflecting our ambition to improve lives and reduce inequalities through high quality, person centred sustainable healthcare.

Figure 2: Our Vision

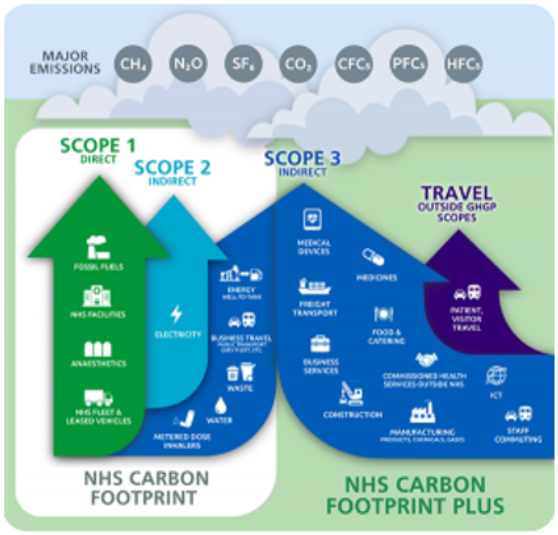
Our vision reflects our ambition to provide exceptional, person-centred healthcare, while also working with our partners to improve the health and wellbeing of our communities. This vision is brought to life through our core values, expressed in the phrase "**We Care**". These values guide how we care for our patients, support our colleagues, and interact with our partners, shaping both our culture and our strategic decisions. These principles also underpin our commitment to sustainability, ensuring that our actions are socially responsible, environmentally conscious, and aligned with the long-term interests of the populations we serve.

Figure 3: We Care Values

Why do we need a refreshed green plan?

The NHS became the world's first health system to commit to net zero carbon emissions in 2020. This ambition was formally set out in the 'Delivering a Net Zero National Health Service' report, and further reinforced through the Health and Care Act 2022, which places a legal duty on NHS organisations to consider environmental sustainability and statutory emissions targets in all key decisions.

The NHS has set ambitious but achievable national targets to drive progress (Figure 4):



We will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 for the emissions we control directly (the NHS Carbon Footprint).

We will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 for the emissions we can influence (our NHS Carbon Footprint Plus).

Figure 4: NHS Carbon Footprint & Carbon Footprint Plus

As one of the largest employers and service providers in our region, DBTH has a responsibility to lead by example. The NHS contributes around 4%-5% of the UK's carbon emissions, and we recognise that climate change is not only an environmental threat but also a public health issue. Communities in our region experience disproportionate levels of air pollution, heat vulnerability, and health inequalities, risks that are expected to worsen as climate impacts intensify.

We launched our first Green Plan in 2022, providing the foundation upon which this document was built. We now aim take the next step in delivering a more sustainable future for DBTH, and this refreshed Green Plan outlines how we will contribute to national net zero goals while improving population health, reducing inequalities, and ensuring the long-term resilience of the services we provide over the next three years.

What are we seeking to achieve?

Aligned with our vision of **"Healthier together – delivering exceptional care for all",** this Green Plan sets out our commitment to environmental sustainability as a core component of how the Trust delivers safe, effective and resilient services. We recognise that the health of our population is intrinsically linked to the health of our environment, and that taking decisive climate action is essential to safeguarding both current and future generations.

In delivering the objectives of our Green Plan, we will contribute to the NHS's national vision **"To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations."**

Our Aims:

To achieve this vision, our refreshed Green Plan recommits our aim to:

- Support the NHS to become the world's first net zero national health service, identifying our trajectory to achieve net zero emissions by:
    - 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2032
    - 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2039
- Embed sustainability into our clinical, operational and strategic practices
- Improve health outcomes and reduce health inequalities through Net Zero clinical transformation
- Embed sustainability at the core of the Trust, developing the knowledge of our staff

Our progress so far

The Trust has made considerable progress since launching its Green Plan in 2022. Key achievements so far include:

- A reduction in emissions totalling 6,550 tCO2e between 2021 and 2024, a reduction of 39% from the 2021 baseline
- A transition to the procurement of clean renewable electricity for all sites
- Increased use of low carbon technology, on-site renewables and improved building efficiency

- A transition away from the use of the volatile anaesthetic gas desflurane, and a significant reduction in emissions from all volatile anaesthetic gases within the Trust
- The removal of piped nitrous oxide from each of the Trust's main sites and ongoing work to reduce nitrous oxide waste, leading to a sizeable reduction in emissions from nitrous oxide and gas and air
- Attainment of Green Flag Awards for Green Spaces at Doncaster Royal Infirmary, Bassetlaw Hospital, and Montagu Hospital, recognising the positive impact that these green spaces have on biodiversity and the health and wellbeing of patients, visitors and colleagues
- Adopting zero waste to landfill for all waste streams across the Trust
- An increased use of digital technology to reduce the environmental impact of Trust services through initiatives such as virtual wards and an increased utilisation technology to support remote and hybrid working
- The introduction of initiatives targeting Net Zero clinical transformation via Greener Theatres, Greener Dialysis and Greener Endoscopy

Developing this plan

This Green Plan refresh is based on a comprehensive review of our progress to date, alongside engagement with stakeholders across the Trust and local system. We have drawn on insights from Estates and Facilities, Clinical Teams, Pharmacy, Digital Transformation, and Procurement, as well as from frontline staff and the Trust's Sustainability Steering Group. We have aimed for a collaborative approach, based on evidence, following national guidance and examples of best practice.

This plan has also been shaped by our understanding of local needs and challenges. Doncaster and Bassetlaw are adversely impacted by health inequalities and poor air quality, factors linked to lower life expectancy and poorer health outcomes. Our refreshed Green Plan therefore acknowledges the role we play as an anchor institution and outlines how our efforts to improve the sustainability of our services can help to address these broader social and health inequalities.

We have ensured that our statutory duties under the Public Sector Equality Duty, the Health and Care Act 2022, and our obligations to reduce inequalities have been integrated into the plan's development. These duties underpin our decision making and are reflected in our design of objectives to improve sustainability and reduce emissions.

The refreshed Green Plan is aligned with national priorities, South Yorkshire Integrated Care Board's (SY ICB) Green Plan, and other relevant regional strategies that support coordinated system wide delivery. By working with partners across the system, we strengthen our collective capacity to reduce emissions, adapt to climate change, and deliver sustainable healthcare services.

Working with our partners

Achieving a sustainable and climate resilient health and care system cannot be delivered by individual organisations in isolation. It requires a coordinated, whole system approach. Whilst Doncaster and Bassetlaw Teaching Hospitals (DBTH) works in partnership with both the South Yorkshire Integrated Care System (SY ICS) and the Nottingham and Nottinghamshire ICS (Notts ICS), we most actively work with SY ICS in relation to sustainability, and as a result our refreshed Green Plan aligns with the shared ambitions, statutory duties, and system-wide commitments outlined in the South Yorkshire ICB Sustainability and Green Plan 2025–2028.

The SY ICB's vision for their Green Plan is:

'To work with patients and partners to improve the health of our population and respond to the urgent threat of the climate crisis by putting sustainability and net zero at the heart of everything that we do and collaborating to deliver a greener, more sustainable NHS for South Yorkshire'.

The ICB recognise that climate change poses a threat to the health of our population, and that collective action is required across organisational boundaries to create lasting transformational change. DBTH fully supports this integrated approach and is committed to collaborative delivery of aligned objectives and mutual support in key areas of sustainability.

We both contribute to and benefit from active regional forums, including the South Yorkshire Sustainability Steering Group, which brings together partners from throughout the system to share progress, co-develop initiatives, and address shared challenges.

There are multiple areas of strategic alignment between DBTH and the ICS priorities. These include:

Medicines: DBTH's removal of desflurane and decommissioning of piped nitrous oxide are in line with system-level reductions in emissions from high-impact pharmaceuticals.

Digital Sustainability: Our investment in digital technology supports the ICB ambition to reduce emissions through improved interoperability and data sharing, as well as finding low carbon solutions to support digital service provision.

Estates and Facilities: Through site development and continued investment in infrastructure modernisation, we are contributing to system-wide energy efficiency targets.

Travel and Transport: We align with the ICB in our commitment to promote active travel, deploy zero-emission fleet vehicles, and partner with local authorities to improve transport access to NHS sites.

Net Zero Clinical Transformation: We are engaged in the assessment and redesign of care pathways to reduce environmental impact while improving outcomes throughout the system.

We also recognise the strategic importance of policy alignment across the ICS. As the ICB prepares to implement the Model ICB Blueprint and adjust functions in line with NHS England guidance, we will continue to support the transfer of green planning responsibilities to provider organisations and maintain system-wide coherence and accountability.

Our contribution to the SY ICB Green Plan reflects our recognition that population health, health inequalities, and sustainability are deeply interconnected. DBTH will continue to engage fully in system governance and reporting mechanisms and ensure that our progress contributes to the broader success of the South Yorkshire ICB as it delivers on its net zero and sustainability objectives.

Areas of focus

To ensure that we maintain progress towards our Net Zero targets and wider sustainability goals, this refreshed Green Plan remains structured around the same nine interrelated areas of focus outlined in our original plan. These areas reflect the full scope of our organisational activity and provide a comprehensive framework for reducing emissions and embedding sustainability into our operational and clinical practice.

Each area of focus is underpinned by specific, measurable, and time bound actions, aligned to national guidance and local priorities. These actions have been informed by stakeholder input, current performance, and national priorities.

This section sets out our key commitments, with details of the performance indicators that we will use to monitor progress against each focus area for the period 2025 to 2028.

Workforce and leadership

Our people are central to the successful delivery of the Green Plan. Building awareness, skills and leadership capacity for all colleagues is essential to embedding sustainability into operational and clinical practice. Strong governance and executive oversight are also critical to ensuring accountability and maintaining momentum.

Recognising that our people are pivotal to the success of our Green Plan, DBTH will provide colleagues with the training, knowledge and practical tools to support a more sustainable approach to service delivery. This includes training on health inequalities, providing clarity on the vital role that sustainability plays in addressing inequalities within our communities. We will embed sustainability and health inequalities into our culture by engaging colleagues at all levels, supporting behavioural change, and aligning these important functions into the objectives of the Trust.

This will be reinforced by visible and active leadership from senior leaders throughout the organisation. The Trust's Chief Finance Officer is the board level Net Zero lead, supported by both the Director of Infrastructure and the Operational Director of Estates and Facilities as operational sustainability leads. This reflects a clear commitment at a senior level to champion and drive the sustainability agenda, helping to create a greener DBTH and a more sustainable future for the Trust.

Action	Measurement
To help build a culture of sustainable practice at DBTH, we'll introduce information on how colleagues can adopt a more sustainable approach to their role into our induction materials by 2026, ensuring all new colleagues understand how they can make a difference.	Induction completion data
We will provide colleagues with the necessary training to help them identify how they can reduce emissions and contribute to a Greener NHS by actively promote the E-Learning for Healthcare training module 'Building a Net Zero NHS', aiming for at least 50% of Trust employees to have completed the training by 2028.	Training completion data

Action	Measurement
We will also identify roles that underpin the delivery of the Green Plan and complete a training needs analysis to identify any further specialist training that may be required to support delivery. Once complete, we will implement the training by the end of 2027.	Training needs analysis and targeted delivery plan in place by 2025 Training delivery plan progress
Recognising that sustainable practice can't just be top down, we'll recruit Green Champions throughout the organisation to support the Trust's sustainability objectives, targeting the successful recruitment of at least one Green Champion to support each area of focus by 2026.	Number of Green Champions recruited Number of sustainability initiatives led or supported by Green Champions and the impact of those initiatives.

Net Zero Clinical Transformation

Whilst clinical care is at the heart of the NHS, it is also a significant contributor to its carbon footprint. Our path to Net Zero requires us to transform the way in which care is designed and delivered to ensure it is high quality, preventative, and sustainable. This means embedding environmental considerations into clinical decision making and service design, providing models of care that reduce emissions while continuing to deliver high quality healthcare.

DBTH is already benefiting from sustainable clinical innovation. The introduction of virtual wards helps us to deliver care outside of a hospital setting, developments in technology have increased virtual consultations, and projects led by our people have reduced emissions in dialysis and surgery, providing examples of what can be achieved. These efforts have not only improved efficiency but also enhanced patient experience and reduced our environmental impact.

Looking ahead, we will continue to work with clinical teams to identify opportunities for decarbonisation, to incorporate sustainability into quality improvement and clinical governance frameworks, and to ensure that our transformation priorities align with both population health needs and environmental responsibility.

The following objectives set out how we will deliver net zero clinical transformation over the span of this Green Plan.

Action	Measurement
To support this essential work stream, we will appoint a clinical lead with oversight of Net Zero clinical transformation, with formal links into board-level leadership and governance.	The successful appointment of clinical lead with oversight for Net Zero
By the end of 2026, we will develop and implement a sustainability impact assessment to evaluate the environmental impact of clinical care pathways. Using this tool, we will complete detailed assessments of at least three high emission pathways, identifying carbon hotspots and opportunities for service redesign, waste reduction, or substitution with lower impact alternatives	Number of clinical pathways assessed using the sustainability impact framework. Number of improvement opportunities identified and implemented. Emission reductions achieved.
Building on our existing Green Theatres Group, we will establish at least one Green Champion led sustainability working group in each clinical division to identify, implement, and monitor initiatives to reduce the environmental impact of clinical services at DBTH by 2026.	Number of sustainability working groups established. Initiatives identified/implemented Emission reductions achieved
We will incorporate sustainability principles into the Trust's Quality Improvement (QI) training and methodology by 2026. This will ensure that all QI initiatives consider environmental impact alongside improvements in the quality of care, operational efficiency, and health inequalities.	Number of staff trained in sustainability inclusive Qi methodology Number of Qi initiatives fully or partially targeting improved sustainability Emission reductions achieved as a result of Qi initiatives

Digital Transformation

Digital technology offers powerful and scalable solutions for improving patient care while reducing our environmental impact. From reducing the need for physical travel to streamlining operations and improving energy efficiency, digital transformation plays a critical role in the transition to a Net Zero healthcare system. This area of focus explores how we will harness digital systems to support decarbonisation by enabling virtual care, reducing reliance on paper, extending device lifespans, optimising building performance, and supporting more flexible and environmentally friendly ways of working.

The scope for innovation in this area is considerable, most especially in the context of the recently published Fit for the Future: 10-Year Health Plan for England which aims to shift analogue to digital, with considerably expanded functionality of the NHS app as just one example.

We have already begun to realise the benefits of digital solutions at DBTH through initiatives such as virtual wards, the automated shutdown of IT equipment when not in use, building control systems that regulate energy usage, and digital platforms that enable agile and remote working practices. These technologies not only enhance the quality and responsiveness of care, but also offer clear opportunities to reduce emissions, minimise waste, and create more resilient, efficient services.

Looking ahead, we will build on this strong foundation to integrate sustainability considerations in to our digital strategy and operations. The following objectives set out how we will maximise the environmental value of digital transformation in support of our Green Plan and wider net zero ambitions.

Action	Measurement
Establish a baseline for the ICT carbon footprint according to the guidelines set out in the published materials by the UK Government's Sustainable Technology Advice & Reporting (STAR), and develop attainable carbon reduction targets by 2026.	Current carbon ICT footprint and carbon reduction commitment in place.
Throughout the term of the Green Plan we will explore the feasibility of adopting the principles of a circular economy into the acquisition and reuse of digital hardware, with the objective of	Quantity of devices reused Reduction in items to landfill (kg)

Action	Measurement
supporting communities and reducing waste where doing so delivers financial, environmental and ethical benefits.	
We will reduce the environmental impact of data storage by prioritising energy efficient and low carbon local or cloud-based data centres for hosting data and systems where feasible to do so from 2026 onwards.	Contracts awarded that include energy efficient / low carbon hosting
To enable more patients to be safely monitored and treated in their own homes, we will build on the successful implementation of virtual wards at DBTH by supporting an increase in capacity (where appropriate in line with clinical strategy), reducing avoidable travel, lowering the consumption of resources, and improving patient experience.	Virtual bed capacity Virtual bed utilisation
To improve levels of awareness and understanding of sustainability within Digital Transformation, digital sustainability will be incorporated within the 'Digital and Data Academy' by 2026	Training completion data
We will review our data destruction policy for all major systems by 2026, ensuring that we do not keep electronic data for longer than necessary. This will reduce the storage needed for data, and by association, our electricity consumption.	Data destruction performance in line with legislative requirements
Through the successful implementation of Electronic Patient Records (EPR) by Spring 2028, we will reduce our reliance on paper records, reducing paper consumption, printer usage, resources required to transport records, and estates-related resources associated with the storage of records.	Evidence of reduced paper records in line with the EPR plan

Action	Measurement
By supporting an increased use of distributed working, including working from home, we will reduce emissions from travel to site.	Travel time data Data on working locations
To reduce energy consumption, automation via Windows 11 will ensure that more devices are powered down when not in use by 2026.	Energy consumption data Powered down device data

Medicines

Medicines contribute significantly to the NHS's overall carbon footprint, accounting for around 25% of all emissions across the health and care system. This includes emissions from the manufacturing, procurement, and use of pharmaceuticals, with particular impact from nitrous oxide, volatile anaesthetic agents such as desflurane, and metered dose inhalers (MDIs) that use hydrofluorocarbon propellants. Reducing the environmental impact of medicines is therefore a key priority for NHS organisations aiming to deliver their Net Zero commitments.

This area of focus aims to integrate decarbonisation into medicine management across the lifecycle, from prescribing to disposal, without compromising safety or efficacy in patient care. It also supports the development of clinical awareness and behaviour change among prescribers and pharmacy professionals, empowering them to make more environmentally conscious choices aligned with national guidance.

Since the launch of its first Green Plan, the Trust has made notable progress in this area. Emissions have been significantly reduced through the elimination of desflurane from clinical use and the implementation of robust controls on nitrous oxide, including the complete removal of piped nitrous oxide infrastructure across all sites. These changes reflect a growing awareness of the environmental impact of clinical practices and the willingness of our clinical teams to lead innovation.

The following objectives outline our next steps in reducing the environmental impact of medicines over the life of this Green Plan.

Action	Measurement
Building on our successful efforts to eliminate desflurane use at DBTH, we will maintain a commitment to ensure that it is no longer used unless a clinically essential need arises. We will also continue to monitor and reduce emissions from other volatile anaesthetic agents to support our commitment to low-carbon clinical practice.	Desflurane usage and emission data and confirmation that any use is clinically necessary Volatile anaesthetic agent emission data
To further support a reduction in emissions from volatile anaesthetic agents, we will develop low carbon anaesthesia guidance to support decision making within our anaesthetic teams by 2027.	Implementation of low carbon anaesthesia guidance Volatile anaesthetic agent usage and emission data
Building on the efforts we have already made to minimise nitrous oxide waste, by the end of 2025 we will establish a multi-disciplinary nitrous oxide waste reduction group, implementing tools and techniques in line with national guidance to ensure nitrous oxide and gas and air is used responsibly to minimise waste.	Usage and emission data for nitrous oxide and gas and air
We will engage with our clinical teams throughout the Trust to reduce medicine waste via the optimisation of our medicine management processes, targeting a 20% reduction in waste by 2028.	Medicine waste data

Travel and Transport

Travel and transport are significant contributors to the Trust's carbon footprint and local air pollution, affecting public health and disproportionately impacting vulnerable communities. This section outlines how we will reduce the environmental impacts of travel in alignment with the NHS Net Zero Travel and Transport Strategy

We will promote sustainable travel choices for staff, patients, and visitors, targeting improved access to public transport, active travel infrastructure, and digital alternatives to travel in line with the Fit for the Future: 10-Year Health Plan for England. We will also continue to decarbonise our fleet by investing in zero emission vehicles and supporting infrastructure, while working with partners to influence modal shifts across the wider health and care system. Supporting behaviour change through education and engagement will be central to our approach, ensuring that sustainable travel becomes the default, not the exception.

Action	Measurement
We will engage with our colleagues and key stakeholders to develop a sustainable travel plan by December 2026, which will then be incorporated into this Green Plan as an annex.	Approved sustainable travel plan and delivery plan outlining key milestones and target completion dates.
To support the development and delivery of our sustainable travel plan, we will also complete an application to the Modeshift Stars accreditation scheme, targeting level 1 accreditation by December 2026.	Modeshift accreditation
We will install electric vehicle (EV) charging infrastructure at each of our main hospital sites by 2026 to support those choosing ultra-low or zero emission vehicles to travel, as well as also supporting our own transition to an electrified fleet.	Number of EV charging points installed within the Trust

Action	Measurement
Once charging infrastructure is in place, the Trust will commence our transition to an electrified fleet, replacing at least 50% of our leased vehicles with zero emission vehicles by December 2026, and ensuring that only zero emission vehicles are purchased or leased from December 2027 onwards.	Fleet emission data
Over 90% of vehicles leased via our employee salary sacrifice schemes are already EV or hybrid vehicles. To further encourage colleagues to make sustainable choices when selecting vehicles through the scheme, we will develop promotional materials highlighting the benefits of zero and ultra-low emission vehicles throughout the life of this Green Plan.	EV and Hybrid vehicle data from Trust salary sacrifice schemes

Estates and Facilities

Our buildings and infrastructure are amongst the largest contributors to our direct (Scope 1) and indirect (Scope 2) carbon emissions, making this one of the most critical areas of focus for our Green Plan. Our estate also offers some of the greatest opportunities for both environmental and financial efficiency. Through strategic investment, effective planning, and smarter resource use, we can significantly reduce our operational footprint while creating more resilient, comfortable, and efficient environments for patients, staff, and visitors.

This area of the Green Plan sets out how we will continue to modernise our estate to support the delivery of net zero. It includes a focus on the development and implementation of plans to operate our estate more efficiently, including measures to reduce our reliance on fossil fuels in line with national NHS guidance. It also recognises the importance of integrating renewable energy sources, sustainable design principles, and robust energy monitoring across our estate portfolio.

The Estates and Facilities team has a vital role to play in the delivery of this plan, not only in managing the operational estate, but also by working collaboratively with colleagues

throughout the organisation to embed environmental considerations into capital projects, refurbishments, and ongoing service delivery.

The following objectives outline how we will reduce the environmental impact of our buildings, infrastructure, and facilities services over the next three years, in line with national NHS targets and our commitment to a greener, more sustainable DBTH.

Action	**Measurement**
To support our transition away from a reliance on fossil fuels, we will aim to develop site specific heat decarbonisation plans (HDP's) for all Trust Hospital sites by 2028.	Heat decarbonisation plans in place for Trust sites
We will develop site Master Plans for each of our main hospital sites and a 5 year Trust Infrastructure Strategy by 2026 , providing a long term development strategy that targets critical infrastructure and backlog maintenance reduction, alongside demolitions, improved estate optimisation and a more sustainable approach to healthcare at DBTH.	Site Master Plans for all hospital sites within DBTH A 5 year Trust Infrastructure Strategy
Site development and modernisation offers opportunities for sustainable building design incorporating low carbon technology and on site renewable energy generation. To make progress in these areas, we will ensure that all new building projects and major refurbishment schemes are designed in line with the NHS Net Zero Building where practicable.	NHS Net Zero Building Standard Compliance Matrix
Looking ahead, we will develop a Trust-wide Energy Strategy by 2028, setting out our baseline energy position, priority areas for energy reduction and decarbonisation, and proposals to meet future demand in the most efficient and resilient way. To support this, a sub-metering programme will be	Energy Strategy in Place Number of buildings with sub meters installed

Action	Measurement
designed and implemented by 2027 across high-consumption areas, enabling accurate monitoring, benchmarking, and targeted energy saving interventions.	Total number of sub-meters installed in high consumption areas Sub-metering data
By 2026 we will develop a Trust wide Energy Reduction Opportunities Proposal, including a prioritised pipeline of costed energy efficiency schemes. This will support future capital planning and maximise readiness for external capital funding opportunities such as the Public Sector Decarbonisation Scheme (PSDS).	Completion of Energy Reduction Proposal Number of scoped projects Predicted / delivered reduction in energy (kWh)
By the end of 2026, we will complete a comprehensive review of waste management at the Trust to ensure compliance with the Government's 'Simpler Recycling' requirements. This will include the introduction of standardised recycling streams across all sites, updated signage and guidance, and measures to ensure that waste is correctly segregated, collected, and processed in line with best practice.	Completion of waste service review % of areas processing waste in line with Simpler Recycling requirements % reduction in incorrectly segregated waste Volume of waste diverted from landfill

Supply Chain and Procurement

The supply chain contributes significantly to the total carbon footprint of the NHS, accounting for approximately 62% of all emissions under the Carbon Footprint Plus category. These emissions arise from the manufacture, transport, use, and disposal of goods and services procured by the health system, from medical equipment and consumables to catering, digital infrastructure, and construction materials. As a result, sustainable procurement is one of the most critical areas of focus in the pursuit of a net zero NHS.

This section sets out how DBTH will embed environmental, social, and ethical sustainability into our procurement policies and practices. We will work towards alignment with NHS England's Net Zero Supplier Roadmap, ensuring contracts over the relevant thresholds include mandatory carbon reduction planning requirements. We will also seek to influence the

market by actively engaging suppliers to inform them of our Net Zero expectations, promoting circular economy principles, and reducing our reliance on single use items where clinically appropriate.

Working in partnership with NHS Supply Chain, regional procurement networks, and our clinical teams, we will also identify and reduce waste arising from unnecessary or inefficient procurement activity, better align supply with demand, and drive efficiencies that benefit both the environment and the Trust's financial position.

The following actions outline how we will improve the environmental performance of our supply chain and procurement function over the next three years.

Action	**Measurement**
We will work with our suppliers to ensure that those proving contracts above £5 million have published and shared an up to date Carbon Reduction Plan (CRP) in line with the NHS' Net Zero Supplier Roadmap and the UK Government's Procurement Policy Note PPN 006 by 2028, commencing with the 100 suppliers providing the highest value contracts by 2026.	Supplier Carbon Reduction Plans
We will also work with suppliers providing services or goods with a value of between £10,000 and £5 million to ensure that they have made a net zero commitment as required by the NHS Net Zero Supplier Roadmap by 2028, starting with all new tenders over the value of £111K by 2026.	Supplier Net Zero Commitments
To support transparency and benchmarking of supplier sustainability, we will introduce a requirement for suppliers to undertake a NHS Evergreen Sustainable Supplier Assessment as part of our standard procurement process. To progress this objective, we will commence with top 100 suppliers and all new procurement exercises over £111K by 2026.	Supplier NHS Evergreen Assessments

Action	Measurement
The Trust currently allocates a minimum of 10% of the scoring criteria on all tenders above £111K to social value and Net Zero, and we will commit to continuing this practice, with a further aspiration to build this requirement into all competitive tender exercises by 2028.	Number of procurement exercises that included 10% Net Zero and Social Value weighting (% of total)
To encourage a reduction in the number of single use items used at DBTH, we will work with colleagues throughout the organisation to identify opportunities to safely transition to reusable equipment. To support this, we will develop a comprehensive database of single use items by 2026, enabling a targeted reduction plan to be developed and delivered throughout the term of the Green Plan.	Number of different single use items procured

Food and Nutrition

The food we serve, and how it is sourced, prepared, consumed and disposed of, has a direct impact on both environmental sustainability and health. Food production and supply are responsible for significant greenhouse gas emissions, land and water use, and waste generation. The NHS has an opportunity to lead by example by promoting healthier diets and encouraging sustainable consumption for patients, staff, and visitors.

This area of focus sets out how DBTH will align our catering services with both national sustainability standards and public health responsibilities. We will work to ensure that a greater proportion of the food we serve is locally sourced and seasonal. Where possible, we will reduce our reliance on high emission foods and increase the availability of healthy, plant based and culturally appropriate options.

We also recognise that food waste contributes to both environmental harm and financial inefficiency. Reducing food waste will be a key part of our strategy. In addition, we will work with suppliers and staff to minimise packaging waste and explore more sustainable procurement models for food and catering services.

The following objectives set out our commitments to improving the sustainability, quality and nutritional value of food served across our sites over the next three years.

Action	Measurement
The NHS National Standards for Healthcare Food and Drink are the foundation upon which food and nutrition is built in the NHS, and as a result we will continue to work with our catering partner, Sodexo Healthcare, to ensure that the standards are fully delivered and embedded into business as usual by 2026.	Progress against the NHS National Standards for Healthcare Food and Drink delivery plan
To help reduce unnecessary food waste, we will work with Sodexo Healthcare to deliver regular staff awareness campaigns on food waste prevention across all Trust sites, highlighting practical food waste reduction tips by 2026.	Total tonnes of food waste (all destinations) Plate waste Unserved waste Spoilage Production
Food waste is already monitored and reported at ward level to support waste reduction at DBTH. We commit to continuing this practice, alongside a further objective to develop an action plan targeting reductions in unserved and plate waste by 2026, with a notable reduction achieved consistently against a 2025 baseline by 2028.	Plate waste (tonnes) Unserved waste (tonnes)
We will also work with Sodexo Healthcare to ensure that production waste and spoilage is addressed in both patient dining and retail catering, again targeting a notable reduction against a 2025 baseline by 2028.	Spoilage (tonnes) Production waste (tonnes)

Action	Measurement
We will work in partnership with Sodexo to improve real-time dietary and discharge information to reduce overproduction and unserved meals.	Production waste (tonnes) Unserved plate waste (tonnes)
Whilst an element of food waste is unavoidable, Sodexo Healthcare have already taken measures to ensure that food waste from DBTH does not go to landfill. This practice will continue throughout the life of this Green Plan.	Food waste landfill (tonnes)
To further support efforts to reduce retail food waste, we will work with Sodexo Healthcare to support combined initiatives with local partners and charities to redistribute surplus food throughout the next three years.	Retail food waste (tonnes)
Recognising the many benefits of diets that are high in locally produced seasonal fruit and vegetables and low in processed foods, we will work with Sodexo Healthcare on menu development to drive further improvements in this area, as well as increasing options for plant based meals across the next three years.	Nutritional data Supplier data Number of plant based meals provided
Building on the progress already made by Sodexo Healthcare in reducing single use plastics and other single use items from the Trust's patient dining and retail catering services, we will continue to support this work, targeting a notable reduction in single use items against a 2025 baseline by 2028.	Single use item data

Adaptation

Climate change already impacts the health and wellbeing of the populations we serve, and will increasingly challenge the resilience of our services as further changes arise. Rising temperatures, more frequent and severe extreme weather events, and disruptions to supply chains and infrastructure all pose significant risks to healthcare delivery, patient safety, and staff wellbeing.

This area of focus outlines how DBTH will assess and respond to climate related risks to ensure that our sites, services, and workforce are prepared to operate safely and effectively in a changing climate. Our approach to adaptation will complement our mitigation efforts by improving our ability to anticipate, withstand, and recover from climatic events, ensuring continuity of care for our patients and the protection of our critical infrastructure.

As a Trust with high levels of clinical activity, it is essential that we understand how risks such as overheating, flooding, water shortages, and supply disruption could affect our services. This includes assessing vulnerabilities in our physical infrastructure, identifying at risk patient groups, and ensuring that our Emergency Preparedness, Resilience and Response (EPRR) planning incorporates climate resilience.

The following objectives set out how we will complete risk assessments, implement targeted adaptation measures, and ensure DBTH remains a safe, resilient and responsive healthcare provider in the face of an evolving climate.

Action	**KPI(s)**
The NHS Climate Adaptation Framework provides a comprehensive mechanism for organisations to measure adaptation maturity against the framework's four capabilities: 1) Understanding the challenge 2) Organisational culture and resources 3) Planning and implementation 4) Working together DBTH will complete a maturity assessment by the end of 2025 to inform a targeted improvement plan that aims to achieve at least 'intermediate' status against each element of the four capabilities by 2028.	NHS Climate Adaptation Framework Maturity Assessment

Action	KPI(s)
Effective adaptation planning requires an informed understanding of climate risks. We will therefore complete an assessment using the NHS Climate Change Risk Assessment tool by the end of 2026.	Climate change risk assessment
Once complete, we will incorporate climate risks into the organisation's risk register, providing transparency to inform future decision making within the organisation.	Trust risk register
Climate risks will also be used to improve future infrastructure investment decisions and inform design philosophies, ensuring that new facilities are delivered in a way that mitigates the harmful effects of climate change.	NHS Net Zero Building Standard Compliance Matrix
The NHS Climate Adaptation Framework and Climate Change Risk Assessment Tool will inform future adaptation plans. By 2027 the Trust will have plans in place to respond to foreseeable extreme weather events, and a forward looking costed action plan highlighting the improvements required within the estate to better mitigate climatic events.	Adverse weather business continuity plans Site adaptation plans

Governance and accountability

Effective governance ensures that sustainability is embedded at every level of our organisation, from board leadership to frontline delivery. Strong governance provides the foundation for consistent implementation, accountability, and continuous improvement. It enables the Trust to align sustainability with core operational priorities, manage risks, and maintain momentum over the long term.

This section outlines how we will coordinate and monitor the implementation of our Green Plan, maintain clear and visible leadership, and ensure that sustainability is integrated into existing structures, reporting frameworks, and decision making processes. Through regular oversight and transparent reporting, we will track our progress and ensure that the Green Plan remains a live, responsive strategy that drives the change that is required to achieve our goals.

As a partner organisation within the South Yorkshire Integrated Care System (SY ICS), DBTH is also committed to contributing to the system-wide objectives set out in the South Yorkshire ICB Sustainability and Green Plan (2025–2028).

To ensure we deliver our objectives, DBTH has established a structured governance model for sustainability:

- The Chief Finance Officer (CFO) acts as the designated Board level Net Zero Lead, responsible for strategic oversight.
- The Director of Infrastructure and the Operational Director of Estates and Facilities jointly act as the Trust's operational leads for sustainability, coordinating delivery of this Green Plan across divisions and directorates at DBTH.
- A Green Plan Delivery Board, chaired by the CFO in their capacity as Board Level Net Zero Lead, will meet bi-annually to monitor progress, provide a forum to escalate risks to delivery, and coordinate cross-organisational activity.
- A Green Plan Steering Group, chaired by the Director of Infrastructure, will meet quarterly to support colleagues, coordinate delivery of Green Plan objectives, and monitor progress across the organisation.
- Sustainability risks and dependencies will be integrated into the Trust's corporate risk register and reviewed as part of standard assurance processes.

- DBTH will also continue to participate actively in system level governance structures, including the South Yorkshire Sustainability Steering Group, enabling provider and ICB sustainability leads to collaborate, share best practice, and support the delivery of collective priorities. Through this forum, the Trust contributes to regional initiatives and ensures its own Green Plan supports wider system aims.

The chart below provides an overview of the governance structure supporting Green Plan delivery.

This activity will also be supplemented by the following reporting mechanisms:

- A live delivery plan for each action will be maintained, monitored and reviewed quarterly by the Sustainability Steering Group, with status updates, barriers to progress, and mitigation plans recorded.

- A bi-annual Green Plan Delivery Progress Report will be provided to the Trust's Finance and Performance Committee.

- An annual Green Plan Delivery Report will be provided to board and included in DBTH's annual report, including actions taken and planned, with quantitative progress data.

Governance arrangements will continue to evolve over the life of this plan, particularly as responsibilities for sustainability leadership transition from the ICB to provider organisations. DBTH will remain accountable for its own progress and support system leadership by

contributing transparently to shared outcomes, adapting to emerging guidance, and maintaining visible commitment from its Board of Directors.

Through this structured and collaborative approach, we will ensure our Green Plan is not only delivered, but embedded into how we lead, plan, and operate across the Trust.

Conclusion

Delivering a sustainable National Health Service is essential to ensuring that safe, equitable, and resilient services are maintained in the face of climate change. This refreshed Green Plan marks our renewed commitment to sustainability, setting out clear priorities and measurable actions that will shape how Doncaster and Bassetlaw Teaching Hospitals delivers care over the next three years.

By embedding environmental sustainability into everything we do, we will deliver tangible benefits for both our patients and the planet. The actions described in this Green Plan will not only reduce our carbon footprint but also improve air quality, increase operational efficiency, and help create healthier communities.

This Green Plan reflects the values of our organisation and the needs of our population. It also aligns with national NHS priorities, the Government's Fit for the Future: 10-Year Health Plan for England, and the regional ambitions of the South Yorkshire Integrated Care Board (SY ICB), supporting a coordinated, system-wide response to the challenges and opportunities presented by climate change.

We recognise that success depends on sustained action, meaningful engagement, and visible leadership at every level. Through strong governance, transparent reporting, and active partnership working, DBTH will remain accountable for progress and open to innovation and new ideas. Together, we will create a greener, sustainable, and more resilient healthcare system that is truly fit for the future and supports our vision of being **Healthier Together – Delivering Exceptional Care for All**.

2509 - D6 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL REPORT 2024/25

Discussion Item | Denise Smith, Chief Operating Officer | 12:25

5 minutes

REFERENCES

Only PDFs are attached

D6 - EPRR Annual Report 2024-25.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25**			
Executive Sponsor:	Denise Smith, Chief Operating Officer / Accountable Emergency Officer			
Authors:	David Harvey, Emergency Planning Officer			
Appendices:	N/A			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1			

Executive Summary – Key messages and Issues
This report provides a retrospective review of the Trust's Emergency Preparedness, Resilience and Response (EPRR) performance during the 2024/25 financial year. It summarises progress against the EPRR Annual Work Plan, improvements in NHS Core Standards compliance, key achievements, outstanding challenges, and strategic risks. This represents a significant improvement in Trust-wide emergency preparedness governance following a period of operational instability.

Recommendations
The Trust Board of Directors is asked to receive the report for ASSURANCE

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Patients	Strengthens patient safety and service continuity during emergencies through improved preparedness and response planning.
People	Supports staff training, resilience, and confidence through enhanced command training and increased EPRR capacity.
Partnerships	Builds multi-agency collaboration, particularly through joint evacuation planning with ICBs and emergency services.
Pounds	Reduces financial risk by mitigating disruption and ensuring efficient emergency response.
Health Inequalities	Ensures emergency planning considers and protects vulnerable patient groups.
Legal/ Regulation:	Demonstrates compliance with statutory duties under the Civil Contingencies Act and NHS EPRR Framework.
Partner ICB strategies	Aligns with and supports the resilience priorities of both South Yorkshire and Nottinghamshire ICBs.

Assurance Route	
Previously considered by - including date:	Assurance and Risk Committee (24 July 2025)

<table>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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1. Introduction

This report provides an annual review of the Trust's Emergency Planning Resilience and Response (EPRR) activities in 2024/25, including an overview of:

- training and exercises undertaken by the Trust.
- summary of any business continuity, critical incidents and major incidents experienced by the Trust
- lessons identified and learning undertaken from incidents and exercises.
- the Trust's compliance position in relation to the latest NHS England EPRR assurance

2. Background

The Trust has a responsibility for developing and monitoring compliance with the mandatory obligations within the Civil Contingencies Act (2004), and ensuring compliance with the National Guidance set out in the NHS England Emergency Planning Resilience and Response (EPRR) Framework (2015). Specific responsibilities are:

a. To assess the risk of emergencies
b. To plan for emergencies
c. To develop business continuity management
d. To cooperate with other responders
e. To share information
f. To communicate (warning and informing)

3. Definitions

Emergency preparedness: The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

Resilience: Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

Response: Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery.

4. Core standards compliance 2024/25

The Trust final self-assessment and Accountable Emergency Officer statement of compliance for 2024/25 showed a final self-assessment of 'fully compliant' in 34 of the 62 core standards and 'partially compliant' in 28 of the core standards. This gave 55% compliance and overall assessment of non-compliant.

5. Review of the annual work plan for 2024/25

The EPRR team developed a comprehensive action plan to work towards compliance and continually improve EPRR systems during 2024 and beyond. Key areas of focus were:

- **Resource Allocation:** Identifying and allocating the necessary resources and staff to meet compliance standards effectively.
- **Training:** Ensuring that all relevant staff members receive appropriate EPRR training to fulfil their roles.
- **Documentation:** Improving the quality and completeness of documentation (plans, policies and procedures) related to emergency preparedness, resilience and response.
- **Business Continuity:** Development and embedding of systems to ensure that risks are recognised and plans are in place throughout the organisation.

- **Continuous Evaluation:** Regularly monitoring progress and performance to identify areas that require additional attention and improvement.
- **Communication:** Establishing clear lines of communication and collaboration with the ICB to seek guidance and clarification on compliance criteria.

5.1 Governance

The Trust's EPRR policy has been further revised during 2024/25, this has been approved by the EPRR Group and will be considered for approval by the Executive Team in July 2025.

A revised governance trajectory for 2025/26 has been established to ensure sustained compliance, including revised quoracy tracking and defined executive escalation routes.

The EPRR Steering Group (EPRR SG) met monthly, chaired by the Deputy Chief Operating Officer. A comprehensive review of membership and function has been undertaken to improve engagement and effectiveness. The Terms of Reference were refreshed in April 2024 and ratified by the Trust Leadership Team in May.

Monthly Chair's Assurance Reports are provided to the Executive Team and an Annual Report provided to the Assurance and Risk Committee; this will also be provided to the Trust Board of Directors.

5.2 Duty to risk assess

EPRR Corporate Risk Register entries are reviewed monthly, driving improved risk visibility and targeted mitigation. Significant progress was made in strengthening the integration of EPRR risk management within the Trust's broader governance systems. Notable actions included:

- Joint membership of EPRR and Risk Management leads on respective groups.
- Monthly review of EPRR-specific risks, aligned with both the National Security Risk Assessment and the Local Resilience Forum register.
- Introduction of improved documentation and recording processes.

These improvements now provide clearer linkage to the Board Assurance Framework, enabling Executive-level visibility of emerging risks across the EPRR agenda.

While overall risk maturity has improved, these enhancements are in early implementation and will continue to embed throughout 2025/26.

5.3 Duty to maintain plans

During 2024/25 a Trust wide programme to refresh plans commenced, to date the following has been achieved:

- Completion of updated Critical and Major Incident, Outbreak and Countermeasures, Pandemic plans.
- Full revision and near-completion of a unified Business Continuity Plan and BIA structure.
- Publication of all current EPRR documentation via the newly launched internal EPRR Hub on Hive.

This foundational work places the Trust in a significantly improved position.

One of the Trust's highest-priority EPRR activities in 2024/25 has been the development of a multi-agency evacuation framework for Doncaster Royal Infirmary. This workstream:

- Involved more than 3 joint workshops with partner agencies across both ICB footprints.

- Delivered draft response structures, SMART triage alignment, and evacuation flow modelling.
- Has progressed to the exercise planning phase, with Exercise Blue Hammer, a full-scale evacuation simulation, scheduled for September 2025.

This programme is now considered implementation-ready for delivery in 2025/26.

5.4 Command and control

The Trust has a 24/7 operational management structure in place, this includes tactical (silver) and strategic (gold) on call arrangements.

5.5 Training and exercising

The Trust continues to maintain a structured and proactive approach to EPRR training and exercising, in line with NHS Core Standards.

All managers on the Silver on call rota have completed the NHS England Tactical Training and all except one manager on the Gold on call rota have completed the NHS England Strategic Training. The one outstanding manager on the Gold on call rota has booked onto the relevant training course.

A Trust-wide tabletop exercise, Exercise Scoop, was delivered on Friday 9th August 2024. The aim was to test the feasibility of using Outpatients as places of safety for patient holding, in the event of a partial evacuation of the Doncaster Royal Infirmary Site.

Key lessons identified and learning undertaken included:

- The need for clearer signage and wayfinding to ensure patient and staff flow to Outpatients is intuitive in a high-pressure scenario.
- Strengthening communication between ward areas and the designated holding zone to reduce delays in patient movement.
- The importance of pre-identifying staff to manage the holding area and provide reassurance to patients in transit.
- Ensuring appropriate stocks of emergency supplies and documentation are held in satellite areas designated for evacuation use.

In addition, the Trust has conducted multiple communications system exercises throughout the year, incorporating both in-hours and out-of-hours scenarios. These exercises have been delivered at least every six months, maintaining full compliance with NHS Core Standards and ensuring resilience in emergency notification and escalation pathways.

5.6 Response

The Trust's Incident Coordination Centre (ICC) remained effective and available throughout 2024/25. Improvements included:

- Launch of an EPRR Document Tracker to ensure version control and auditability.
- Deployment of the EPRR Hub on Hive, providing universal staff access to response plans and SOPs.

During 2024/25, the Trust continued to rely on loggists being available on a voluntary basis however it is noted that a loggist was available to all incidents that occurred throughout the year. A review of the Loggist Policy is currently in progress so that these arrangements can be strengthened as part of the 2025/26 work plan.

5.7 Warning and informing

The Trust maintained strong communications capability during incidents, led by the Communications Team. Achievements included:

- Development and dissemination of new Incident Communications Guidance.
- Progress toward procurement of an internal mass notification system, to be finalised in 2025/26.

5.8 Co-operation

The Trust actively contributed to the South Yorkshire and Nottinghamshire Local Health Resilience Partnerships (LHRPs). The AEO or delegate attended all meetings. Key achievements included:

- Joint planning for Exercise Blue Hammer (scheduled for September 2025).
- Continued engagement in evacuation and multi-agency planning workshops.

The Trust has become a more active and recognised partner in the wider health resilience community.

Strengthened relationships with South Yorkshire and Nottinghamshire ICBs, emergency services, and partner agencies have enabled shared learning and alignment on incident response.

5.9 Business continuity

The Business Continuity internal audit gave a 'limited assurance' rating, and a remedial action plan is in place, with remaining actions due for closure in July 2025.

A comprehensive programme to review and revise all Business Continuity Plans commenced and this is on track for completion in 2025/26.

5.10 Business Continuity Incidents and Organisational Learning

Throughout 2024/25, the Trust experienced a broad range of Business Continuity (BC) incidents, with events occurring at varying levels of severity. These incidents provided regular and practical tests of our resilience arrangements and have significantly contributed to organisational learning.

The most frequent sources of BC disruption were Digital (IT and connectivity failures) and Estates (infrastructure and environmental issues). Key themes identified through these reviews included:

- **Escalation and Notification:** The need for faster, more consistent escalation pathways to ensure timely mobilisation of support and command functions.
- **Service Impact Assessment:** Strengthen the ability to rapidly assess and communicate how incidents were affecting critical functions.
- **Contingency Planning:** Inconsistent application of Business Continuity Plans at local level, highlighting the need for further training and plan familiarisation.
- **Staff Communication:** A requirement for improved internal communications to keep staff informed of status updates, operational decisions and workarounds during disruptions.
- **IT System Interdependencies:** A clearer understanding of system linkages is required, particularly where failures have cross-service impacts.
- **Facilities Readiness:** Recurrent themes around ventilation, temperature control, and water ingress have pointed to the need for more proactive infrastructure resilience planning.

To ensure these lessons identified become lessons learnt, the Trust has implemented the following:

- A lessons log and tracking process, embedded within the EPRR governance structure, ensuring actions are owned, monitored and reviewed.
- Integration of themes from BC incidents into divisional governance reviews, encouraging accountability at service level.
- Targeted updates to departmental Business Continuity Plans (BCPs), informed by incident debriefs.
- Development of a Trust-wide Business Continuity Exercise Programme, designed to test known pressure points and embed recent learning.
- Increased visibility of key incident learning through EPRR communications, including summary briefings, case reviews and training content.

This structured approach ensures that organisational memory is strengthened, resilience is improved, and the Trust continues to mature in its response to business continuity risks.

5.11 Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT)

In 2024/25 the Trust was assessed as fully compliant in all of the CBRN / HAZMAT core standards except one, relating to PPE access, which was partially compliant.

Decontamination equipment was audited and maintained, with adequate stock levels of PPE and PRPS suits confirmed at all sites.

Annual training and exercising requirements were met, and a rolling programme of refresher training is in place. All documentation has been centralised via the EPRR Hub, supporting staff access and operational readiness.

6. Summary

The Trust made clear and measurable progress in delivery of the workplan for 2024/25, particularly in relation to governance, documentation, risk alignment, and partnership engagement. However, it is noted that in some domains, not all of the work plan has been fully delivered and any areas outstanding have been incorporated into the work plan for 2025/26.

7. Recommendations

The Trust Board of Directors is asked to receive the report for ASSURANCE.

2509 - D7 PROPOSED AMENDMENTS TO THE TRUST CONSTITUTION

Discussion Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

10 minutes

REFERENCES

Only PDFs are attached

D7 - Proposed Amendments to the Trust Constitution.pdf

D7 - Appendix 2 Trust Constitution 2025 review V1.5 Material changes only.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Proposed amendments to the Trust Constitution to include the Standing Orders for the Board of Directors**			
Executive Sponsor:	Suzy Brain England OBE, Chair of the Board			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance			
Appendices:	Appendix 1: Schedule of amendments to the constitution Appendix 2: Proposed Constitution – showing all track changes			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	Compliance to the Risk Policy and Board Assurance Framework impacts the effectiveness of the Board to monitor the Trusts Strategic risks			

Executive Summary – Key messages and Issues

The Board of Directors is asked to review the proposed amendments highlighted in Appendix 1 and consider the recommendations made. If the Board of Directors is satisfied with the proposed amendments, it should recommend those amendments to the Council of Governors and subject to the Council of Governors approval with no material changes, the Board should approve the revised Constitution to take effect from the day following the Council of Governors meeting.

Background Summary:

1. The Constitution is a key part of the Trust's Regulatory Framework and is required by the NHS Act 2006 (as amended).
2. The Constitution and its incorporated annexes are required to be reviewed annually. The Constitution was reviewed in 2022 with a number of changes updated at that time, however, a complete review has not been carried out in line with the Model Constitution. Amendments to the Constitution and its related Annexes must be approved by both the Board of Directors and the Council of Governors. In each case approval requires more than fifty percent of the members present and voting to approve the proposed amendments.
3. Governors have considered the proposed material changes required and have made recommendations that have been included into the contents of this paper and its two appendices.
4. The Review of the Constitution has been conducted pursuant with the requirements of the:
    a. National Health Service Act 2006 (as amended)
    b. Health and Social Care Act 2012
    c. Health and Care Act 2022
    d. Code of governance for NHS provider trusts (NHS England, 2023)
    e. Companies Act 2006 (as amended)
    f. Equality Act 2010 (as amended)
    g. Core constitution for foundation trusts
    h. Model election rules for foundation trusts.
5. A full schedule of proposed amendments, including the rationale for changes, has been attached to this paper as appendix 1, along with a tracked copy of the Constitution illustrating all the proposed amendments, attached as appendix 2. The following paragraphs further detail the most material changes proposed.
6. The current constitution is not fully compliant with all the present legislation; the gender specific language is contrary to the Equality Act 2010; all gender specific references have been removed. Changes to regulators brought about by the Health and Care Act 2022 have been amended, along with a number of other changes relating to amendments to the NHS Act 2006 (as amended).
7. New provisions have been included in the Standing Orders for the Council of Governors (Annex 7) to ensure these SO's are captured within the one document and not separated out.

8. In para 4.2.1 of the Standing Orders for the Council of Governors (Annex 7). The period of time in which a reserve governor can be appointed has been extended from 6 to 11 months after the date of the election.
9. Introduce the Standing Orders for the Procedure and Process of the Board of Directions, to ensure these SO's are captured within the one document and not separated out.
10. The Composition of the Council of Governors (Annex 3) and the minimum number of members in each constituency (Annex 1) have each been amended to reduce the overall number of Governors, in line with feedback from the Council of Governors workshops. The changes in minimum membership numbers maintain the principle of a minimum of 10 members within the class, per elected governor.
11. Amendments to remove redundant or non-standard clauses that are not in line with the model constitution, and include realigning numbering of paragraphs where required.
12. General updates have been made to address language and typographical errors. These updates have included the introduction of 'not used' for redundant sections that are not required following initial foundation trust status to maintain the integrity of the numbering and referencing. They also include the updating of several definitions and interpretations and changes to other organisations and bodies that have occurred over time.

The Council of Governors have a further workshop on the 28 August to review and discuss the proposed changes which may not be reflected within Appendix 1 and 2, however where there are no material changes this will not impact the recommendations made by the Board of Directors.

Recommendations

The Board of Directors are asked to:

- approve the revised Constitution (including the Standing Orders for the Council of Governors and for the Board of Directors)
- enable the Board of Directors to recommend to the Council of Governors that it should consider and approve the revised Constitution

Healthier together – delivering exceptional care for all

Patients	Regular review of the Constitution ensures compliance to latest legislation to support the delivery of safe and effective services.
People	Regular review of the Constitution ensures compliance to latest legislation to support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships; however, it identifies key partner governors therein
Pounds	Regular review of the Constitution ensures compliance to latest legislation to support financial management
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities
Legal/ Regulation	Regular review of the Constitution ensures compliance to latest legislation and regulation
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies

Assurance Route

Previously considered by - including date:	Various workshops with Governors, plus email correspondence with the board of directors.
Any outcomes/next steps / time scales	To be approved by the Board of Directors on 02 September 2025, subject to approval by the Council of Governors.
In line with Current risk appetite **Yes**	**Risk Appetite levels: -** highlight only if this report is outside of Board Assessment

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Appendix 1

Schedule of Amendments to the Constitution September 2025

Para	Proposed amendment	Comments / considerations
Drafting note	Any deleted Paragraphs, Subparagraphs have had the number left in place and "[….No longer in use]", to maintain paragraph numbering throughout and avoid multiple referencing amendments being required across other documents in future.	
Drafting note	Missing annexes have been inserted in line with the model constitution.	
Table of Contents	Numbering and paragraphs updated	
Interpretations and Definitions	Clarify the Definition of Executive Director to include "having voting rights"	
Interpretations and Definitions	Update on Independent Regulator or NHS England to include "any successor regulator"	
Interpretations and Definitions	Meeting defined to include reference to face to face and virtual formats	
Interpretations and Definitions	Addition of the Fit and Proper Persons Definitions	
Interpretations and Definitions	Addition of a "Co-opted Governor" to ensure compliance to the model election rules.	Clarify this change is agreed
References to Monitor and NHS England	Updated to reflect changes to the Regulator	
References to the Code of Governance	Updated to reflect the latest version	
Gender specific references	Revised to non-gender specific pronouns	
References to Chairman	Amended to 'Chair' throughout the document	
Para 3 – Principle Purpose	Additional clauses moved from Para 4, in line with the Model Constitution	
Para 4 - Powers	Removed sections that are not relevant	
Para 6	New section added	
Para 7	Removed redundant clause	
Para 12	Updated clauses on restriction for membership	Clarify on the age for membership – currently set at 16 years suggest 14
Para 14	Composition of the CoG Co-opted Governor as outlined.	Clarify this change is agreed
Para 15	Updated in line with Para 14 and election requirements – deleted clause	
Para 16	Tenure of Governors – proposed as 6 years	Clarify this change is agreed
Para 17	Updated clauses in line with the model constitution. Removed non-conforming clauses	

Para 18	Clause added reflecting changes to the Health and Care Act 2022 Clarify the requirement to fulfil governor duties.	
Para 19	Tidy up clauses and requirements in this section	
Para 20	Standing orders of the council re-instated at Annex 7	
Para 21	Addition of section 21 in line with the model constitution	
Para 22	Tidy up clauses and requirements in this section	
Para 25	Updated clauses and wording to reflect Model Constitution. Updated clause on Senior Independent Director appointment to the correct section Updated titles to include 'Chief' Removed clause for requirement of a NED to have had a clinical qualification Updated to the 'minimum statutory' Director roles required	
Para 28	Updated section to include process for the appointment and removal of non-executive directors via a nomination and remuneration committee for CoG	
Para 30	Updated to reflect Model constitution wording	
Para 34	Non-standard clauses removed and added to the SO in Annex 8 (previously missing)	
Para 36	Updated clauses and wording to reflect Model Constitution.	
Para 37	Updated clauses and wording to reflect Model Constitution.	
Para 41	Updated on clauses to reflect changes to requirements	
Para 43	Removal of redundant clauses and reference to committee observations	
Para 48	Updates on the amendments to the constitution to include the requirements under Schedule 7 of the 2006 Act	
Annex 1	Amendments to the public constituency from 20 to 11 Amendments to the minimum members number per governor to 20	
Annex 2	Amendments to the staff constituency from 6 to 4 Amendments to the minimum members number per governor to 20	
Annex 3	Amendments to partner governors named and numbers 2 local authority, 2 university, 2 'other' partners who are named. From 9 to 6	
Annex 4	Typos and formatting errors resolved	
Annex 5 – para 2 Para 2.5 Para 3 Para 3.3 Para 4.1	Clarity on eligibility criteria to be on the council of governors Clarity on complaints process regarding a governor – aligning this to a member Removal from office of a governor aligned to standard processes Reduction of tenure to 6 years in line with paragraph 16 Council of Governors vacancies increased from 6 to 12 months	Check agreement on tenure and associated points in this annex

Para 4.2 Para 5 Para 7	Window of vacancy increased from 6 to 11 months Roles and responsibilities of Governors section added Declarations section tidied and duplicate sections removed	
Annex 6 –	Clarification on membership termination of tenure process Remove redundant clauses	
Annex 7	Addition of Standing orders for the practice and procedure of the Council of Governors Clarification on declarations and registers of interests Incorporation of a Declaration of Suitability to be a Governor Incorporation of a Declaration of Interest, where on-line not used	
Annex 8	Addition of Standing orders for the practice and procedure of the Board of Directors Minutes to be retained via electronic form and archive Clarification on declarations and registers of interests	
Annex 9	Annual members meeting moved from Annex 8 to Annex 9	

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

CONSTITUTION

Name and title of author/reviewer:	~~Fiona Dunn,~~ ~~Company Secretary~~Rebecca Allen, Associate Director Strategy, Partnerships and Governance
Approved by The Board of Directors (subject to CoG and AMM approval):	~~27 September 2022~~ 2 September 2025
Approved by The Council of Governors and Annual members Meeting:	~~29 September 2022~~30 September 2025
Date Issued:	30 September ~~2022~~2026

Date of Next Review:	September ~~2025~~2028

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1. INTERPRETATION AND DEFINITIONS

In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006 as amended from time to time;
"the 2012 Act"	means the Health and Social Care Act 2012 as amended from time to time;
"the 2022 Act"	means the Health and Care Act 2022 as amended from time to time;
"Accounting Officer"	is the person who from time to time discharges the functions specified in NHS England's NHS Foundation Trust Accounting Officer Memorandum;
"Annual Members' Meeting"	means the annual members' meeting of the Trust as defined in paragraph 13 of this Constitution.
"Appointed Governors"	means the Partner Governors; those Governors appointed by the Partnership Organisations;
"Area of the Trust"	means the areas of Bassetlaw District and the City of Doncaster (specified in Annex 1 as areas of the public constituency);
"Board of Directors"	means the board of directors as constituted in accordance with this Constitution;
"Chair"	means the chair of the Trust appointed in accordance with paragraph 2~~8~~5 of this Constitution;
"Chief Executive"	means the chief executive officer of the Trust appointed in accordance with the terms of this Constitution;
"Constitution"	means this Constitution and all annexes to it;
"Co-optee" and "Co-opted Governor"	means an individual formally appointed by resolution of the Council of Governors who has reached the end of their elected term of office to participate at meetings of the Council of Governors under the terms specified
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the council of governors in the 2006 Act and the 2012 Act;
"Deputy Chair"	means the Non-Executive Director appointed as deputy chair of the Trust in accordance with paragraph ~~25~~ 30 of this Constitution;
"Director"	means an Executive Director or a Non-Executive Director on the Board of Directors;

"Elected Governor"	means the Public Governors and the Staff Governors; those Governors elected by the Public Constituencies and the classes of the Staff Constituency;
"Election Scheme"	means the election scheme set out in Annex 4;
"Executive Director"	means an executive director of the Trust who have voting rights on the Board;
"Fit and Proper Person Requirements (FPPR)"	means those requirements stipulated under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations)
"Financial Year"	means a period of 12 months beginning on 1st April in a calendar year and ending on 31st March in the following calendar year;
"Governor"	means a Governor on the Council of Governors and being either an Elected Governor or an Appointed Governor;
"Health Service Body"	means a body which is a health service body for the purpose of section 9(4) of the 2006 Act;
"Independent Regulator" or "NHS England"	is the body corporate known as NHS England, as provided by Section 61 of the 2012 Act; or any successor regulator.
"Lead Governor"	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England) and to Chair any meetings of Governors when the Chair or Deputy Chair are absent, for whatever reason
"Local Authority"	means the local authorities specified in Annex 3, which are local authorities for an area which includes the whole or part of the area of the Trust;
"Local Authority Governor"	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
"Meeting"	Means a meeting of individuals for the purpose of conducting business on behalf of the Trust and where they are authorised to do. This includes face-to-face, virtual and hybrid meeting formats.
"Member"	means a member of the Trust;
"Membership	means membership of the Trust as determined in accordance with the provisions of this Constitution and as specified in Annex 3;
"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by the Department of Health and as currently set out in Annex 4;

“Non-Executive Director”	means a non-executive director of the Trust;
"Partner Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partner Organisation"	means those organisations designated as Partnership Organisations for the purposes of this Constitution specified in Annex 3;
“Public Constituencies”	means a public constituency as defined in Annex 1;
“Public Governor”	means a member of the Council of Governors elected by the Members of the Public Constituency;
“Registered Dentist”	a registered dentist within the meaning of the Dentists Act 1984;
“Registered Medical Practitioner”	a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;
"Secretary"	means the Trust Company Secretary or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary;
"Senior Independent Director"	means the Non-Executive Director appointed by the Board as the senior independent director of the Trust;
“Staff Class”	means a class of Membership within the Staff Constituency as provided for in Schedule 7 to the 2006 Act and as set out in Annex 2;
“Staff Constituency”	means the part of the Trust’s Membership consisting of the staff of the Trust and which is divided into the classes as specified in Annex 2;
“Staff Governor”	means a member of the Council of Governors elected by a Staff Class in accordance with the provisions of this Constitution;
“the Trust”	means Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act as amended by the Health and Social Care Act 2012.

1.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder ~~references to paragraph numbers are references to paragraphs of this constitution unless the context provides otherwise~~

1.3 References to legislation include all regulations, statutory guidance and directions.

1.4 Headings are for ease of reference only and are not to affect interpretation.

1.5 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein or the law, then the provisions of this Constitution shall prevail unless the law requires otherwise.

1.6 All Annexes referred to in this Constitution form part of it.

1.7 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an Annex to this Constitution it shall be a reference to a paragraph in that Annex unless the contrary is expressly stated, or the context otherwise so requires

2. NAME

2.1 The name of the foundation trust is Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust).

3. PRINCIPAL PURPOSE

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also ~~carry on~~undertake activities other than those mentioned in section 3 ~~the above paragraph~~ for the purpose of making additional income available in order better to carry on ~~its~~ the Trust's principal purpose.

3.5 Notwithstanding the provisions of 3.1 above, the purpose of the Trust is to provide goods, and services, including education, training and research and other facilities for the provision of healthcare, in accordance with its statutory duties.

3.6 The Trust may carry out research in connection with the provision of healthcare and make facilities and staff available for the purposes of education, training or research carried on by others

4. POWERS

4.1 The powers of the Trust are set out in the 2006 Act and amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Subject to any restriction contained in this Constitution or in legislation, ~~A~~any of these powers may be delegated to a committee of directors or to an executive director.

~~4.4 Without prejudice to the generality of paragraph 4.1, the Trust may:~~

~~4.4.1 provide hospital and other accommodation for the purposes of any of its activities;~~

Commented [RA1]: These are not powers - have moved to the purpose section and removed the duplication

~~4.4.2 provide the services of medical, dental, midwifery and nursing staff, other health care professionals, other staff and volunteers;~~

~~4.4.3 provide such other facilities for the care of expectant and nursing mothers and young children as it considers appropriate;~~

~~4.4.4 provide such facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness as it considers appropriate;~~

~~4.4.5 provide such other services as it considers are required for the diagnosis and treatment of illness and the care of those suffering from illness;~~

~~4.4.6 conduct, or assist by grants or otherwise any person to conduct, research into any matters relating to the causation, prevention, diagnosis or treatment of illness and into any such other matters connected with any service provided by the Trust as it considers appropriate and publish the results of such research;~~

~~4.4.7 educate and train its own staff and students and those from other organisations or educational establishments in any trade, profession or other occupation relevant or related to any part of the Trust's functions and collaborate with other organisations in the provision of such education and training;~~

~~4.4.8 in fulfilling its statutory duty to co-operate with another body, provide to that body, and receive from it, goods and services on such terms as the Trust considers appropriate, including terms under which the goods or services are provided for are received free of charge;~~

~~4.4.9 provide goods and services outside England;~~

~~4.4.10 provide, or assist in providing, information, training and support to voluntary and community bodies within the area of the Trust or providing services within the area of the Trust;~~

~~4.4.11 raise charitable funds and, in so doing, appeal for any contributions, donation, grant or gift of money or property;~~

~~4.4.12 insure the property of the Trust against any foreseeable risk and take out other insurance policies to protect the Trust when required or enter into arrangements which have a similar effect;~~

~~4.4.13 insure the Governors, Directors, volunteers and any employee of the Trust against the cost of a defence to a criminal prosecution brought against them in their capacity as such or against personal liability incurred in respect of any act or omission which is, or is alleged to be, a breach of trust or a~~

~~breach of duty, unless the Governor, Director, volunteer or employee concerned knew that, or was reckless whether, the act or omission was a breach of trust or a breach of duty or enter into arrangements which have a similar effect;~~

~~4.4.14 provide and participate in external quality assurance schemes; and~~

~~4.4.15 carry out investigations into any aspect of the activities of the Trust.~~

5. MEMBERSHIP AND CONSTITUENCIES

5.1 The Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

5.1.1 a Public Constituency; or

5.1.2 a Staff Constituency.

6. APPLICATION FOR MEMBERSHIP

Commented [RA2]: New section added so it maps to the MC

6.1 An individual who is eligible to become a Member of the Trust may do so on application to the Trust.

6.2 Applications for membership will be handled by the Trust in accordance with the provisions set out in Annex 6

~~6.~~7. PUBLIC CONSTITUENCY

~~6.1~~7.1 The Public Constituency comprises three areas as set out in Annex 1. Each area of the Public Constituency is to be known by the name listed in Annex 1.

~~6.2~~7.2 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust provided that:

~~6.2.1~~7.2.1 they have made an application for Membership to the Trust; and

~~6.2.2~~7.2.2 they are not eligible to become a Member of the Staff Constituency; and

~~6.2.3~~7.2.3 they are not otherwise disqualified from Membership under paragraph 4 or paragraph 2 of Annex 6.

~~6.3~~7.3 Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

~~6.4~~7.4 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

~~7.~~8. STAFF CONSTITUENCY

~~7.1~~8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided ~~that~~:

~~7.1.1~~8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve (12) months; or

~~7.1.2~~8.1.2 they have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

~~7.2~~8.2 Those individuals who are eligible for Membership of the Trust by reason of ~~paragraph 7.1~~the previous provisions are referred to collectively as the Staff Constituency.

~~7.3~~8.3 The Staff Constituency shall be divided into four (4) classes of individuals who are eligible for Membership of the Staff Constituency, each class of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

~~7.4~~8.4 The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

~~7.5 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, or who provides services to the Trust (for no remuneration) does not come within the category of those who qualify for Membership of the Staff Constituency.~~

Commented [RA3]: Not needed as criteria specified above

~~8.~~9. AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION – STAFF

~~8.1~~9.1 An individual who is:

~~8.1.1~~9.1.1 ~~is~~ eligible to become a Member of the Staff Constituency ~~pursuant to paragraph 7.1 above~~, and

~~8.1.2~~9.1.2 invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate Staff Class within the Staff Constituency, shall become a Member of the Trust as a Member of the Staff Constituency and appropriate Staff Class within the Staff Constituency without an application being made, unless ~~s/he~~they inform~~s~~ the Trust ~~that s/he~~they do~~es~~ not wish to do so.

~~8.2~~9.2 The process by which an individual shall be invited or shall apply to become a Member of the Staff Constituency shall be in accordance with the provisions of Annex 6.

~~9.~~10. SECTION 10 PATIENTS CONSTITUENCY

Not Used

~~10.~~11. SECTION 11 AUTOMATIC MEMBERSHIP BY DEFAULT -PATIENTS

Not Used

~~11.~~12. RESTRICTION ON MEMBERSHIP

~~11.1~~12.1 An individual who is a Member of a constituency, or of a class within a constituency, may not while Membership of that constituency or class continues, be a Member of any other constituency or class.

~~11.2~~12.2 An individual who satisfies the criteria for Membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

~~11.3~~12.3 An individual shall not be eligible for membership of the trust if they:

~~11.3.1~~12.3.1 ~~is~~ are under (1~~6~~4) years old at the date of their application or invitation ~~(as the case may be)~~ to become a Member (as the case may be) ~~of the Trust.~~

12.3.2 ~~12.3.2~~fail or cease to fulfil the criteria for membership of any Public or Staff Constituency

12.3.3 has been placed on the sex offenders Register or is the subject of a Sex Offenders Order;

12.3.4 demonstrates aggression, violent or abusive behaviour at any hospital or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, and following such behaviour they have been asked to leave.

12.3.5 has been confirmed as a "vexatious complainant" in accordance with the Trusts policy for handling complaints;

12.3.6 has been removed as a Member of the Trust of another NHS Foundation Trust

~~11.3.2~~12.3.7 is deemed to have acted in a manner contrary to the interests of the Trust.

~~11.4~~12.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Annex 6.

Commented [RA4]: Is this a number that the trust would consider reducing to 14 in line with other Trusts

~~12.~~13. ANNUAL MEMBERS' MEETING

~~12.1~~13.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

~~12.2~~13.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 – Annual Members' Meeting.

~~13.~~14. COUNCIL OF GOVERNORS - COMPOSITION

~~13.1~~14.1 The Trust is to have a Council of Governors, which shall comprise both Elected and Appointed Governors and the Chair of the Trust.

~~13.2~~14.2 The composition of the Council of Governors is specified in Annex 3.

~~13.3~~14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their Constituency or, where there are classes within a constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency, or, where appropriate, by each class of each Constituency, is specified in Annex 3.

14.4 The Council of Governors may co-opt individuals who have reached the end of their elected term of office to remain as members of the Council of Governors but only for a time period until the next elections and will not exceed the usual term of office of an elected Governor.

14.5 The agreement and removal of a Co-opted Governor will be subject to the approval of the Council of Governors by a majority of the Council of Governors present and voting.

14.6 Co-opted Governors shall not have voting rights at a general meeting nor be counted in the quorum but will have free access to contribute to discussions therein.

~~14.~~15. COUNCIL OF GOVERNORS - ELECTION OF GOVERNORS

~~14.1~~15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014.

~~14.2~~15.2 The Model Election Rules as may be varied from time to time, form part of this Constitution and are attached at Annex 4.

~~14.3~~15.3 A subsequent variation of the Model Election Rules by the Department of Health & Social Care 2014 shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 4~~8~~2 of the Constitution (amendment of the Constitution).

~~14.4~~15.4 An election, if contested, shall be by secret ballot.

~~In the event that a vacancy is not filled by election, or a vacancy arises, the Council of Governors, by agreement at a meeting, may co-opt to that vacancy for an agreed period of time but the co-optee must be from the same constituency as the vacancy.~~

~~15.~~16. COUNCIL OF GOVERNORS - TENURE

~~15.1~~16.1 An Elected Governor may hold office for a period of up to three (3) years.

~~15.2~~16.2 An Elected Governor shall cease to hold office if ~~s/he~~they cease~~s~~ to be a Member of the Constituency or class by which ~~s/he was~~they were elected.

~~15.3~~16.3 An Elected Governor shall be eligible for re-election at the end of ~~his/her~~their term but no Elected Governor may hold office for more than ~~nine~~ (Six (~~9~~6) years. An Elected Governor may not stand for election again on completion of the maximum ~~nine~~ Six years. An Elected Governor who does not complete the maximum ~~nine~~six-year term may stand for re-election but only for the remaining years to achieve ~~nine~~ six (~~6~~9) years in total.

~~15.4~~16.4 An Appointed Governor may hold office for a period of three (3) years.

~~15.5~~16.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of ~~him/her~~them. ~~Or if the appointed governor loses contact or has no opportunity to report into the appointing organisation.~~

~~15.6~~16.6 An Appointed Governor shall be eligible for re-appointment at the end of ~~his/her~~their term but no Appointed Governor may hold office for more than ~~nine~~ six (~~9~~6) years.

Commented [RA5]: Need to have something in place if elections are not held. Nothing in this constitution or via election rules allows for a governor to remain as a governor if not elected, Cross reference to Rotherham

Commented [RA6]: Moved and amended to previous section

Commented [RA7]: As stated - maximum 6

Commented [RA8]: To reduce this from 9 years to 6 years in line with NED appointments ?

~~16.~~17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

~~16.1~~17.1 The following may not become or continue as a member of the Council of Governors:

~~16.1.1~~17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~16.1.2~~17.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

~~16.1.3~~17.1.3 a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on ~~him/her~~them;

~~16.1.4~~17.1.4 a~~A~~ governor, whose term of office is terminated in line with Annex 5 section 3. ~~is the subject of a conduct/disciplinary investigation, will be suspended from governor duties pending the outcome of the investigation (*see section 2.5 Annex 5*)~~

~~16.1.5 A governor, who makes a formal written complaint about another governor, non-executive director, director, member of staff, or volunteer, may be requested to stand down as a governor while the complaint is investigated, pending the outcome of the investigation.~~

~~16.2~~17.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

~~16.3~~17.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

~~16.4~~17.4 Provisions for the removal of governors are set out in Annex 5. ~~and the Standing Orders of the Council of Governors.~~

~~17.~~18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

~~17.1~~18.1 The general duties of the Council of Governors are:

~~17.1.1~~18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

~~17.1.2~~18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

18.1.3 as a result of the Health and Care Act 2022 governors are required to factor into their decision making a balance between serving the public interest of their constituents (ie the Trust and local community which elects them) with a wider (regional) public interest across the Integrated Care Systems the Trust is linked with.

~~17.2~~18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

~~17.3~~18.3 Governors must take up the opportunities that the Trust offers to provide them with these skills and knowledge. In the event that a Governor is deemed to not be fulfilling these roles and responsibilities, then the Trust Secretary will carry out a review with that Governor and identify any programme of support required to address the situation. In the absence of any improvement, then a Council of Governors decision could be made to remove the Governor from their role.

~~Refusal to take up a reasonable request for training and development will be a breach of the Governor Code of Conduct.As much of the Trust's business e.g. Board meetings and Committees, is carried out electronically, governors must have a working knowledge of commonly used IT platforms, and the equipment to access them.~~

~~18.~~19 COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

~~18.1~~19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph ~~24~~ 28 below) or, in ~~his/her~~their absence, the Deputy Chair (appointed in accordance with the provisions of paragraph ~~25~~ 30 below), shall preside at meetings of the Council of Governors save that if the Chair and Deputy Chair are unable to preside whether for reasons of absence, conflict of interest or otherwise the Senior Independent Director or Lead Governor shall preside.

~~18.2 The Lead Governor shall be a Public Governor and shall be elected by a majority of the Council of Governors in a secret ballot for a term of up to 3 years. The provisions of paragraph 8 of Annex 5 shall also apply.~~

~~18.3~~19.2 Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting ~~on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution~~ ~~on the grounds of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution.~~

~~18.4~~19.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, and to be able to hold the non-executive directors to account for the performance of the Board, the Council of Governors may require one or more of the non-executive directors to attend a meeting.

~~18.5~~19.4 Details on the standing orders for the procedure and practice of the Council of Governors is given in Annex 7~~*In extremis*, where the circumstances are beyond the Trust's control, meetings of members and the Council of Governors may be suspended until the circumstances that have caused the cessation of governors' meetings and activities have passed. The Chair is responsible for ceasing or re-starting governors' meetings.~~

~~18.6~~

~~18.7 There may be times and reasons why Council of Governors meetings are held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor~~

~~18.8 Members of the public or representatives of Council of Governors are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy~~

~~Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography, including use of social media.~~

~~19.~~20. COUNCIL OF GOVERNORS – STANDING ORDERS

~~19.1~~20.1 The Council of Governors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, in particular for its procedure and practice at meetings and are attached at Annex 7.

21. COUNCIL OF GOVERNORS – REFERRAL TO THE PANEL

Commented [RA9]: Missing section from the constituion

21.1 In this paragraph, the "Panel" means a panel of persons appointed by the Regulator to which a member of the Council of Governors may refer a question as to whether the Trust has failed or is failing:

21.1.1 to act in accordance with this Constitution, or

21.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

21.2 A member of the Council of Governors may refer a question to the Panel only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the referral.

~~20.~~22. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

~~20.1~~22.1 Governors are required to declare any pecuniary, personal or family interest on nomination ~~for election~~ and on appointment as a governor, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

~~In addition, governors should declare interests, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors. The governor shall disclose that interest to the members of the Council of Governors as soon as s/he becomes aware of it.~~

~~20.2~~22.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed. The Chair of the meeting decides on exclusion on the facts.

~~20.3 See also Annex 5, section 7 for declarations of interest.~~

~~21.~~22. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

~~21.1~~23.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. For the avoidance of doubt, members of the Council of Governors are not to receive remuneration but can receive expenses incurred as part of their role as Governors.

~~22.~~24. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

~~22.1~~24.1 Further provisions with respect to the Council of Governors are set out in Annex ~~5~~6.

~~23.~~25. BOARD OF DIRECTORS – COMPOSITION

~~23.1~~25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

~~23.2 The Board of Directors should include an appropriate combination of executive and non-executive directors (and in particular, independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.~~

~~23.3~~25.2 All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.

~~23.4~~25.3 The Board of Directors is to comprise:

~~23.4.1~~25.3.1 a non-executive Chair (who shall have a casting vote)

~~23.4.2~~25.3.2 other Non-Executive Directors (i.e. not including the Chair) ~~One Non-Executive Director will be nominated by the Chair, and noted by the Council of Governors, as the Senior Independent Director); and~~

~~23.4.3~~25.3.3 Executive Directors (but not exceeding the combined number of Non-Executive Directors and the Non-Executive Chair)

~~23.5~~25.4 One of the Executive Directors shall be the Chief Executive.

~~23.6~~25.5 The Chief Executive shall be the Accounting Officer.

~~23.7~~25.6 One of the Executive Directors shall be the ~~Finance Director~~Chief Finance Officer.

~~23.8~~25.7 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

~~23.9~~25.8 One of the Executive Directors is to be a registered nurse or a registered midwife.

~~23.10 One of the Non-executive Directors is to be, or have been in the past, a registered medical practitioner, registered dentist, registered nurse, registered midwife, registered pharmacist or other healthcare professional registered with the Health and Care Professions Council.~~

~~23.11~~25.9 For the avoidance of doubt, the Deputy Chair shall have the casting vote in the event that the Chair is not participating at the meeting where voting takes place.

25.10 The Senior Independent Director will be nominated by the Chair, and approved by the Council of Governors and shall perform the role set out in the Code of Governance for NHS Provider Trusts.

~~24.~~26. BOARD OF DIRECTORS – GENERAL DUTY

~~24.1~~26.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

~~25.~~27. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

~~25.1~~27.1 A person may be appointed as a Non-Executive Director only if:

~~25.1.1~~27.1.1 ~~s/he is~~they are a Member of the Public Constituency; and

~~25.1.2~~27.1.2 ~~s/he is~~they are not disqualified by virtue of paragraph ~~27~~33 below.

~~26.~~28. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

~~26.1~~28.1 The Chair and Non-Executive Directors are appointed for a term of up to three years. This may be extended by a further term of up to three years if the needs of the organisation so determine. The Chair and Non-Executive Directors may not usually serve for more than six years, unless it considers such an extension is in the best interests of the Trust.

~~26.2~~28.2 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

~~26.3~~28.3 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors attending the meeting.

~~26.4~~28.4 The provisions of paragraph ~~5~~9 of Annex ~~5~~ 5 and paragraph 6 of Annex 6 ~~and paragraph 6 of Annex 6~~ shall also apply.

28.5 If any resolution to remove a Non-Executive Director (including the Chair) is not approved at a meeting of the Council of Governors in accordance with paragraph 28.2 above, no further resolution can be put forward to remove such Non-Executive Director, or the Chair which is based on the same reasons within 12 calendar months of the meeting of the Council of Governors at which the resolution mentioned in paragraph 28.2 above was considered.

28.6 Subject to the provisions of paragraphs 28.1 to 28.5, new Non-Executive Directors and the Chair will be appointed using the procedures set out below:

28.6.1 only a member of a Public Constituency may be appointed as the Chair or other Non-Executive Director; and

28.6.2 the Chair and other Non-Executive Directors shall be appointed in accordance with paragraphs 28.7 to 28.13 below.

28.7 The Council of Governors shall establish a committee of its members to be called the Nominations and Remuneration Committee to discharge those functions in relation to the appointment of the Chair and Non-Executive Directors described in paragraphs 28.8 - 28.11 below.

28.8 The Nominations and Remuneration Committee shall consist of no more than seven members which shall comprise of at least:

28.8.1 3 Public Governors;

28.8.2 1 Staff Governor; and

28.8.3 The Chair of the Trust, except where their performance or remuneration is being considered at which point the Senior Independent Director should assume this position.

28.9 The functions of the Nominations and Remuneration Committee shall be as follows:

28.9.1 to determine the criteria and process for the selection of candidates for office as Chair or other Non-Executive Director of the Trust having first consulted with the Board of Directors as to those matters and having regard to such views as may be expressed by the Board of Directors;

28.9.2 where the Nominations and Remuneration Committee considers that either the Chair or the Non-Executive Director coming to the end of their term of office should be reappointed for a further term, the Nominations and Remuneration Committee shall make a recommendation to the Council of Governors to that effect, save that the Nominations and Remuneration Committee may not make any such recommendation other than for a first re-appointment of the Chair or the Non-Executive Director in question;

28.9.3 Where:

(a) the Nominations and Remuneration Committee does not make a recommendation that the Chair or a Non-Executive Director should be reappointed in accordance with paragraph 28.9.2 above; or

(b) the Chair or (as the case may be) the Non-Executive Director in question does not want to be reappointed; or

(c) the Council of Governors rejects a recommendation that the Chair or (as the case may be) a Non-Executive Director should be reappointed in accordance with paragraph 28.9.2 above,

(d) the Nominations and Remuneration Committee shall initiate a process of open competition for the appointment of the Chair or (as the case may be) the Non-Executive Director, and the post will be advertised. Further, the Nominations and Remuneration Committee shall assess and select for interview such candidates as are considered appropriate and in doing so the Nominations and Remuneration Committee shall be at liberty to seek advice and assistance from persons other than members of the Nominations and Remuneration Committee or the Council of Governors;

28.9.4 on a regular and systematic basis monitor the performance of the Chair and other Non-Executive Directors and make reports thereon to the Council of Governors from time to time when requested to do so or when in the opinion of the Nominations and Remuneration Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors; and

28.9.5 to consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors.

28.10 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the Board of Directors and of the Nominations and Remuneration Committee as to the suitability of the available candidates.

28.11 The Council of Governors will not consider nominations for membership of the Board of Directors other than those made by the appropriate Nominations and Remuneration Committee.

29. SECTION 29 (INITIAL FOUNDATION TRUSTS'S)

Not used

~~27.~~30. BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR

~~27.1~~30.1 ~~The Board of Directors shall appoint one of the Non-Executive Directors as a Deputy Chair. The Deputy Chair will also be Deputy Chair of the Council of Governors.~~ The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chair. The Deputy Chair will be the Deputy Chair of the Council of Governors.

~~27.2~~30.2 The Deputy Chair shall be appointed for a term of 3 years and shall be eligible for re-appointment at the end of that term but may not serve as Deputy Chair for more than a total of 6 years, unless it considers such an extension is in the best interests of the Trust.

~~28.~~31. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

~~28.1~~31.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

~~28.2~~31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

~~28.3~~31.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

~~29.~~32. SECTION 32 (INITIAL FOUNDATION TRUSTS'S)

Not used

~~30.~~33. BOARD OF DIRECTORS – DISQUALIFICATION

~~30.1~~33.1 The following may not become or continue as a member of the Board of Directors:

~~30.1.1~~33.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~30.1.2~~33.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, ~~his/her~~their creditors and who has not been discharged in respect of it;

~~30.1.3~~33.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on ~~him/her~~them;

33.1.4 a person who does not satisfy all of the 'fit and proper person' requirements set out in regulation 5(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended (2023);

~~30.1.4~~33.1.5 The Regulator has exercised its powers to remove them as a Director of the Trust or has suspended them from office or has disqualified them from holding office as a Director of the Trust for a specified period or the Regulator has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS foundation trust or

~~30.1.5~~33.1.6 a person who falls within the further grounds for disqualification set out in Annex 6.

~~31.~~34. BOARD OF DIRECTORS – MEETINGS

~~31.1~~34.1 Meetings of the Board of Directors ~~are meetings held in public and~~ shall~~, therefore,~~ be open to members of the public as observers. Members of the public may be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. ~~Members of the public may be excluded from a meeting for special reasons. Members of the public may not participate in Board meetings.~~

~~31.2~~34.2 Before holding a meeting, the Board of Directors must make available the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must make available the approved minutes of the meeting to the Council of Governors.

~~31.3 The Chair (or Deputy Chair) shall give such directions as s/he thinks fit in regard to the arrangements for meetings and accommodation of the public such as to ensure that business shall be conducted without interruption and disruption.~~

~~31.4 There may be times and reasons why the Board of Directors meetings are held "virtually online" and not in person. The Chair will decide these times in consultation with the Chief Executive Officer.~~

~~31.5 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Deputy Chair). Where permission has been granted, the Chair (or Deputy Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt,~~

~~"recording" refers to any audio or visual recording, including still photography, including use of social media.~~

Commented [RA10]: Not standard clauses - meetings of the BoD has its own annex

~~32.~~35. BOARD OF DIRECTORS – STANDING ORDERS

~~32.1~~35.1 The Board of Directors shall adopt its own standing orders, as may be varied from time to time, for its practice and procedure, ~~in particular for its procedure at meetings~~and are given in Annex 8.

~~33.~~36. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

~~33.1~~36.1 The duties that a director of the Trust has by virtue of being a director include in particular:

~~33.1.1~~36.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

~~33.1.2~~36.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

~~33.2~~36.2 The duty referred to in sub-paragraph ~~30.1.1~~36.1.1 is not infringed if:

~~33.2.1~~36.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

~~33.2.2~~36.2.2 The matter has been ~~authorized~~ authorised in accordance with the constitution.

~~33.3~~36.3 The duty referred to in sub-paragraph ~~30.1.2~~36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~33.4~~36.4 In sub-paragraph ~~30.1.2~~36.1.2, "third party" means a person other than –

~~33.4.1~~36.4.1 The Trust, or

~~33.4.2~~36.4.2 A person acting on its behalf.

~~33.5~~36.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or, arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

~~33.6~~36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

~~33.7~~36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

~~33.8~~36.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

~~33.9~~36.9 A director need not declare an interest –

~~33.9.1~~36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

~~33.9.2~~36.9.2 if, or to the extent that, the directors are already aware of it;

~~33.9.3~~36.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

(a) By a meeting of the Board of Directors, or

(b) By a committee of the directors appointed for the purpose under the constitution.

~~33.10~~36.10 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

~~33.11 The Standing Orders for the Board of Directors shall make provision for the Board of Directors to determine whether a situation may reasonably be regarded as likely to give rise to a conflict of interest.~~

~~33.12 The Standing Orders for the Board of Directors shall make provision for the authorisation of a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.~~

~~33.13 Where a Non-executive Director has declared a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust, the Board of Directors will disclose details of this to the Council of Governors following any action it takes in accordance with paragraphs 31.1 and 31.2. The Council of Governors may then take further action in accordance with its powers under this Constitution.~~

~~34.~~37 BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

~~34.1~~37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the ~~appoint members to form a Nomination & Remuneration Committee. This Committee shall agree the~~ remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors. ~~The Committee will ask a general meeting of the Council of Governors to approve its recommendations. The provisions of paragraph 6 of Annex 6 shall also apply.~~

~~34.2~~37.2 A committee of Non-Executive Directors shall be established to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

~~35.~~38 REGISTERS

~~35.1~~38.1 The Trust shall have:

~~35.1.1~~38.1.1 a register of Members showing, in respect of each Member, the constituency to which ~~s/he~~they belong~~s~~ and, where there are classes within it, the class to which ~~s/he~~they belong~~s~~;

~~35.1.2~~38.1.2 a register of members of the Council of Governors;

~~35.1.3~~38.1.3 a register of interests of Governors;

~~35.1.4~~38.1.4 a register of Directors; and

38.1.5 a register of interests of the Directors.

~~36.~~39. ADMISSION TO AND REMOVAL FROM THE REGISTERS

~~36.1~~39.1 The process of admission to and removal from the registers shall be as set out in Annex 6.

~~37.~~40. REGISTERS – INSPECTION AND COPIES

~~37.1~~40.1 The Trust shall make the registers specified in paragraph ~~32~~ 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

~~37.2~~40.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

~~37.3~~40.3 So far as the registers are required to be made available:

~~37.3.1~~40.3.1 they are to be available for inspection ~~online and~~ free of charge at all reasonable times; and

~~37.3.2~~40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

~~37.4~~40.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

~~38.~~41. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

~~38.1~~41.1 The Trust shall make the following documents available for inspection by members of the public free of charge ~~on the website~~at all reasonable times:

~~38.1.1~~41.1.1 a copy of the current Constitution;

~~38.1.2~~41.1.2 a copy of the latest Aannual Aaccounts and of any report of the ~~External~~ auditor on them;

~~38.1.3~~41.1.3 a copy of the latest Aannual Rreport ~~and quality accounts~~;

~~38.1.4~~41.1.4 a copy of the latest ~~Care Quality Commissioning report~~Annual Quality Report.

~~38.2~~41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge ~~on the website~~ at all reasonable times:

~~38.2.1~~41.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of

State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

~~38.2.2~~41.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

~~38.2.3~~41.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

~~38.2.4~~41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

~~38.2.5~~41.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

~~38.2.6~~41.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England), 65KB (Secretary of State's response to NHS England decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

~~38.2.7~~41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

~~38.2.8~~41.2.8 a copy of any final report published under section 65I (administrator's final report),

~~38.2.9~~41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

~~38.2.10~~41.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

~~38.3~~41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with access to ~~the extract or document online~~a copy.

~~38.4~~41.4 If the person requesting access to a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

~~39.~~42. AUDITOR

~~39.1~~42.1 The Trust shall have an External auditor.

~~39.2~~42.2 The Council of Governors shall appoint or remove the External auditor at a general meeting of the Council of Governors.

~~39.3 The provisions of paragraph 11 of Annex 6 shall apply.~~

~~40.~~43. AUDIT AND RISK COMMITTEE

~~40.1~~43.1 The Trust shall establish a committee of Non-Executive Directors as an audit and risk committee to perform such monitoring, reviewing and other functions as are appropriate. ~~The Council of Governors may appoint up to two governors as observers to the committee.~~

~~41.~~44 ACCOUNTS

~~41.1~~44.1 The Trust must keep proper accounts and proper records in relation to the accounts.

~~41.2~~44.2 ~~NHS England~~The Regulator may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

~~41.3~~44.3 The accounts are to be audited by the Trust's external auditor.

~~41.4~~44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as ~~NHS England~~the Regulator may with the approval of the Secretary of State direct.

~~41.5~~44.5 The functions of the Trust with respect to the preparation of the annual accounts as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

~~41.6 The provisions of paragraph 11 of Annex 6 shall apply.~~

~~42.~~45 ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

~~42.1~~45.1 The Trust shall prepare an Annual Report and send it to ~~NHS England.~~the Regulator.

~~42.2~~45.2 The Trust shall give information as to its forward planning in respect of each financial year to ~~NHS England.~~the Regulator.

~~42.3~~45.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

~~42.4~~45.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

~~42.5~~45.5 Each forward plan must include information about:

~~42.5.1~~45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

~~42.5.2~~45.5.2 the income it expects to receive from doing so.

~~42.6~~45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph ~~38.5.1~~45.5.1 the Council of Governors must:

~~42.6.1~~45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

~~42.6.2~~45.6.2 notify the directors of the Trust and its determination.

~~42.7~~45.7 ~~A~~ Where the trust ~~which~~ proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and

services for the purposes of health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

~~43.~~46. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

~~43.1~~46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

~~43.1.1~~46.1.1 the annual accounts;

~~43.1.2~~46.1.2 any report of the external auditor on them; and

~~43.1.3~~46.1.3 the annual report.

~~43.2~~46.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

~~43.3~~46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph ~~39~~46.1 with the Annual Members' Meeting.

~~44.~~47. INSTRUMENTS

~~44.1~~47.1 The Trust shall have a seal.

~~44.2~~47.2 The seal shall not be affixed except under the authority of the Board of Directors.

~~45.~~48. AMENDMENT OF THE CONSTITUTION

~~45.1~~48.1 The Trust may make amendments to its Constitution only if:

~~45.1.1~~48.1.1 more than half of the members of the Council of Governors voting at a meeting approve the amendments; and

~~45.1.2~~48.1.2 more than half of the members of the Board of Directors voting at a meeting approve the amendments.

~~45.2 The Constitution shall be formally reviewed by the Council of Governors and Board of Directors every 3 years.~~

~~45.3~~48.2 Amendments made under paragraph ~~41~~48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

~~45.4~~48.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

~~45.4.1~~48.3.1 At least one member of the Council of Governors most likely the Lead Governor must attend the next Annual Members' Meeting and present the amendment, and

~~45.4.2~~48.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

~~45.5~~48.4 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

48.5 Amendments by the trust of its constitution are to be notified to the Regulator. For the avoidance of doubt, the Regulator's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

~~46.~~49. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

~~46.1~~49.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors voting at a general meeting.

~~46.2~~49.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting at a general meeting ~~of the Trust voting~~ approve entering into the transaction~~, voting at a general meeting~~.

~~46.3~~49.3 For the purpose of paragraph ~~42~~49.2, "significant transaction" means a transaction which meets any one of the following criteria:

~~46.3.1~~49.3.1 where the *gross assets subject to the transaction are greater than or equal to 25% of the gross assets of the Trust;

~~46.3.2~~49.3.2 where the income attributable to the assets or the contract associated with the transaction is greater than or equal to 25% of the income of the Trust;

~~46.3.3~~49.3.3 where the **gross capital of the company or business being acquired or divested, or the effects on the ***total capital of the Trust resulting from a transaction, is greater than or equal to 25% of the total capital of the Trust following completion of the transaction.

* Gross assets is the total of fixed assets and current assets
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets

*** Total capital of the Trust equals taxpayers' equity

ANNEX 1 – THE PUBLIC CONSTITUENCY

Table 1

1	2	3	4
Name of the Public Constituency	**Area of the Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**	**Number of Governors to be Elected**
Bassetlaw	Bassetlaw District Council (or any successor organisation)	~~300~~20	~~5~~3
Doncaster	City of Doncaster (or any successor organisation)	~~470~~20	7~~13~~
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	~~50~~20	~~2~~1
Total	Public Governors		11

ANNEX 2 – THE STAFF CONSTITUENCY

Table 1

Staff Class	Minimum Number of Members	Number of Governors to be elected
Medical and Dental Practitioners Staff Class	~~75~~20	1
Nurses and Midwives Staff Class	~~450~~20	~~2~~1
Other Healthcare Professionals Staff Class	~~100~~20	1
Non-Clinical Staff Class	~~375~~20	~~2~~1
TOTAL	~~1000~~80	~~6~~4

1. CLASSES OF THE STAFF CONSTITUENCY

1.1 The Staff Constituency shall be divided into four classes as follows:

1.1.1 Medical and Dental Practitioners Staff Class;

1.1.2 Nurses and Midwives Staff Class;

1.1.3 Other Healthcare Professionals Staff Class; and

1.1.4 Non-Clinical Staff Class.

1.2 Medical and Dental Practitioners Staff Class

1.2.1 The Members of the Medical and Dental Staff Class are individuals who are Members of Staff Constituency who:

(a) are fully registered persons within the meaning of the Medicines Act 1956 or the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph ~~7~~ 8 of the Constitution to become a Member in

accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.3 Nurses and Midwives Staff Class

1.3.1 The Members of the Nurses and Midwives Staff Class are individuals who:

(a) are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of the Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants; and

(b) who are employed by the Trust in that capacity at the date of their invitation or application under paragraph ~~7~~ 8 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.4 Other Healthcare Professionals Staff Class

1.4.1 Members of the Other Healthcare Professionals Staff Class are clinical staff who do not fall within paragraphs 1.2 or 1.3 of this Annex 2, including clinical therapists, scientists and technical staff, who are employed by the Trust in that capacity at the date of their invitation or application under paragraph ~~7~~ 8 of the Constitution to become a Member in accordance with the provisions of Annex 6 and at all times thereafter remain employed by the Trust in that capacity.

1.5 Non-Clinical Staff Class

1.5.1 Members of the Non-Clinical Staff Class are Members of the Staff Constituency who do not come within paragraphs 1.2, 1.3 or 1.4 of this Annex 2.

2. MINIMUM NUMBERS AND NUMBERS OF GOVERNORS

2.1 The minimum number of Members in each Staff Class and the number of Governors to be elected by each such Staff Class are given in Table 1.

3. CONTINUOUS EMPLOYMENT

3.1 For the purposes of paragraph 7.1.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

1. INTRODUCTION

1.1 The Council of Governors shall comprise:

1.1.1 The Chair of the Trust

1.1.2 Governors who are:

(a) elected by the respective Constituencies in accordance with the provisions of this Constitution; or

(b) appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of Governors who are elected by Members of the Public Constituency.

2. BODIES ENTITLED TO APPOINT A MEMBER TO THE COUNCIL OF GOVERNORS

2.1 The Trust may ~~following bodies in this paragraph 2 shall be entitled to~~ appoint ~~a~~ partnering Governor or Governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Local Authority Governors

2.2.1 City of Doncaster Council (or its successor organisation) shall be entitled to appoint one Governor in accordance with a process of appointment agreed by it with the Trust.

2.2.2 Bassetlaw District Council (or its successor organisation) shall be entitled to appoint one Governor in accordance with a process of appointment agreed by each of them with the Trust.

~~The absence of any agreed process of appointment as referred to in paragraphs 2.2.1 and 2.2.2 above shall not preclude the said local authority from appointing its Governor(s).~~

~~If the local authority named in paragraphs 2.2.1 or 2.2.2 above declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult each local authority whose area includes the whole or part of the area of the Trust and the Trust in its absolute discretion may extend an invitation to any of those local authorities to appoint a Governor in substitution for the local authority which has failed or declined to do so.~~

~~A Governor appointed under this paragraph 2.2 shall then serve on the Council of Governors for the period stipulated in Annex 5. At the end of that period the Trust shall in its absolute discretion decide whether to permit the local authority which had failed or declined to appoint a Governor to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.~~

2.3 Partner Governors

2.3.1 In addition to the organisations listed in 2.1 and 2.2, the following organisations have also been nominated by the Trust as Partnership Organisations for the purposes of this Constitution:

~~(a) Bassetlaw Council for Voluntary Service;~~

~~(b)~~(a) University of Sheffield;

~~(c)~~(b) Sheffield Hallam University;

~~(d) Doncaster College;~~

~~(e) Doncaster Deaf Trust;~~

~~(f) Partial Sighted Society Doncaster;~~

2.3.2 In addition to the organisations listed above (2.2 and 2.3), the Trust may nominate 2 further organisations to appoint governors (1 per organisation).

~~2.3.2~~2.3.3 Each ~~of the above~~of the partnering organisations shall be entitled to appoint a Governor ~~Governors~~ in accordance with a process of appointment agreed by it with the Trust. ~~The absence of any such agreed process of appointment shall not preclude that Partnership Organisation from appointing its Governor provided the appointment is duly made in accordance with its own internal processes. A further two (2) appointed governors from new partnership organisations, nominated by the Trust may be proposed and added to this constituency. In this instance the Company Secretary will present the proposed nomination to the Council of Governors.~~

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

	Electing / Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		~~20~~11
	1.1 Bassetlaw District	~~5~~3	
	1.2 City of Doncaster	~~13~~7	
	1.3 Rest of England and Wales	~~2~~1	
2.	**Staff Constituency**		~~6~~4
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	~~2~~ 1	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	~~2~~1	
3.	**Appointed Governors**		~~9~~up to 6

	3.1 City of Doncaster Council 3.2 Bassetlaw District Council (or its successor organisation) 3.3 ~~Nottinghamshire County Council~~ 3.4 University of Sheffield 3.5 Sheffield Hallam University ~~3.6 Doncaster College~~ ~~3.7 Doncaster Deaf Trust~~ ~~3.8 Bassetlaw Council for Voluntary Service~~ ~~3.9 Doncaster Partial Sighted Society~~ ~~3.10~~ Provision available for further two (2) appointed governors from ~~new~~ partnership organisations appointed by the Trust ~~when appropriate)~~	1 1 ~~1~~ ~~1~~ 1 1 ~~1~~ ~~1~~ 2	
	Total Elected Governors		15
	Total Maximum Appointed Governors		6
	Total Number of Governors including appointed ~~(maximum membership)~~		~~37~~21

4. FURTHER PROVISIONS

4.1 Further provisions relating to the composition of the Council of Governors are at Annex 6.

ANNEX 4 – THE MODEL ELECTION RULES ~~2014~~

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this Constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"the Regulator" means the Independent Regulator for NHS Foundation Trusts

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor elected by the Council of Governors to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTION

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as ~~he or she~~they consider~~s~~ necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of ~~his or her~~their functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of ~~his or her~~their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 ~~Subject to rule 9.2, e~~Each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer. ~~and a nomination can, subject to rule 13, be in an electronic format.~~

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party ~~or pressure group,~~ and if so, which party ~~or pressure group~~, and if the candidate has no such interests, the paper must include a statement to that effect.

~~The Trust has guidance available on the types of interest to be declared at nomination.~~

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that ~~s/he or she is~~they are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and,
(b) for a member of the public constituency, of the particulars of ~~his or her~~their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of

nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer may order a new election to fill any vacancy which remains unfilled, on a day appointed by him/her in consultation with the corporation unless the Council of Governors at a meeting agrees to co-option.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (including a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public constituency)

21.1 The corporation shall require each voter who participates in an election for a public constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that ~~he or she has~~they have not marked or returned any other voting information in the election, and

(c) the particulars of ~~his or her~~their qualification to vote as a member of the constituency or class within the constituency for which the election is being held, ("declaration of identity") and

(d) the corporation shall make such arrangements as it considers appropriate to facilitate

the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return ~~his or her~~their declaration of identity with ~~with his or her~~their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which ~~his or~~their ~~her~~ voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.2 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:
(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.3 The corporation may determine that any member of the corporation shall:
(a) only be sent e-voting information; or
(b) only be sent postal voting information; or
(c) be sent both postal voting information (only if no e-mail) and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
(i) enter ~~his or her~~their voter ID number; and
(ii) where the election is for a public constituency, make a declaration of identity;
in order to be able to cast ~~his or her~~their vote;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than ~~he or she~~they are ~~is~~ entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with

confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast ~~his or her~~their vote; and

(ii) where the election is for a public constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than ~~he or she is~~they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide ~~his or her~~their voter ID number; and

(ii) where the election is for a public constituency, make a declaration of identity;

in order to be able to cast ~~his or her~~their vote;

(b) prevent a voter from voting for more candidates than ~~he or she is~~they are entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as ~~he or she~~they consider~~s~~ necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if ~~he or she~~they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless ~~he or she~~they:

(a) ~~is~~ are satisfied as to the voter's identity; and

(b) ~~has~~ have ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter on a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with ~~his or her~~their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if ~~he or she~~they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless ~~he or she is~~they are satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter on a list ("the list of spoilt text message votes"):
(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(e) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received ~~his or her~~their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless ~~he or she~~they:
(a) ~~is~~ are satisfied as to the voter's identity,
(b) ~~has~~ have no reason to doubt that the voter did not receive the original voting information,
(c) ~~has~~ have ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter on a list ("the list of lost ballot documents"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, ~~he or she is~~they have also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter on a list ("the list of tendered voting information"):
(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public constituency)

32.1 In respect of an election for a public constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast ~~his or her~~their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast ~~his or her~~their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom ~~he or she~~they wish~~es~~ to cast ~~his or her~~their vote.

33.5 The voter will not be able to access the internet voting system for an election once ~~his or her~~their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast ~~his or her~~their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter ~~his or her~~their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast ~~his or her~~their vote by keying in the numerical voting code of the candidate or candidates, for whom ~~he or she~~they wish~~es~~ to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once ~~his or her~~their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast ~~his or her~~their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain ~~his or her~~their voter ID number and the numerical voting code for the candidate or candidates, for whom ~~he or she~~they wish~~es~~ to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, ~~he or she is~~they are to:
(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, ~~he or she~~they are to:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper on a list of disqualified documents (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, ~~he or she is~~they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled they are to:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper on the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) on the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the Board of Directors and the Council of Governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (i) ballot papers that have been returned; and
  (ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by ~~him/her~~them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him/her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is

now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at

that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall

be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:
(a) record:
  (i) the total value of votes, or
  (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare:
  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon

be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

Council of Governors

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance

with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that ~~his or her~~their vote was given, and

(ii) that ~~Monitor (or successor body i.e. NHS England)~~ the Regulator has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement/England under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or ~~his or her~~their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:
(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings, whether online or face-to-face, to enable the candidates to speak and respond to questions, or to themselves gain further information.
as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:
(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting (face-to-face or online) to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:
(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of ~~his or her~~their own services voluntarily, in ~~his or her~~their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor or successor body (NHS England) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor or successor body (NHS England) by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by ~~Monitor or successor body (NHS England)~~the Regulator.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 ~~Monitor or successor body (NHSEngland~~The Regulator~~)~~ shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:
(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as ~~he or she~~ they think~~s~~ fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom ~~he or she~~they have ~~has~~ voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as ~~he or she~~they consider~~s~~ appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section ~~13~~14)

a Governor shall:

1.1 ~~1.1~~ be elected or appointed for a term of three years;

1.2 ~~1.2~~ be eligible for re-election or re-appointment at the end of that term; but may not serve as a Governor for more than a total of 3 terms;

~~1.2~~1.3 shall cease to hold office if:

~~1.2.1~~1.3.1in the case of an Elected Governor ~~s/he~~they cease~~s~~ to be a m~~M~~ember of ~~a Trust~~the constituency they represent or where relevant, the class of the constituency they represent and ~~or,~~ in the case of an Appointed Governor, ~~if the body which appointed~~the sponsoring organisation ~~him/her~~ withdraws ~~its appointment at any time;~~ its sponsorship of them.

~~1.2.2~~1.3.2~~his/her~~their term of office is terminated in accordance with paragraph 3 below and/or ~~s/he is~~ they are disqualified from or ~~is~~ are otherwise ineligible to hold office as a Governor; or

~~1.2.3~~1.3.3~~s/he~~they resign~~s~~ by notice in writing to the Trust.

~~1.3~~1.4 A Governor shall cease to hold office on death.

2. Council of Governors: Eligibility to be on the Council of Governors

~~1.4~~2.1 A ~~Governor~~ person shall not be eligible to become or continue in office as a Governor if:

~~1.4.1~~2.1.1In the case of an elected governor they~~s/he~~ cease~~s~~ to be eligible to be a Member~~, save in the case of Appointed Governors;~~ of the constituency or class within the constituency which they represent

~~1.4.2~~2.1.2in the case of an Appointed Governor, the appointing organisation withdraws its ~~appointment~~ sponsorship of ~~him/her~~them;

~~1.4.3~~2.1.3any of the grounds contained in paragraph ~~14~~ 17 of the Constitution apply to ~~him/her~~them;

~~1.4.4~~2.1.4~~s/he has~~they have within the preceding two years been lawfully dismissed otherwise than by reason of redundancy, by the coming to the end of a fixed term contract, by retirement or through ill health from any paid employment with a Health Service Body;

~~1.4.5~~2.1.5~~s/he is~~they are a person whose term of office as the Chair or as a member or director of a Health Service Body has been terminated on the grounds that ~~his/her~~their continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

~~1.4.6~~2.1.6they are a person who by reference to information revealed by a Disclosure and Baring Service (DBS) check is considered by the Trust to be inappropriate on the grounds that their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute ~~s/he has had his/her name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his/her name included on such a list~~;

2.1.7 ~~s/he has~~they have failed to make, or ~~has~~ have falsely made, any declaration as required to be made under Section 60 of the 2006 Act or ~~has~~ have spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and ~~s/he is~~they are judged to have acted so by a majority ~~of not less than 75%~~ of the Council of Governors voting at a meeting;

2.1.8 they are subject to a direction made under section 142 (prohibition from teaching) of the Education Act 2002 (as amended);

~~1.4.7~~2.1.9They are a person who is the subject of a disqualification order made under the company Directors Disqualification Act 1986;

~~1.4.8~~2.1.10~~NHS England~~The Regulator has exercised its powers to remove ~~him/her~~them as a Governor of the Trust or has suspended ~~him/her~~them from office or has disqualified ~~him/her~~them from holding office as a Governor of the Trust for a specified period or ~~NHS England~~the Regulator has exercised any of those powers in relation to ~~him/her~~them on any other occasion whether in relation to ~~the Trust~~DBTH or some other NHS Foundation Trust;

~~1.4.9~~2.1.11~~s/he~~they ha~~s~~ve received a written warning from the Trust for verbal and/or physical abuse towards Trust staff in the preceding 10 years;

~~1.4.10~~2.1.12~~s/he has~~they have at any time been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended);

~~1.4.11~~2.1.13~~s/he has~~they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on ~~him/her~~them;

~~1.4.12~~2.1.14~~his/her~~their term of office is terminated pursuant to paragraph 3 below;

~~1.4.13~~2.1.15~~s/he is~~they are a Member of a Staff Class and any professional registration relevant to ~~his~~ their eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six 6 months;

2.1.16 ~~s/he is~~they are a person incapable by reason of mental disorder, illness or injury in managing and administering ~~his~~ their property and/or affairs;

2.1.17 They area a person who is an immediate family member of a Director or Governor

2.1.18 they are a person who has refused without reasonable cause to undertake training which the trust and /or the Council of Governors requires Governors to undertake;

~~1.4.14~~2.1.19They are a person who has failed to sign and deliver to the Company Secretary a statement form required by the Trust confirming acceptance of the Governors' Code of Conduct

~~1.4.15~~2.1.20the relevant organisation which ~~s/he~~they represent~~s~~ ceases to exist;

~~1.4.16 s/he is a member of the UK Parliament;~~

~~1.4.17 s/he is a Director of the Trust;~~

~~1.5~~2.2 Where a person has been elected or appointed to be a Governor and ~~s/he~~they become~~s~~ disqualified from that appointment ~~s/he~~ they shall notify the Company Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered ~~him/her~~them disqualified or removed.

~~1.6~~2.3 If it comes to the notice of the ~~Trust~~ Company Secretary that a Governor is disqualified, the ~~Trust~~ Company Secretary shall immediately declare ~~him/her~~the Governor disqualified and shall give ~~him/her~~ them notice in writing to that effect as soon as practicable.

~~1.7~~2.4 Upon the giving of notice under paragraphs 2.2 and 2.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Governor and ~~his/her~~their name shall be removed from the Register of Governors.

~~1.8~~2.5 If a complaint is received against a member of the governing body it shall follow the same process as members of the Trust ~~be referred to the Trust Board Chair~~;

Commented [RA11]: As governors are primarily members - this could all be removed and handled the same as through the membership appointment and termination process.

~~1.8.1 the Chair shall appoint a suitably experienced person to undertake the role of investigating officer on behalf of the Trust~~

~~1.8.2 the investigating officer (IO) shall conduct a short initial investigation into the matter to establish whether there may be a case to answer~~

~~1.8.3 if the IO determines the matter does not constitute a viable complaint they shall make such a recommendation, in writing, to the Chair. If the Chair accepts that recommendation the matter ends there~~

~~1.8.4 if the IO determines there may be a case, then a fuller investigation shall commence. At that point the question as to whether the governor about whom a complaint has been made can continue to operate as a governor in the interim shall be considered. The IO shall examine the facts and circumstances known at that time and make a written recommendation to the Chair.~~

~~1.8.5 when considering whether suspension is appropriate there shall be a presumption that the governor will remain in office unless there are factors that, on the balance of probability, make that unacceptable. Suspension is a significant step, not to be taken lightly~~

1.8.6 factors that shall be considered –
Either –
(a) the investigation of the case may be prejudiced unless the governor is suspended, or
(b) having regard to the nature of the allegation and any other relevant considerations the public interest requires that the governor should be suspended
AND
(c) it is not practicable to restrict the role of the governor in any way that may still enable them to continue in their principal role
(d) for example asking a governor to step down temporarily from committee or meeting attendance or placing restrictions upon them to prevent routine contact with a complainant.

1.8.72.5.1The Chair upon receipt of the IO's report shall determine whether or not suspension shall be made whilst an investigation takes place.

2.3. Council of Governors: Termination of Tenure

2.13.1 A Governor's term of office shall be terminated:

2.1.13.1.1by the Governor giving notice in writing to the Company Secretary of his/hertheir resignation from office at any time during that term of office;

2.1.23.1.2by the Trust if any grounds exist under paragraph 2 above;it becomes aware of the Governors ineligibility to continue in office for any of the previously stated reasons;

2.1.33.1.3by the Council of Governors if s/hethey have has failed to attend two consecutive meetings of the Council of Governors unless within one month of the second meeting, the Council of Governors is satisfied that:

(a) the absence was due to reasonable cause; and

(b) the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

2.1.43.1.4if the Council of Governors resolves to terminate his/hertheir term of office for reasonable cause on the grounds that in the reasonable opinion of not less than 75% of the majority of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that his/hertheir continuing as a Governor (with no rights of appeal in case of 3.1.4j), would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(f) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and ~~his/her~~their continuance in office would not be in the best interests of the Trust; or

(g) ~~s/he has~~They have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required ~~him/her~~them to undertake in ~~his/her~~their capacity as a Governor by a date six months from the date of ~~his/her~~their election or appointment; or from a date when they have been asked to undertake additional training or development for any reason;

(h) ~~s/he has in his/her~~Their conduct as a Governor has failed to comply and support in a material way with the values and principles of the National Health Service or the Trust, and the Constitution; or

(i) ~~s/he has~~They have committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors Standing Orders;

~~(j) a Governor who has breached a code of conduct and has attended a formal Conduct Committee (*see 6.2*), the outcome and recommendation of which is referred to the Council of Governors, has no means of appeal.~~

~~2.2~~3.2 Upon a Governor resigning under paragraph 3.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and ~~his/her~~their name shall be forthwith removed from the Register of Governors.

~~2.3 The Standing Orders adopted by the Council of Governors (section5) may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating his tenure of office, except in the case of 3.1.4j above.~~

~~2.4~~3.3 A Governor who resigns or whose tenure of office is terminated under this paragraph 3 shall not be eligible to stand for re-election for a period of 3 years from the date of ~~his/her~~their resignation or removal from office ~~or the date upon which any appeal against his/her removal from office is disposed of whichever is the later except by resolution carried by a majority of the Council of Governors present and voting at a general meeting~~. Any re-election would take into account time served as a Governor so that a maximum term would not exceed ~~nine~~Six years.

Commented [RA12]: Should this be reduced to six years in line with NED appointments (NHSE oversight requirements)

3.~~4~~5 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out ~~in paragraph 2 or paragraph 3~~above, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below ~~and, in the case of~~

~~.Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.~~

4. Council of Governors Vacancies – ~~Elected Governors~~

where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the following provisions apply:

~~2.5~~4.1 In the case of an Elected Governor, where a vacancy arises within ~~6~~ 12 months of the election then the candidate who secured the next highest number of votes for that Constituency will be appointed. In the case of Appointed Governors, the Trust shall invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office in accordance with the processes referred to in Annex 3 within 30 days of the vacancy having arisen.

~~2.6~~4.2 If the vacancy arises during the last ~~6~~ 11 months of office, the office will remain vacant until it is filled at the next scheduled election.

~~2.7~~4.3 If a vacancy arises at any other time it will be filled at the next scheduled election, in accordance with the Election Scheme. ~~The Council of Governors may co-opt a member of the appropriate constituency whose term is just finishing, to fill a vacancy until the next scheduled election, but this shall be reserved for where deemed essential for reasons to ensure full functioning of Council of Governors business (see 4.3 below).~~

~~2.8~~4.4 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

~~3.~~5. Council of Governors: Role and Responsibilities of Governors

5.1 The general duties of the Council of Governors are:

5.1.1 At a general meeting:

(a) To appoint or remove the Chair and the other non-Executive Directors. The removal of a Non-Executive Director requires the approval of three quarters of the members of the Council of Governors.

(b) To decide he remuneration ad allowances, and the other terms and conditions of office of the Chair and the Non-Executive Directors;

(c) To appoint or remove the Auditors

(d) To be presented the annual accounts, any report of the Auditor on them and the Annual Report;

(e) To consider resolutions to remove a governor or a member pursuant to paragraph 17 of this constitution.

(f) To consider and give/withhold approval for applications for a merger, acquisition, separation or dissolution. Approval requires approval; of more than half the Council of Governors.

(g) To consider and give/withhold approval for the Trust to enter a significant Transaction. Approval requires the approval of more than half of the members of the Council of Governors of the Trust present and voting at a meeting of the Council of Governors.

5.1.2 At a general meeting or otherwise

(a) Approve an appointment of the Chief Executive. Approval requires the approval of more than half of the Council of Governors present and voting at the meeting.

(b) Give the views of the Council of Governors to the Directors for the purpose of the preparation (by the Directors) of the Forward Plan in respect of each Financial Year to be given to the Regulator.

~~3.1~~5.2 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and any code of conduct for the Council of Governors.

~~3.2~~5.3 Subject to the requirements specified ~~in paragraph 5.1~~ above, each Governor shall exercise ~~his/her~~their own skill and judgement in ~~his/her~~ their conduct of the Trust's affairs and shall in ~~his/her~~their stewardship of the Trust's affairs bring an~~s~~ appropriate ~~the~~ perspective of the constituency or organisation by which ~~s/he~~ they were was elected or appointed~~, as the case may be. Public governors are expected to represent all members and the public, and not to promote a single issue or cause.~~.

~~3.3~~5.4 ~~Subject to the further provisions of this Constitution and without in any way derogating from them,~~The general duties of ~~the~~ Council of Governors ~~shall~~are;

~~3.3.1~~5.4.1To hold the Non-Executive Directors to individually and collectively to account ~~in assisting the~~for the performance of the Board of Directors~~; in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and~~

~~3.3.2~~5.4.2~~observe the activities of the Trust with the~~to represent the interests of the Trust as a whole and the interests of the public~~ view to ensuring that they are being conducted in a manner consistent with this Constitution.~~

~~4.~~6. Council of Governors: Meetings

~~4.1~~6.1 The Council of Governors shall hold not less than 3 general meetings each financial year. ~~However, in extremis (*see para 16.5*), the Chair may decide to suspend Council of Governors' meetings.~~

~~4.2~~6.2 The Council of Governors may appoint sub-committees, consisting of its members, which are relevant and proportionate, to advise and assist it in the discharge of its functions. The outcomes of such committees will be in the form of recommendations to be presented to the Council of Governors. Recommendations presented to the Council of Governors therefore provide a second layer of oversight on a particular matter of interest by governor peers.

~~5.~~7. Council of Governors: Declarations

~~5.1~~7.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of his qualification to vote as a Member and that ~~s/he is~~ they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

~~5.2~~ The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme ~~and shall state as follows:~~

~~5.3 "I, the above-named candidate, consent to my nomination and agree to stand for election to the Council of Governors in the constituency indicated in Section One of this form. I also declare that I am a member in that constituency. I, the above-named candidate, hereby declare that I am not:~~

~~a. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged~~

~~b. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it~~

~~c. a person who within the preceding 5 years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on him/her~~

~~d. excluded by any other provision detailed within the Trust's Constitution~~

~~e. agree to support the values of the Trust and abide by the Governor Code of Conduct.~~

~~I confirm that, to the best of my knowledge, the information provided on (or in connection with) this form is accurate."~~

~~6.~~8. Council of Governors: Lead Governor

~~6.1~~8.1 No person may serve as the Lead Governor for more than a total of ~~nine~~ six years.

~~6.2~~8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if ~~s/he~~ they cease~~s~~ to be a Governor or Member and the Lead Governor's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors.

~~7.~~9. Council of Governors: Appointment of Senior Independent Director

~~7.1~~9.1 A majority of the Governors shall at a general meeting of the Council of Governors agree the appointment of one of the Non-Executive Directors as recommended by the Board of Directors to be the Senior Independent Director for a term of three years. The Senior Independent Director shall be eligible for re-appointment at the

end of that term but may not serve as Senior Independent Director for more than a total of six years.

~~7.2~~9.2 The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of the Chair~~,~~ or Chief Executive or ~~Finance Director~~Chief Finance Officer has failed to resolve or for which such contact is inappropriate.

~~7.3~~9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if ~~s/he~~they cease~~s~~ to be a Non-Executive Director and the Senior Independent Director's term of office may be terminated by a majority of not less than 75% of the Governors present and voting at a meeting of the Council of Governors on the recommendation of the Chair.

ANNEX 6 – FURTHER PROVISIONS

1. Eligibility for Membership

It is the responsibility of Members to ensure their eligibility and not the Trust, but if the Trust is on notice that a Member may be disqualified from Membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

2. Public Constituency

2.1 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

2.1.1 ~~his/her~~Their name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

2.1.2 the Trust is otherwise satisfied that the individual lives in the said area.

2.2 An individual who is a Member of the Public Constituency shall cease to be eligible to continue as a Member if ~~s/he~~they cease~~s~~ to live in the area of the Public Constituency of which ~~s/he is~~they are a Member save as may otherwise be provided in this paragraph 2.

2.3 Where a Member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which ~~s/he~~they ~~is~~ are a Member ~~s/he~~they shall forthwith advise the Trust that ~~s/he~~they are ~~is~~ no longer eligible to continue as a Member and the Trust shall forthwith remove ~~his/her~~their name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter, treat that individual as a Member of that other Public Constituency and amend the Register of Members accordingly provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

2.4 Where a Member ceases to live temporarily in the area of the Public Constituency of which ~~s/he is~~they are a Member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the Member will either return to live in the area of that Public Constituency of which ~~s/he is~~they are a Member or will live in some other part of the area of the Trust in which case the provisions of paragraph 2.1 shall apply as appropriate.

3. Staff Constituency

3.1 A Member of a Staff Class will cease to be eligible to be a Member of that Staff Class if they no longer meet the eligibility requirements of paragraph ~~7~~ 8 of the Constitution and of Annex 2.

3.2 Where an individual is a Member by virtue of their eligibility to be a Member of a Staff Class and they cease to be eligible for Membership of that Staff Class but are

eligible for Membership of some other Staff Class then the Trust may give notice to that Member of its intention to transfer him/her to that other Staff Class on the expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

4. Membership Termination of Tenure

4.1 A Member may be expelled from membership of the Trust by a resolution approved by the majority of Governors voting at a meeting of the Council of Governors. The following procedure is to be adopted:

4.1.1 any Member may complain to the Secretary that another Member has acted in a way detrimental to or contrary to the interests of the Trust, or is otherwise disqualified as set out section 12 above; and

4.1.2 subject to paragraphs 12.2 to 12.6 below, if a complaint is made, the Council of Governors will consider the complaint, having taken such steps as it considers appropriate, to ensure that each Member's point of view is heard and may either:

(a) dismiss the complaint and take no further action;

(b) arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors; or

(c) determine that the complaint should be investigated by an agreed investigating body. For the avoidance of doubt, not every complaint received should result in investigation

4.1.3 If a resolution to expel a Member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4.1.4 At the meeting, the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

4.1.5 If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

4.1.6 A person expelled from membership will cease to be a Member upon the declaration by the person chairing the meeting in question that the resolution to expel them is carried.

~~4.1.1~~4.1.7 No person who has been expelled from membership pursuant to the provisions of paragraph 4.1 above is to be re-admitted as a Member except by a resolution of the Council of Governors carried by the majority of Governor votes present and voting at a meeting of the Council of Governors.

4.2 A Member shall cease to be a Member if:-

4.2.1 they cease to be entitled under this Constitution to be a Member of any of the Public Constituencies or one of the classes of the Staff Constituency;

4.2.2 they resign by notice in writing to the Secretary;

4.2.3 they die;

4.2.4 they are expelled under this Constitution;

4.2.5 if it appears to the Company Secretary that they no longer wish to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the Council of Governors they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a Member.

4.3 All members of the Trust shall be under a duty to notify the Company Secretary of any change in their particulars which may affect their entitlement as a member.

~~4.~~5. Board of Directors: Disqualification

~~4.1~~5.1 In addition to the grounds of disqualification set out in Sections ~~26 - 27~~28 -31 of the Constitution, a person may also not be or continue as a Director of the Trust if:

~~4.1.1~~5.1.1 in the case of a Non-Executive Director, s/he no longer satisfies the relevant requirements for appointment;

~~4.1.2~~5.1.2 s/he is a person whose tenure of office as a chair or as a director of a Health Service Body has been terminated on the grounds that his/her appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

~~4.1.3~~5.1.3 s/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body;

~~4.1.4~~5.1.4 information revealed by a DBS check is such that it would be inappropriate for him/her to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

~~4.1.5~~5.1.5 in the case of an Executive Director, s/he is no longer employed by the Trust;

~~4.1.6~~5.1.6 s/he is a person who has had their name removed by a Direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and have not subsequently had their name included on such a list;

~~4.1.7~~5.1.7 s/he is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

~~4.1.8~~5.1.8 s/he has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that s/he accepts the Trust's Standards of Business Conduct Policy;

~~4.1.9~~5.1.9 s/he has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake.

~~4.1.10~~5.1.10s/he is a partner or spouse of an existing Director.

~~5.~~6. Governors and Directors: Communication and Conflict

~~5.1~~6.1 Summary

This paragraph describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

~~5.2~~6.2 Informal Communications

~~5.2.1~~6.2.1 Informal and frequent communication between the Lead Governor, Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

~~5.2.2~~6.2.2 The Chair shall use ~~his/her~~their reasonable endeavours to encourage effective informal methods of communication including:

(a) participation of the Board of Directors in the induction, orientation and training of Governors;

(b) development of special interest relationships between Non-Executive Directors and Governors;

(c) discussions between Governors and the Chair and/or the Chief Executive and/or Directors through the office ~~of the office~~ of the Chief Executive or ~~his~~ their nominated officer; and

(d) involvement in Membership recruitment and briefing at public events organised by the Trust.

~~5.2.3 Governors will be given information on to whom they should report operational issues.~~

~~5.3~~6.3 Formal Communication

~~5.3.1~~6.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

~~5.3.2~~6.3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

(a) specific requests by the Council of Governors will be made through the Company Secretary to the Chair to the Board of Directors;

(b) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair. Such issues should be raised with the Chair (or, if it involves the Chair then the Deputy Chair) no less than 10 working days before the meeting in order to be included in the

agenda. In the event of disagreement, two thirds of the Governors present must approve the request. The Chair will raise the matter with the Board of Directors and provide the response to the Council of Governors;

(c) joint meetings will take place as and when, as, appropriate between the Council of Governors and the Board of Directors.

~~5.3.3~~6.3.3 The Board of Directors may request the Chair to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

~~5.3.4~~6.3.4 Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:

(a) ~~request the Chair to seek the view of the Council of Governors on~~ the Board of Directors' proposals for the s~~S~~trategic d~~D~~irection and the Annual ~~Plan~~Report and Forward Plan;

~~(b) presentation and approval of annual accounts, annual report and auditor's report;~~

~~(c)~~(b) ~~request the Chair to seek the view of the Council of Governors on~~ the Board of Directors' proposals for developments;

~~(d)~~(c) ~~request the Chair to seek the view of the Council of Governors on~~ Trust Performance;

~~(e) request the Chair to seek the view of the Council of Governors for~~ involvement in service reviews and evaluation relating to the Trusts services ; and~~;~~

(d) ~~request the Council of Governors to seek views of the Membership on~~ proposed changes, plans and developments for the Trust other than those covered above.

~~5.3.5~~6.3.5 The Board of Directors shall also present to the Council of Governors the Annual Accounts, Annual Report and any report of the Auditors in accordance with the terms of this constitution and of the 2006 Act and any subsequent legislation or regulation.

~~5.3.6~~6.3.6 The following ~~F~~formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:~~s will normally be conducted as follows:~~

(a) attendance by the Board of Directors at a meeting of the Council of Governors; or

(b) provision of formal reports or presentations by executive and/or non-executive Directors to a meeting of the Council of Governors;

(c) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

(d) reporting the views of the Council of Governors to the Board of Directors through the Chair ~~or Lead Governor~~, the Deputy Chair or the Senior Independent Director;

~~(e) Governors attend meetings in public of the Board of Directors as observers.~~

~~5.3.7 Wherever possible and practical, written communications will be conducted by e-mail, and meetings by video-conferencing.~~

~~5.4~~6.4 Resolving Conflict between the Council of Governor and the Board of Directors

~~5.4.1~~6.4.1 The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of view quickly, through discussion and negotiation.

~~5.4.2~~6.4.2 If ~~as the first step, the informal efforts of~~ the Chair ~~do~~ cannot achieve resolution of a disagreement or ~~a conflict~~dispute between the Council of Governors and the Board of Directors through informal efforts~~,~~ the Chair will follow the dispute resolution process described ~~in paragraph 7.4.3~~ below. The aim is to resolve the matter at the first available opportunity, and only to escalate to the next step if the step taken fails to achieve resolution.

~~5.4.3 In the event of a conflict between the Council of Governors and Board of Directors, the following action will be taken, in the sequence shown:~~

(a) the Chair will call a joint meeting (Resolution Meeting) of equal numbers of ~~the members of the Council of~~ Governors and Board of Directors, to take place as soon as possible, but no later than twenty working days following the date of the request. ~~The meeting must comprise of two thirds of the Membership of the Council of Governors and two thirds of the membership of the Board of Directors.~~ The resolution meeting will be held in private. ~~The agenda and any papers for the meeting will be issued in accordance with the Standing Orders of the Council of Governors~~. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every effort must be made to reach agreement;

(b) if ~~a~~ the Resolution Meeting fails to resolve the conflict, the dispute will be deferred back to ~~of the members of the Council of Governors and Board of Directors fails to resolve a conflict,~~ the Board of Directors ~~will~~ who shall ~~decide the disputed matter~~make the final decision;

~~(c) if, following the formal Resolution Meeting, and the decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Constitution, the Council of Governors will refer the specific issue of non-compliance to NHS Improvement/England.~~

~~5.4.4 The right to call a Resolution Meeting rests with the following, in the sequence of escalation shown:~~

~~(a) the Chair;~~

~~(b) the Chief Executive;~~

~~(c) two thirds of the members of the Council of Governors;~~

~~(d)~~(c) ~~two thirds of the members of the Board of Directors.~~

~~6.~~7. Resolving Disputes about the Entitlement to Membership of the Trust and Eligibility for Membership of the Council of Governors

~~6.1~~7.1 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other Director of the Trust as the Chief Executive may, in their absolute discretion, nominate) as soon as reasonably practicable thereafter, and in any case, within 14 days of the Trust's decision.

~~6.2~~7.2 The Chief Executive (or their nominated representative) shall:

~~6.2.1~~7.2.1 view the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

~~6.2.2~~7.2.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which they have considered; and

~~6.2.3~~7.2.3 communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

~~6.2.4~~7.2.4 Where a Governor is declared ineligible or disqualified from office or their term of office as a Governor has been terminated (for any reason other than expiry of their term of officer or as a consequence of their own resignation) and that person disputes the decision, they shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive, who shall use their reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

~~7.~~8. Indemnity

8.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any reasonable costs arising in this way will be met by the Trust.

8.2 The Trust may purchase and maintain insurance against the liability for its own benefit of members of the Council of Governors, the Board of Directors and the Company Secretary.

~~7.1~~8.3 ~~and t~~The Trust ~~shall have the power to purchase suitable~~may take out insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority (NHS Resolution) or successor body, in respect of directors and officers liability, including liability arising by reason of the Trust acting as corporate

trustee of an NHS Chairty or Director of a wholly owned subsidiary. ~~to cover such costs.~~

~~8.~~9. Validity of Actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any action taken by them.

~~9.~~10. Registers

~~9.1~~10.1 The Company Secretary shall be responsible for compiling and maintaining the Registers. Removal from any Register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days.

~~9.2~~10.2 Register of Members

~~9.2.1~~10.2.1 Members must complete and sign an application in the form prescribed by the Company Secretary; and

~~9.2.2~~10.2.2 the Company Secretary shall maintain the Register of members will be in two parts. Part 1 shall include the name of each Member Registers (see section 32 and 33) and the Constituency or class to which they belong and shall be open to inspection by the public in accordance with paragraph 33 of this Constitution. Part 2 shall contain all the information from the individual's application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual Membership of the Trust is representative of those eligible for Membership.

~~9.3~~10.3 Register of Members of the Council of Governors

The Register shall list the names of members of the Council of Governors, their category of Membership of the Board (public, staff or organisation represented) and an address through which they may be contacted which may be the Secretary.

~~9.4~~10.4 Register of Interests of the Members of the Council of Governors

Each member of the Council of Governors shall complete and sign a form as prescribed by the Secretary setting out interests to be declared in accordance with the Standing Orders and the register shall contain the names of all members of the Council of Governors and any interests declared including no interests.

~~9.5~~10.5 Register of Interests of Directors

The Register shall list the names of Members of the Board of Directors, their capacity on the Board and an address through which they may be contacted which may be the Secretary.

Each Member of the Board of Directors shall complete and sign a form as prescribed by the Company Secretary setting out any interests to be declared in accordance with the Standing Orders for the Board of Directors and the Register shall contain the names of all members of the Board of Directors and any interests declared including no interests.

~~10.~~11. Auditor

~~10.1~~11.1 A person may only be appointed auditor if they (or in the case of a firm each of its members) is a member of one or more of the following bodies:

~~10.1.1~~11.1.1 the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

~~10.1.2~~11.1.2 any other body of accountants established in the United Kingdom and approved by ~~NHS Improvement/England~~The Regulator.

~~11.~~12. Accounts

~~11.1~~12.1 The following documents will be made available to the Comptroller and Auditor General for examination at ~~his/her~~their request:

~~11.1.1~~12.1.1 the accounts;

~~11.1.2~~12.1.2 any records relating to them; and

~~11.1.3~~12.1.3 any report of the auditor one them.

~~11.2~~12.2 In preparing its annual accounts, the Trust is to comply with any directions given by ~~NHS England~~the Regulator with the approval of the Treasury as to:

~~11.2.1~~12.2.1 the methods and principles according to which the accounts are to be prepared; and

~~11.2.2~~12.2.2 the information to be given in the accounts.

~~11.3~~12.3 The Trust must:

~~11.3.1~~12.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

~~11.3.2~~12.3.2 once it has done so, send copies of those documents to ~~NHS Improvement/England.~~the Regulator

~~11.4~~12.4 Annual reports and forward plans

~~11.4.1~~12.4.1 The annual report submitted by the Trust to NHS Improvement/England in accordance with paragraph 39.1 is to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual Membership of its public constituencies is representative of those eligible for such Membership; and

(b) any other information NHS Improvement/England requires.

~~11.4.2~~12.4.2 The Trust is to comply with any decision NHS Improvement/England makes as to:

~~11.4.3~~12.4.3 the form of the reports;

~~11.4.4~~12.4.4 when the reports are to be sent to it; and

~~11.4.5~~12.4.5 the periods to which the reports are to relate.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND THE PROCEDURE OF THE COUNCIL OF GOVERNORS

Commented [RA13]: New section added - SO all in one place

1. INTRODUCTION
2. DEFINITIONS
3. MEETINGS OF THE COUNCIL OF GOVERNORS
    3.1 Admission of the Public
    3.2 Calling Meetings
    3.3 Notice of Meetings
    3.4 Annual Meeting
    3.5 Setting the Agenda
    3.6 Petitions
    3.7 Chair of Meeting
    3.8 Agenda
    3.9 Report from the Board of Directors
    3.10 Chair's Ruling
    3.11 Voting
    3.12 Special Provisions relating to termination of Governors' Tenure
    3.13 Minutes
    3.14 Suspension of Standing Orders
    3.15 Variation and Amendment of Standing Orders
    3.16 Record of Attendance
    3.17 Quorum
    3.18 Urgent Decisions
4. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR
5. COMMITTEES
6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS
7. STANDARDS OF BUSINESS CONDUCT
8. APPOINTMENTS AND RECOMMENDATIONS
9. REMUNERATION AND EXPENSES
10. MISCELLANEOUS

1. Introduction

1.1 Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire, DN2 5LT.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Council of Governors of the Trust to adopt Standing Orders for the regulation of its proceedings and business and to adhere at all times to the Code of Conduct for Governors.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

2. Definitions

In these Standing orders the definitions outlined in the constitution paragraph 1.

3. Meetings of the Council of Governors

3.1 Admission of the Public

3.1.1 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from a meeting on the grounds that:

a) any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

b) for other reasons stated in the resolution and arising from the nature of the business or the proceedings, that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

c) Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.2 Calling Meetings

3.2.1 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 3 meetings in any year including:

a) an annual meeting no later than the 30 September in each year apart from the first year, when the Council of Governors are to receive and consider the Annual Accounts, any report by the Auditor and the Annual Report; and

b) any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

3.2.2 The Secretary may call a meeting of the Council of Governors at any time. If the Secretary refuses to call a meeting after a requisition for that purpose, signed by at least three quarters of the members of the Council of Governors and specifying the business to be transacted at the meeting, has been presented to the Secretary, or if, without so refusing, the Secretary does not call a meeting within 5 Clear Days after such requisition has been presented to the Secretary at the Trust's Headquarters, such three-quarters or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

3.2.3 The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

3.2.4 The Council of Governors may agree that its Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 2.1~~7~~6 (Quorum).

3.3 Notice of Meetings

3.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf, shall be delivered to, or sent by post to the usual place of residence of every Governor, so as to be available to them at least 7 days before the meeting, save in the case of emergencies.

3.3.2 Before each meeting of the Council of Governors, a public notice of the time and place of the meeting, and if possible, the public part of the agenda, shall be advertised on the Trust's website at least 7 days before the meeting, save in the case of emergencies.

3.3.3 Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than three Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of emailing.

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

3.3.5 Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than 5 Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chair to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

3.3.6 In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SO 3.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 Annual Meeting of the Council of Governors

3.4.1 The Council of Governors shall hold an annual meeting of the Council of Governors in every calendar year so that there is no more than fifteen calendar months between one meeting and the next and no more than 6 months from the end of the previous financial year (30 September) and shall present to that meeting:

a) A report on the proceedings of its meetings held since the last annual meeting;

b) A report on the progress since the last annual meeting in developing the membership strategy including the steps taken to ensure that the actual membership of its Public

Constituency and Service Users' and Carers' Constituency is fully representative of the persons who are eligible to be members under the Constitution;

c) A report on any change to the Governors which has taken place since the last annual meeting; and

d) A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding Financial Year and the future service development plans of the Trust.

3.5 Setting the Agenda

3.5.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A member of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make his request in writing to the Chair or the Secretary at least 21 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 21 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

3.7 Chair of Meeting

3.7.1 At any Council of Governors meeting, the Chair, if present, shall preside. If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair shall preside.

3.7.2 If the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director or the Lead Governor as shall be appointed by the Council of Governors shall preside.

3.8 Agenda

3.8.1 Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 3.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 3.8 shall apply in respect of the proposition:

3.8.2 The mover of the proposition shall have a right of reply at the close of any discussion on the proposition or any amendment thereto.

3.8.3 When a proposition is under discussion or immediately prior to discussion it shall be open to a Governor to move: an amendment to the proposition;

a) the adjournment of the discussion or the meeting;

b) that the meeting proceeds to the next business;

c) the appointment of an ad hoc committee to deal with a specific item of business;

d) that the motion be now put;

e) that the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 3.1.

3.8.4 In the case of sub-paragraphs SO 3.8.3.c and SO 2.8.3.e above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

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

3.8.6 The mover of a proposition shall have a maximum of five minutes to move and five minutes to reply. Once a proposition has been moved, no Governor shall speak more than once or for more than five minutes.

3.9 Report from the Board of Directors

3.9.1 Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Chief executive or nominated representative shall present a report on the Trusts progress and forward planning.

3.10 Chair's Ruling

3.10.1 Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.11 Voting

The Council of Governors will endeavour to ensure that decisions taken are by consensus and without recourse to voting, except where a vote is formally required under the Constitution. Where however consensus is not achieved, the following process of voting will be applied.

3.11.1 A Governor may not vote at a meeting of the Council of Governors unless, within 7 Clear Days prior to the commencement of the meeting they have made a declaration in the form specified within Schedule A of these Standing Orders, that they are a member of the constituency which elected them and are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

3.11.2 Subject to SO 3.11.4 below, matters requiring the conduct of a vote shall be determined by a majority of the votes of the Governors present and voting on the question.

3.11.3 Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal, have a casting vote.

3.11.4 A resolution for the removal of the Chair or a Non-Executive Director shall be passed only in accordance with the provisions of 28.2 to 28.5 of the Constitution.

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

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

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

3.11.8 A Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy, but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.

3.12 Special Provisions relating to Termination of Governor's Tenure:

3.12.1 Where a person has been elected or appointed to be a Governor and they become disqualified from office under paragraph 16 or paragraph 17 of the Constitution, they shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of the first becoming aware of those matters which render them disqualified. The Secretary shall forthwith remove them from the Register of the Governors.

3.12.2 If it comes to the notice of the Secretary that the Governor is disqualified pursuant to SO 2.12.1, whether at the time of the Governor's appointment or later, the Secretary shall immediately declare that the individual in question is disqualified and give them notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the governor disputes that they are disqualified, the governor may refer the matter to the dispute resolution procedure set out in paragraph 7 of Annex 6 within 28 days of the date upon which the notice was given to the Governor.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up by the Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the Chair presiding at it.

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

3.13.2 Minutes of meetings will be taken and circulated in accordance with Governors' wishes.

3.14 Suspension of Standing Orders

3.14.1 Except where this would contravene any statutory provision or any direction made by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Governors are present, and that a majority of those present vote in favour of suspension.

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

3.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Governors.

3.14.4 No formal business may be transacted while Standing Orders are suspended.

3.14.5 Record of Attendance The names of the Chair and Governors present at the meeting shall be recorded in the minutes.

3.15 Variation and Amendment of Standing Orders

3.15.1 Subject always to paragraph 3.14 of Annex 7 of the Constitution, these Standing Orders shall be amended only if:

a) a notice of proposal under Standing Order 3.5 has been given; and

b) at least two thirds of the total number of Governors is present; and

c) the majority of Governors present vote in favour of amendment; and

d) the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision, guidance issued by the Regulator or the Constitution.

3.16 Record of Attendance

3.16.1 The names of the Chair and Governors present at the meeting shall be recorded in the minutes.

3.17 Quorum

3.17.1 No business shall be transacted at a meeting unless at least one third of the total number of Governors are present with the majority of those present being Public Governors.

3.17.2 If at any meeting there is no quorum present within 15 minutes of the time scheduled for its commencement, the meeting shall stand automatically adjourned for a period of seven days and the Chair shall give or procure the giving of notice to all Governors of the date, time and place of that adjourned meeting. Upon reconvening, those present shall constitute a quorum.

3.17.3 If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.18 Urgent Decisions

3.18.1 Where such a decision is required to be taken by the Council of Governors and which cannot await the next scheduled formal meeting of the Council of Governors, a section of the next Council of Governors development session be formally designated a formal general meeting for this specific purpose.

3.18.2 For decisions required to be taken in situations where the approach above does not result in a quorate meeting it is proposed that:

a) A decision to be taken, where justified, by the Lead Governor and Chair following consultation with the Deputy Lead Governor.

b) Where the decision to be taken is one which would ordinarily be required under the Constitution to be subject to a vote by the Council of Governors, that such a vote be conducted electronically outside of the meeting and overseen by the Secretary (for those Governors who do not have access to or preference would be not to utilise IT, a paper vote would be enabled).

3.18.3 Any decision taken under such an approach would be reported to the next meeting of the Council of Governors.

3.18.4 The use of the above approach will only be utilised in exceptional circumstances, with the expectation that all business will be conducted at the formal Council of Governor meetings

4 Lead Governor and Deputy Lead Governor

4.1 In accordance with the code of governance for NHS provider trusts the Council of Governors shall elect a Lead Governor and if required a Deputy Lead Governor who must be a Governor. The Lead Governor (or in their absence a Deputy Lead Governor) has a role in facilitating direct communication between NHS England (or its successor) and the Council of Governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Company Secretary.

4.2 Without prejudice to the rights of any Governor to communicate directly with the Chair, the Lead Governor shall be responsible for receiving from Governors and communicating to the Chair any comments, observations and concerns expressed to the Chair by Governors other than at meetings of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

4.3 The Deputy Lead Governor shall be responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor whenever they are known to be unavailable.

4.4 Each Governor shall communicate any comment, observation or concern which they may have to the Lead Governor in the first instance and only to the Deputy Lead Governor if the Lead Governor is known to be unavailable.

4.5 These appointments shall be made from those Governors who have been elected as Governors from the Public Constituency or appointed by a Partner Organisation

4.6 The Lead Governor and the Deputy Lead Governor so elected shall hold office for a period of three years provided that they continue to hold the governor seat to which they were duly elected or appointed. They may subsequently seek re-election for one more three-year period of office, provided that they continue to hold the governor seat to which they were duly elected or appointed.

4.7 Nominations for appointment as Lead Governor and Deputy Lead Governor shall be sent out with the papers for the first meeting or annual meeting of the Council of Governors as the case may be. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the principal place of business of the Trust addressed to the Company Secretary to arrive by a stipulated date.

4.8 There shall be separate forms of nomination for appointment to the position of Lead Governor and the position of Deputy Lead Governor and eligible Governors may be nominated for both positions. In the event of there being two or more nominations for either appointment a secret postal ballot shall be held of all the Governors with each Governor having one vote for each contested appointment. The Governor whose nomination receives the largest number of votes for each position shall be appointed.

4.9 In the event of the number of votes in any election being equal, a draw will take place overseen by the Company Secretary. The nomination whose name is drawn will be elected to the role.

4.10 The result of the ballot shall be announced at the meeting.

5 Committees

5.1 Subject to such guidance as may be issued by the Regulator, the Council of Governors may appoint committees of the Council of Governors to assist it in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly or partly of the Chair and Governors.

5.2 All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

5.3 A committee appointed under SO 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.4 These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chair" to be read as a reference to the Chair of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits.

5.5 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Regulator, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.6 Where committees are authorised to establish sub-committees, they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.7 Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, provided that the financial and other implications of seeking outside advisors have been discussed and agreed by the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out at paragraph 6.4 of Annex 6.

5.8 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.9 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate in accordance with applicable statute and regulations and with guidance issued by the Regulator.

5.10 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

6 Declarations of Interests and Register of Interests

6.1 Declaration of Interests

6.1.1 The Regulatory Framework and the Constitution require each Governor to declare to the Secretary:

a) any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

b) any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust which is under consideration or is to be considered by the Council of Governors, as described in SOs 6.2.2 and 6.2.3; and

c) any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 6.2.5.

6.1.2 Such a declaration shall be made either at the time of the Governor's election or appointment or within 28 days thereof, or otherwise as soon as they becomes aware of the existence of that interest, and in a form prescribed by the Secretary from time to time.

6.1.3 In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4 Subject to SO 6.2, if a Governor has declared a pecuniary interest (as described in SOs 6.2.2 to 6.2.5) they shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the Governor's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.5 This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a Governor).

6.1.6 The interests of Governors in companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.2 Nature of Interests

6.2.1 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

a) directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

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

c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS; or

d) a position of authority in a charity or voluntary organisation in the field of health and social care; or

e) any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

f) any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks; or

g) research/funding grants that may be received by an individual or their department; or

h) interests in pooled funds that are under separate management.

6.2.2 A Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

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

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

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

a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

b) of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

c) of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

6.2.4 Where a Governor:

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

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

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

d) the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however it is their duty to disclose the interest.

6.2.5 A family interest is an interest of the spouse or partner or any parent, child, brother or sister of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of theirs.

6.2.6 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including General Practitioners should also be considered.

7 Standards of Business Conduct

7.1 Members of the Council of Governors shall comply with the Trust's Code of Conduct for Governors and any guidance or best practice advice issued by the Regulator.

8 Appointments and Recommendations

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

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

8.3 Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any Governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4 The Chair and every Governor shall disclose to the Trust Secretary any relationship between themself and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Company Secretary to report to the Council of Governors any such disclosure made.

8.5 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

8.6 Where the relationship to a member of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9 Remuneration and Expenses

9.1 Governors are not to receive remuneration.

9.2 The Trust will pay travelling expenses to Governors in accordance with the relevant Trust policies for attendance at General Meetings of the Governors, or any other business authorised by the Secretary as being under the auspices of the Council of Governors.

9.3 Expenses will be authorised and reimbursed through the Secretary's office on receipt of a completed and signed expenses form provided by the Secretary.

9.4 A summary of expenses paid to Governors will be published in the Annual Report.

10 Miscellaneous

10.1 The Company Secretary shall provide a copy of these Standing Orders to each Governor and endeavor to ensure that each Governor understands their responsibilities within these Standing Orders.

10.2 These Standing Orders including all documents having effect as if incorporated in them shall be reviewed regularly by the Board of Directors and the Council of Governors.

10.3 Any written notice required by these SOs shall be deemed to have been given on the day the notice was sent to the recipient.

10.4 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these SOs to the Chair as soon as possible.

10.5 A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

Schedule A: Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

I hereby declare that I am at the date of this declaration a member of the Public/Staff/Constituency (delete as necessary), and I am not prevented from being a member of the Council of Governors by reason of any provision of the Constitution.

Signed:

Print name:

Date:

Schedule B: Prescribed Form of Declaration of Interests

Declaration to the Secretary of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust

Date

To the Secretary **of Doncaster and Bassetlaw Teaching Hospital NHS Trust Foundation Trust**

Dear

In fulfilment of the obligations imposed on me by paragraph 22 of the Constitution of the Foundation Trust and the provisions of Standing Order 6 of the Standing Orders for the Council of Governors generally, and in particular Standing Order 6.1.2, I hereby give notice to the Trust of my interest in:

[insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non-pecuniary, direct, indirect, actual, potential, etc.)**]**

as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's Register of Interests of the Members of the Council of Governors.

Yours faithfully
[name]

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS~~ANNUAL MEMBERS' MEETING~~

Commented [RA14]: Move this section to Annex 9 as per the MC

1. INTRODUCTION
2. THE BOARD OF DIRECTORS
3. MEETINGS OF THE TRUST
4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
5. COMMITTEES
6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS
7. STANDARDS OF BUSINESS CONDUCT
8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS
9. SIGNATURE OF DOCUMENTS
10. MISCELLANEOUS

1. Introduction

Statutory Framework

1.1 Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust became a Public Benefit Corporation on 1 April 2004 following authorisation by Monitor.

1.2 The principal place of business of the Trust is: Doncaster Royal Infirmary, Armthorpe Road, Doncaster, South Yorkshire.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 35 of the Constitution requires the Board of Directors to adopt Standing Orders for the regulation of its proceedings and business.

1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

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

1.6 The Trust shall deal with the Regulator in an open and co-operative manner and shall promptly notify the Regulator of anything relating to the Trust of which the Regulator would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its Authorisation or any financial or performance thresholds which the Regulator may specify from time to time.

1.7 The Chair, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Nolan Committee, now the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service. They will also ensure that they follow the best practice advice set out in the Code of Governance for NHS Provider Trusts.

1.8 Delegation of Powers – Scheme of Delegation

Under the Standing Orders relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

1.9 In these Standing orders the definitions outlined in the constitution paragraph 1 shall apply.

2. The Board of Directors

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to be made to the Charity Commission.

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided for in SO 3.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

3. Meetings of the Trust

3.1 Admission of the Public and the Press

3.1.1 Subject to SO 3.1.2, meetings of the Board of Directors shall be held in public, unless the Board of Directors in their absolute discretion determine that any part of a meeting of the Board of Directors shall be held in private.

3.1.2 Where the Board of Directors determines that meetings of the Board of Directors will be held in public, the public and representatives of the press may, at the absolute discretion of the Chair, be afforded facilities to attend a meeting of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" (Section1(2) Public Bodies (Admission to Meeting) Act 1960).

3.1.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on

grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

3.1.4 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.2. Calling Meetings

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of Directors, and this has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's Headquarters, such one third or more members of the Board of Directors may forthwith call a meeting.

3.2.3 The Trust will publicise and hold an Annual Public Meeting, which shall be on or before 30 September every year.

3.3. Notice of Meetings

3.3.1 Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an Officer of the Trust authorised by the Chair to sign on his behalf, shall be delivered to every Director, by email so as to be available to him at least 7 days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

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

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

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite 7 days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4. Agendas

3.4.1 Agendas will be accessible to members of the Board of Directors six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be accessible no later than three days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.4.2 A public notice of the time and place of the meeting, and the agenda (excluding any part of the agenda for which members of the public may be excluded from for special reasons), shall be displayed on the Trusts website at least three days before the meeting

3.5. Setting the Agenda

3.5.1 The Chair, or in their absence the Deputy Chair, shall determine the agenda for each meeting of the Board of Directors, being advised in this regard by the Chief Executive and the Company Secretary.

3.5.2 A Director desiring a matter to be included on an agenda shall make his request to the Chair at least ten Clear Days before the meeting, subject to SO 3.3. Requests made less than ten Clear Days before a meeting may be included on the agenda at the discretion of the Chair. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6. Petitions

3.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

3.7. Chair of Meeting

3.7.1 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if there is one who is present, shall preside. If the Chair and Deputy Chair are absent, such Non-Executive Director (and who is not also an Officer of the Trust) as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

3.8. Chair's Ruling

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9. Notices of Motion

3.9.1 Subject to the provisions of SO 3.11 and SO 3.12, a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chair.

3.9.2 The notice shall be delivered at least 10 Clear Days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these SOs and the appropriate Regulations. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10. Emergency Motions

3.10.1 Subject to the agreement of the Chair, and subject also to the provision of SO 3.11, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.11. Motions: Procedure at and during a meeting

3.11.1 Who may propose

i) A motion may be proposed by the Chair of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 Contents of motions

i) The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

a) the reception of a report;

b) consideration of any item of business before the Board of Directors;

c) the accuracy of minutes;

d) that the Board of Directors proceed to next business

e) that the Board of Directors adjourn; or

f) that the question be put now.

3.11.3 Amendments to motions

i) A motion for amendment shall not be discussed unless it has been proposed and seconded.

ii) Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors

iii) If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.4 Rights of reply to motions

i) Amendments

a) The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

ii) Substantive/original motion

a) The member of the Board of Directors who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 Withdrawing a motion

i) A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11.6 Motions once under debate

i) When a motion is under debate, no motion may be moved other than:

a) an amendment to the motion;

b) the adjournment of the discussion, or the meeting;

c) that the meeting proceeds to the next business;

d) that the question should be now put;

e) the appointment of an 'ad hoc' committee to deal with a specific item of business;

f) a motion under SO 3.1.2 resolving to exclude the public (including the press); and

g) that a member be not further heard.

ii) In the cases of a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d), in the interests of objectivity, such a motion should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

iii) If a motion under SO 3.11.6.i)c) or SO 3.11.6.i)d is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

iv) The mover of a motion shall have a maximum of five minutes to move and five minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak for more than five minutes.

3.12. Motion to Rescind a Resolution

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate. This provision shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13. Voting

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

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

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

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

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

13.3.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14. Minutes

3.14.1 The minutes of the proceedings of a meeting shall be drawn up by the Company Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained via electronic form and archive.

13.14.3 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.15. Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by the Regulator, any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

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

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chair and the Directors.

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

3.15.5 The Audit and Risk Committee shall review every decision to suspend SOs.

3.16 Variation to Standing Orders

3.16.1 Subject always to paragraph 3.15 of Annex 8 of the Constitution, these SOs shall be amended only if:

(i) relevant notice of a meeting has been served in accordance with SO 3.3;

(ii) a notice of motion under SO 3.9 has been given;

(iii) no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment;

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

(v) the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by the Regulator.

3.17. Record of Attendance

3.17.1 The names of the Chair and the Directors present at the meeting shall be recorded in the minutes.

3.18. Quorum

3.18.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors are present including at least one Executive Director and one Non-Executive Director and the Chair.

3.18.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.18.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Appointment and Terms of Service Committee).

3.19. Meetings: Electronic Communication

3.19.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.19.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Board of Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present ***and maintained*** throughout the meeting.

3.19.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 Arrangements for the Exercise of Functions by Delegation

4.1 Subject to SO 2.6 and such guidance as may be given by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.4 below, or by a Director or an officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 Notwithstanding the provisions of SO 4.1, the provisions of paragraphs 4.2 to 4.3~~4~~ of the Constitution apply.

4.3 Emergency Powers

4.3.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.4 Delegation to Committees

4.4.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.5 Delegation to Officers

4.5.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

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

4.5.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

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

4.6 Duty to Report Non-Compliance with Standing Orders

4.6.1 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5. Committees

5.1 Appointment of Committees

5.1.1 Subject to SO 2.6 and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator, shall appoint committees of the Trust consisting wholly or partly of Directors of the Trust or other Health Service Bodies or wholly of persons who are not Directors of the Trust or other health service bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to such guidance as may be given by the Regulator, the Board of Directors or the other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of Directors (whether or not they are Directors of the Trust in question) or wholly of persons who are not Directors of the Trust or the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any relevant legislation and/or regulations, and such guidance or best practice advice issued by the Regulator. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees, they may not delegate Executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

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

i) Audit and Risk Committee;

ii) Nominations and Remunerations Committee;

ii) Finance and Performance Committee;

iv) Quality Committee; and

v) People Committee.

vi) as Trustees on behalf of DBTH of the Trust Charity – The Charitable Funds Board

5.1.8 The terms of reference of those Committees in paragraph 5.1.7 above shall be agreed by the Board of Directors.

5.1.9 The Board of Directors may also operate as a committee in accordance with SO 5.1.2. Any decisions taken by the Board of Directors in committee (i.e. Seminar meeting of the Board of Directors) must be brought to the next meeting of the Board of Directors.

5.2 Confidentiality

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

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

6. Interface Between The Board of Directors and The Council of Governors

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution.

6.2 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each Financial Year to be given to the regulator.

6.3 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them, and the Annual Report.

6.4 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 48 and 49 of the Constitution is included on the Agenda for a meeting of the Board of Directors.

6.5 If the Council of Governors so desires, such a matter as described within SO 6.4 to be included on an Agenda item, they shall make their request in writing to the Chair at least 14 Clear Days before the meeting of the Board of Directors, subject to SO 3.3. The Chair shall decide whether the matter is appropriate to be included on the Agenda. Requests made less than 14 Clear Days before a meeting may be included on the Agenda at the discretion of the Chair.

7. Declarations of Interests and Register of Interests

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Company Secretary:

7.1.1 any pecuniary interest in any contract, proposed contract or other matter which is under consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust irrespective of whether those interests are direct or indirect, actual or potential.

7.2 All existing members of the Board of Directors should declare such an interest as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within seven Clear Days of becoming aware of the existence of a relevant and material interest.

7.4 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.5 If a Director has declared a pecuniary interest in accordance with SO 7 they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Board of Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.6 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by the Regulator:

7.6.1 Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.6.2 ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.6.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

7.6.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.6.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.6.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks;

7.6.7 any other commercial interest in the decision before the meeting.

7.7 Any travelling or other expenses or allowances payable to a Director in accordance with the Constitution shall not be treated as a pecuniary interest.

7.8 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.9 A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.9.1 they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, or which has a direct pecuniary interest in the other matter under consideration; or

7.9.2 they are a partner of or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

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

7.10.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.10.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.11. Where a Director:

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

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

7.11.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.12 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of the Constitution and the SOs to be also an interest of the other.

7.13. If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more

important in assessing the relevance of an interest. The interests of partners in professional partnerships should also be considered.

7.14. Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.15. SO 7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a Director).

7.16 Register of Interests

7.16.1 The Register of Interests shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.16.2 It is the obligation of the Director to inform the Company Secretary in writing within seven Clear Days of becoming aware of the existence of a relevant or material interest. The Secretary must amend the appropriate Register of Interests upon receipt of new or amended information as soon as is practical and, in any event, within fourteen Clear Days.

7.16.3 The Register of Interests will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register of Interests to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register of Interests must be provided to Members free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests

7.16.4 The details of Directors' interests recorded in the Register of Interests will be kept up to date by means of a regular review as necessary of the Register of Interests by the Company Secretary during which any changes of interests recently declared will be incorporated.

8. Standards of Business Conduct Policy

8.1 Policy

8.1.1 Directors and Officers should comply with the Code of Governance for NHS Provider Trusts, the Trust Code of Conduct and any guidance and/or best practice advice issued by the Regulator. This section of SOs should be read in conjunction with these documents.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of Director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Secretary of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Director or officer must also declare to the Chief Executive or Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the Register of Directors interests.

8.3. Canvassing of, and Recommendations by**,** Directors in Relation to Appointments

8.3.1 Canvassing of Directors or members of any committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

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

8.4. Relatives of Directors or Officers

8.4.1 Candidates for any staff appointment shall when making an application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The Directors and every member and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that member or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 8 shall apply.

8.5. External Consultants

8.5.1 SO 7 and SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Trust's Scheme of Delegation should be adhered to at all times.

9. Custody of Seal and Sealing of Documents

9.1 Custody of Seal

9.1.1 The common seal of the Trust shall be kept by the Company Secretary in a safe at Trust Headquarters. The seal shall only be released from the safe to enable it to be affixed to a document in accordance with these Standing Orders.

9.2 Sealing of Documents

9.2.1 The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

9.2.2 Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of two Directors or a Director and the Secretary duly authorised by the Chief Executive and not also from the originating department and shall be attested by them.

9.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an Officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an Officer nominated by him/her who shall not be within the originating Directorate).

9.3 Register of Sealing

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

9.3.2 Every contract for building and engineering works, which exceeds the sum of £250,000 shall be executed under the common seal of the Trust.

9.3.3 The Officer responsible for the register of the opening of tender/quotation envelopes shall retain this under secure custody and will make it readily available to external and internal audit for inspection as required.

9.3.4 Trust officers issuing and receiving the tender/quotation documents shall retain those documents and envelopes under secure custody, for the following periods:

i) for documents under seal, 12 years; and

ii) for documents under hand, 6 years.

10. Signature of Documents

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

10.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been

approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11. Miscellaneous

11.1 Standing Orders to be given to Members and Officers

11.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to Officers designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies, where appropriate, of SOs.

11.2 Documents having the standing of Standing Orders Standing Financial Instructions and the Scheme of Delegation shall have the effect as if incorporated into SOs.

11.3 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

ANNEX 9 –ANNUAL MEMBERS' MEETING

1. ANNUAL MEMBERS' MEETING

1.1 The Trust shall publicise and hold an annual meeting of its members ('Annual Members' Meeting') prior to 30 September each year (unless the circumstances of para 16.5 apply).

1.2 The following documents are to be presented to the members and governors of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

1.2.1 the annual accounts;

1.2.2 any report of the External auditor on them; and

1.2.3 the annual report.

1.3 There may be times and reasons that the Annual Members' Meeting may be held "virtually online" and not face to face. The Chair will decide these times in consultation with the Lead Governor and Board of Directors.

2. ADMISSION OF THE PUBLIC AND PRESS

4.3 Members, the public and representatives of the press shall be afforded facilities to attend the Annual Members' Meeting.

4.4 The Chair (or Deputy Chair) shall give such directions as s/he thinks fit in regard to the arrangements for meetings and accommodation of members, the public and representatives of the press such as to ensure that business shall be conducted without interruption and disruption.

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

5. CHAIR

5.1 The Chair, if present, shall preside at the annual members meeting. If the Chair is absent from the meeting the Deputy Chair shall preside.

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

6. NOTICE OF MEETING

6.1 The Company Secretary shall give at least fourteen days' notice of the date and place of the Annual Members' Meeting to all Governors. Notice will also be published in communications to Trust members and on the Trust's website.

6.2 The notice of the meeting will specify the business proposed to be transacted at it

6.3 Lack of service of the notice on any Governor shall not affect the validity of a meeting.

6.4 Before the Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, shall be placed on the Trust's website and shall be delivered to every Governor by e-mail or sent by post to the usual place of residence of such Governor if e-mail facility not available, so as to be available to him/her at least three clear days before the meeting.

Where the AMM is held virtually, members will have opportunities to ask questions on the business transacted before and after the meeting presentations by submitting directly to the AMM website and/or via the Trust Board Office.

7. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS

7.1 The following documents are to be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

7.1.1 the annual accounts;

7.1.2 any report of the auditor on them; and

7.1.3 the annual report.

8. AMENDMENT OF THE CONSTITUTION

8.1 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

8.1.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment(s), and

8.1.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

8.2 If more than half of the members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

9. QUORUM

9.1 There may be times and reasons why the AMM is held "virtually online" and not in person. The Chair will decide these times in consultation with the Lead Governor and quoracy arrangements dependant on the nature of the business transacted.

9.2 In extremis (*see para 16.5*), the Chair may decide to review the terms of the meeting.

9.3 Where the Annual Members' Meeting is combined with a Council of Governors meeting for the purpose of receiving the annual accounts and reports, the quorum of the Council of Governors shall apply.

10. VOTING

10.1 Every question for decision at a meeting will be determined by a majority of the votes of the members present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote.

10.2 As members, governors may vote at the Annual Members' Meeting except where the matter under consideration is a Constitution amendment regarding the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

10.3 With the exception of the Chair, Directors may not vote at the Annual Members' Meeting.

10.4 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands.

10.5 If a majority of the members present so request, the voting on any question may be recorded to show how each member present voted or abstained.

10.6 If a member so requests, his/her vote shall be recorded by name upon any vote

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

11. MINUTES

11.1 The names of Governors, Directors and Members present at the meeting shall be recorded. However, if meeting is held virtually then monitoring of "virtual views" will be performed by a member of the Communications team and information given to both Chair and Company Secretary.

11.2 The Minutes of the proceedings of a meeting shall be drawn up and maintained as a public record and submitted for final agreement at the next ensuing meeting where they will be signed by the person presiding at it.

11.3 They may be circulated for information prior to the next year's meeting and interim agreement of accuracy acknowledged by the Council of Governors (CoG) .

11.4 Minutes shall be made available to the public in draft (interim CoG accuracy approved) format and then once finally approved at the next AMM, unless AMM was held virtually where agreement of accuracy will be acknowledged by the Council of Governors.

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

12. AGENDA

12.1 A governor or member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear days before the meeting is notified to Governors and members. Requests made less than ten days before a meeting is notified to Governors may be included on the agenda at the discretion of the Chair.

13. MOTIONS

13.1 A Governor or member of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting is notified to Governors to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being

permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved without notice during the meeting, on any business mentioned on the agenda.

13.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

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

13.4 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or member to move:

(i) An amendment to the motion.

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

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

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

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

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

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

14. CHAIR'S RULING

14.1 Statements of Governors and members shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2509 - D8 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 12:40

5 Minutes

REFERENCES

Only PDFs are attached

D8 - Chair's Assurance Log - Finance & Performance Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Finance and Performance Committee - Chair's Highlight Report to Trust Board

Subject:	Finance and Performance Committee	**Board Date: September 2025**
Prepared By:	Mark Bailey, Committee Chair & Non-Executive Director	
Approved By:	Committee Members	
Presented By:	Mark Bailey, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the **key highlights** from the Finance and Performance Committee meeting held on 14 August 2025	

Matters of Concern/Escalation Items (with Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
Financial Performance – Month 3 Year to date deficit £2.1m in line with plan. Above plan levels of new outpatient, elective and day case activity continued with all points of delivery including follow-up outpatients cumulatively above plan year to date. Efficiency / cost improvement commitment met; it has required the use of non-recurrent reserves earlier than planned albeit a lower level than in the previous month. Net financial risk reduction with progress on efficiency schemes and contract agreement with commissioners on income. Favourable cash due to capital creditors. Capital expenditure behind plan, business cases being developed to ensure no slippage at year-end. Note: Cashflow forecasts do not include risk in late quarter 3 / 4 from loss of deficit support funding per advice of SYICB. Trust maintaining close scrutiny of position.	**Efficiency /cost improvement 2025/6** Future F&P assurance will look for evidence of sustaining and momentum through specific examples of ownership and cost releasing delivery within divisional structures alongside cross cutting 'corporate changes'. **Winter Plan 2025/6** Stress testing through regional exercises of the winter plans for 2025/6 against the expectations of the NHSE / DHSC urgent and emergency care plan published in June 2025. Board assurance statements required by end September. **Board Assurance Framework (BAF) – Strategic Risk 4: Care Environment** F&P recognise that there are several high risk elements against Risk 4 and specifically the DRI estate. It is assured that these continue to be well managed, and this is supported with external assurance. However, the risk level has remained high for an extended period (more than 12 months). Risk reduction is dependent on transformative estate investment schemes most pressing being alternative DRI east-block capacity. It is recognised that securing this investment is an agreed priority for the DBTH Board.
Significant or Full Assurances to Provide	**Decisions Made**
DBTHi & NHSE Efficiency deep dive: Transformative approach to delivery of recurrent change with emphasis on engagement and contribution from all areas with the launch of the DBTHi and the "Bright Ideas Clinic". Governance (including F&P assurance oversight) and performance reviews in operation with evidence of senior executive challenge and delivery with sharpening of prioritisation both in year and desire to extend to multi-year using benchmarking and data. Note: Future F&P assurance will look for evidence of sustaining and momentum through specific examples of ownership and delivery within divisions alongside 'corporate projects'.	**Winter Plan 2025/26 -** approval of schemes to increase in-patient capacity, ambulance handover capacity, maintain patient flow, support infection prevention and control and increase senior decision making in ED overnight. **Procurement Enabling Plan 2025-28** - Trust priorities and approach for achieving best value for money from procurement and supply chain activities. Confirming adherence to national procurement guidance and standards.

Operational Performance - June 2025

Performance at or close to required level of improvement commitment in 5 of 8 areas:

Emergency care (4 hour ahead / 12 hours on plan)/ average ambulance handover time ahead). Elective care is slightly behind trajectory for patients waiting longer than 52 weeks and Trust falls into Tier2. Elective Improvement Support Team engaged on demand v capacity planning. Cancer – faster diagnosis review of escalation process between cancer services and divisional teams but ahead of trajectory. Diagnostics waiting times impacted by known issues in audiology which are being addressed.

Note: F&P review and assurance level agreed ex-committee and is based on planning clarity and statistically sound progress against trajectory with improvement actions being identified or in the process of 'bedding in'.

Digital & Data Quality: Comprehensive cover of progress on digital projects and priority based timescale changes to data quality kitemark completion. Noting a business continuity investigation and escalation arising from introduction of a radiology information system.

Date Security Protection Toolkit (DSPT): DSPT annual submission against the National Cyber Security Assessment Framework fully met and received significant assurance from 360 Assurance internal audit.

Green Plan – approval to submit to Board a refreshed roadmap to deliver sustainable healthcare services for 2025-28. Builds from approved 2022 'green plan' for NHS net zero by 2045.

Treasury Management Policy - update to reflect changes in local counter fraud specialist.

Board Assurance Framework (BAF)

Assurance ratings confirmed and agreed for the key risks with action planning to address gaps in control for BAF Risk 4: Care environment and Risk 5: Financials (ex-committee).

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.
External - Third Line of Defence	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2509 - D9 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 12:45

5 Minutes

REFERENCES

Only PDFs are attached

D9 - Chair's Assurance Log - Quality Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Committee Meeting - Chair's Highlight Report to Trust Board

Subject:	Quality Committee meeting	**Board Date:** 2 September 2025
Prepared By:	Jo Gander, Non-executive Director & Quality Committee Chair	
Approved By:	Quality Committee Members	
Presented By:	Jo Gander, Non-executive Director & Quality Committee Chair	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 7 August 2025	

Matters of Concern (Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
• Learning from Deaths and Structured Judgement reviews, due to ongoing challenges in relation to medical SJR recruitment **Partial Assurance**	• Quality Committee workplan under review and in process of being updated • CNST Training requirement delivery being closely monitored but remains challenging • Work on improvements to the Audiology Service continues • Medicines Management Internal Audit report update received confirming ongoing process in place for avoidance of medicines wastage. Outcomes submitted to 360 Assurance to close action. • Audiology update received although SME visit on 30 June delayed. EMD now taken over leadership of work from Deputy Chief Executive • Clarity on responsibilities for reporting following updates to Fuller report in progress to be added to workplan once confirmed by SY Pathology Board • Risk Management Group leadership confirmed as transferred to Deputy Chief Executive
Significant or Full Assurances to Provide	**Decisions Made**
• Maternity & Neonatal Safety Report **Significant Assurance** • Safeguarding Annual Report approved - report received by the Board for information in accordance with the Safeguarding Accountability & Assurance Framework. **Significant Assurance** • CQC action plan now complete **Significant Assurance** • Patient Safety Report **Significant Assurance** • Care Quality Commission & Young People Survey 2024 **Significant Assurance** • Patient Experience Annual Report approved – report received by the Board for information. **Significant Assurance** • Clinical Audit Progress Report (including NICE compliance & National Clinical Audit alerts **Significant Assurance** • Mortality Surveillance Systems and Process Compliance, acknowledged the work of Chris Hill and coding department in progress made **Significant Assurance**	• Mental Health Act Compliance progress noted • QC as a committee of the Trust Board took assurance from the detail provided within the Maternity & Neonatal Safety & Quality report and recorded in the Committee minutes to provide evidence for the Maternity Incentive Scheme the following : - Reviewed and approved on behalf of the Trust Board SLBs Q4 - Reviewed and approved on behalf of the Trust Board Atain Q1 - Reviewed and approved on behalf of the Trust Board Transitional Care Year 7 action plan and progress from MIS year 6 - Reviewed and approved on behalf of the Trust Board the Trust Quality metrics - Noted on behalf of the Trust Board the number of Maternity and Newborn Safety investigation (MNSI/Early notification scheme (ENS) cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place • Noted that Board Safety Champions are meeting with the perinatal leadership team

• Infection Prevention and Control Annual Report approved – report received by the Board in accordance with the Health & Social Care Act 2008 IPC Code of Practice **Significant Assurance** • Care Accreditation Recognition for Excellence (CARE) update **Significant Assurance** • Board Assurance Framework Risk 1,including Trust Risk Register **Significant Assurance**	bi monthly and any support required of the Trust Board has been identified and is being implemented • Noted that progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the Board Safety Champion meetings, and the maternity and neonatal safety Quality Committee and any identified support being considered and implemented. • Information received from Finance & Performance Committee regarding positive progress made on sharps bin (needle stick) incidents following concerns raised at previous ARC **Significant Assurance** • Change in the QC TOR page 3 of 6 section 4.3.3 Maternity safety to Maternity Neonatal Safety & Quality agreed to recommend to the Board of Directors for approval

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.
External - Third Line of Defence	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2509 - D10 QUALITY COMMITTEE TERMS OF REFERENCE

Decision Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

5 minutes

REFERENCES

Only PDFs are attached

D10 - Quality Committee Terms of Reference.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	2 September 2025
Report Title/ Ref:	**Quality Committee Terms of Reference**			
Executive Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance			
Appendices:	Appendix 1: ToR Quality Committee 2025_August			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**All BAF risks**: The Terms of Reference for the committees explicitly state a requirement for the monitoring of strategic risks			

Executive Summary – Key messages and Issues

As part of annual governance arrangements, the Terms of Reference (ToR) for all committees are reviewed at committee level and amended as required. As part of the in-year review the Quality Committee have reviewed the wording on a section of the Terms of Reference that relate to maternity.

The requested change to the wording is given below:
Clause 4.3.3, page 3

'Maternity safety' to change to '***Maternity Neonatal Safety & Quality'***

This is consistent with the requirements of the Clinical Negligence Scheme for Trusts (CNST).

Recommendations

The Board of Directors is asked to:

- Approve the in-year changes to the Quality Committee Terms of Reference

Healthier together – delivering exceptional care for all	
Patients	These documents support the Board to be assured around the delivery of safe and effective patient care
People	These documents support the Board to be assured about delivery of the people aspects of the strategy, and to know the appropriate appointment and remunerations principles are followed
Partnerships	These documents support the Board to be assured around the partnership and collaboration activities taking place across the Trust and system
Pounds	These documents support the Board to be assured around the financial position, control and management of the Trust finances
Health Inequalities	These documents have no positive or negative impact on health inequalities
Legal/ Regulation:	It is a regulatory and legal requirement to have these ToR in place and reviewed on a regular basis
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies

Assurance Route	
Previously considered by - including date:	Reviewed at Quality Committee August 2025
Any outcomes/next steps / time scales	If approved – to be signed by the Trust Chair

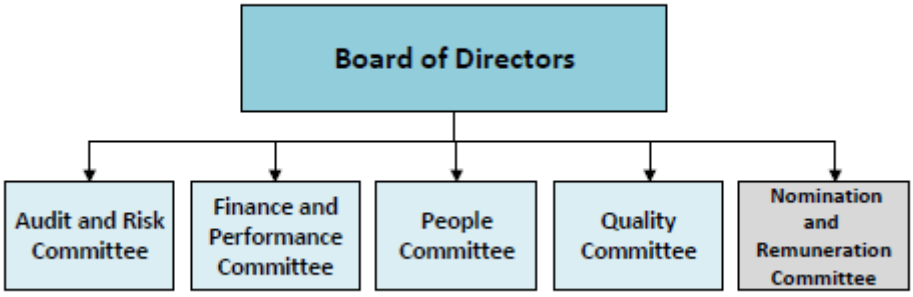
In line with Current risk appetite **YES**	**Risk Appetite levels: - highlight if this report is outside of Board Assessment**

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Appendix 1: Quality Committee Terms of Reference August 2025

Quality Committee

Terms of Reference



1. Constitution

The Quality Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.

2.3 The Committee is authorised by the Board of Directors to create sub-committee or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.

2.4 In carrying out its role the Committee is authorised to seek reports and assurance form executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.

2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.

2.6 Committee members and attendees will be expected to conduct business in line with the Trust values, objectives, constitution and supporting governance policies and demonstrably consider the equality and diversity implications of decisions they make.

3. Purpose

The committee is established to:

3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes, and controls to ensure that the legislative requirements within these terms of reference that

ensure the safety, rights and quality of service delivery is maintained to all service users, carers, staff, and the public.

3.2 Provide direction on behalf of the Board of Directors regarding the delivery of the Trust's quality improvement priorities and strategic objectives in respect of quality.

3.3 Provide assurance to the Board of Directors that appropriate and effective governance systems are in place for all aspects of quality including patient experience, health outcomes and compliance with national, regional and local requirements, where these are provided directly or commissioned by DBTH.

3.4 Give consideration to the wider impacts of Trust decision making as part of the Integrated Care System.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to set annual objectives and a forward plan that enables it to delivery its responsibilities and to review and update any strategic risks and mitigating actions in line with the Board Assurance Framework. To provide the Board of Directors with assurance, information on key issues and clear decision points in respect to each of the following:

4.1 Annual Quality Strategy, Plan and Reports

4.1.1 To scrutinise the strategic content and direction of any Annual Quality Report, Priorities and Plan, the Trust determines locally, engaging with the Council of Governors, on behalf of the Board of Directors prior to publishing.

4.1.2 To scrutinise Quality Performance Impact Assessments and Equality Impact Assessment of any Cost Improvement Plans or transformational change programme, that may impact the quality-of-service delivery in accordance with the Trust's QPIA Policy CORP/COMM 28.

4.1.3 To scrutinise the review of any identified Integrated Care System or national developments that may impact on the Trust in respect of service quality and patient risk.

4.1.4 To review progress on the Maternity and Neonatal 3 Year strategy.

4.2 Legislative and Statutory Compliance

4.2.1 To gain assurance on Mental Health Act (MHA) via an annual report, and by exception reporting when required, that demonstrate the Mental Health Act is appropriately applied and compliant with legislative requirements, plus any actions to improve compliance where identified.

4.2.2 To have oversight and report to the Board of Directors as the Non-Executive Director (NED) lead role for safeguarding and gain assurance from all evidence presented to the committee that the Trust is compliant with all its regulatory duties. Evidencing associated actions to improve compliance including Mental Capacity Act and Deprivation of Liberty.

4.3 Regulatory Assurance

4.3.1 To scrutinise and enable a discursive forum to review Care Quality Commission (CQC) compliance reports, notices or licence requirements and ensure that actions are taken to address all issues identified in CQC compliance reports.

4.3.2 To gain assurance from triangulation of information, including internal audit as appropriate, that progress on the actions identified in CQC compliance reports are embedded into clinical practice. This will be received through existing reports that will reference relevant regulatory requirements.

4.3.3 To carry out the assurance duties of the Board champion requirements, via triangulated data, receiving reports across all areas and specifically where required in respect to:

- Maternity Neonatal Safety and Quality
- Hip Fracture, Falls and Dementia
- Learning from Deaths
- Children and Young People
- Resuscitation
- Safeguarding
- Palliative and End of Life Care

For the avoidance of doubt these are **not** all individual named leads.

4.3.4 To scrutinise and recommend for the Board of Directors the Clinical Negligence Scheme for Trusts, (CNST) Maternity Incentive Scheme declaration and compliance against the standards.

4.4 Patient Safety, Experience and outcomes

4.4.1 To gain assurance via reports to each committee, and where necessary deep dive reports, that the Trust has in place legislatively compliant systems and controls that ensure patient incidents, complaints, duty of candour, compliments and claims are effectively monitored to ensure high quality care is delivered and to enable lessons learnt and ensure actions are progressed.

4.4.2 To review the annual clinical audit programme and recommend its approval to the Board of Directors, and monitor its delivery via clinical audit reports at each meeting.

4.4.3 To gain assurance on the implementation of internal audit recommendations that directly affect clinical standards and quality of services, via progress and monitoring reports at each committee on any outstanding internal audit actions.

4.4.4 To consider the results, issues raised and trends on the quality of the patient environment, through an annual report and where necessary exception reports, on the Patient Led Assessments of the Care Environment (PLACE).

4.4.5 To receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

4.4.6 To consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern via an annual report.

4.4.7 To gain assurance via six-monthly and exception and highlight reports, as required, that the Trust is legislatively compliant and is implementing guidance and best practice in respect of its mortality surveillance systems and learning-from-deaths processes.

4.5 Medicines Optimisation and Medical Devices

4.5.1 To gain assurance the Trust has in place processes and controls that ensure medicines are effectively managed and compliant with legislative requirements.

4.5.2 To gain assurance the Trust has in place processes and controls that ensure medical devices are effectively managed and compliant with legislative requirements.

4.6 Infection Prevention and Control

4.6.1 To gain assurance via a six-monthly and annual report that the Trust has in place Infection Prevention and Control systems and controls to ensure this is effectively managed and compliant with all legislative requirements.

4.6.2 To approve the annual Infection Prevention and Control plan.

4.6.3 To scrutinise and recommend to the Board of the Directors the Annual Infection Control Statement.

5. MEMBERSHIP

5.1 The membership of the Committee will comprise of executives and Non-executive directors only:

- Three Non-executive Directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
- Chief Nurse
- Medical Director

5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-Executive Director to chair the meeting.

6. ATTENDANCE

6.1 The Chief Executive Officer and The Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.

6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an Executive Director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.

6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.

6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

6.6 Others who may be invited to attend the meeting include:

- Director of Midwifery
- Director of Allied Health Professionals
- Associate Medical Director, Clinical Safety
- Clinical Governance and Professional Standards Co-Ordinator
- Trust Secretary / Deputy Trust Secretary

7. FREQUENCY OF MEETING

7.1 The Committee will meet bi-monthly and a minimum of five times per year with additional ad hoc meetings as required.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.

7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two Non-Executive Directors

9. REPORTING

9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

9.2 The Committee shall scrutinise and recommend to the Board of Directors the quality section of the Board Assurance Framework.

9.3 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

9.4 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved
(Chair of the Board of Directors)

2509 - D9 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 12:55

5 minutes

REFERENCES

Only PDFs are attached

D11 - Chair's Assurance Log - Audit & Risk Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Audit and Risk Committee (ARC) - Chair's Highlight Report to Trust Board

Subject:	Audit & Risk Committee	**Board Date: September 2025**
Prepared By:	Kath Smart, Non-executive Director & Committee Chair	
Approved By:	Audit & Risk Committee Members	
Presented By:	Kath Smart, Non-executive Director & Committee Chair	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 24 July 2025	

Matters of Concern (with moderate, partial, limited or no assurance)	**Work Underway / Major Actions Commissioned**
a) Moderate/ Partial Assurance reports i. Emergency Planning: Annual Review of EPRR 24/25 – The management review of EPRR provided a look back at 24/25 against the workplan, NHS Core Standards compliance, key achievements and challenges. The Trust statement of compliance showed 34/62 standards as "fully compliant" and 28/62 as "partially compliant", which results in a 55% compliance rate and this falls into NHSE category of non-compliant. Plans are underway to improve this and work to achieve the next category. All Audit actions relating to Business continuity were noted as now being achieved. ii. Cyber Security – Bi-annual review – This management review demonstrated there has been continual improvements in the arrangements for Cyber Security (*noting this is also in the IA plan for 25/26) & provided an update on the progress with the Trusts Cyber Action Plan. Notwithstanding the effort going into cyber protection, ARC agreed a Partial assurance rating to reflect the continuing evolving and dynamic threat, especially given national high profile cyber attacks. b) <u>Key risks to escalate</u> None	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery

Significant Assurances to Provide	Decisions Made
a) **Counter Fraud arrangements and progress 24/25 and Q1 25/26 – Significant assurance** was given to the arrangements in place to prevent, detect, investigate fraud. The Trust is meeting the required published standards of the NHSCFA. **b) Internal Audit :-** i. Audit Recommendations closure rate for high & medium risks -100% (timeliness for high & mediums risks) – Significant Assurance & evidence of continual improvement & good risk mitigation; ii. Fit and Proper Person Test Audit (FPPT) – Significant Assurance – This was a review of the Trusts governance of meeting requirements for the FPPT requirements for Board level appointments. Three low risk findings have been agreed & confirmed as implemented following the audit work conclusion. iii. Equality Diversity and Inclusion – Significant Assurance – This audit was to provide assurance on the progress against the Trusts Equality, Diversity and Inclusion action plan, including the high impact actions determined by NHSE. One low risk finding have been agreed with management iv. Data Security and Protection Toolkit (DSPT) – High Confidence/ Low risk – This outcome terminology is determined by NHSE, and slightly different to our Trusts. However, as there was positive validation of the areas under review, and the auditors' assessment was "Green", then ARC noted the high confidence/ low risk outcome as significant assurance. c) **External Audit – ISA 260** – This report had already been reviewed at Trust Board, and was brought to ARC for completeness. It confirmed the financial statements give a true and fair view of the financial position of the Trust, were properly prepared in accordance with the Group Accounting Manual & the National Health Service Act. There were control issues raised with ARC will follow up on, and one uncorrected misstatement as recorded in the report and the Letters of Representation. d) **Bank and Agency controls follow up** – Significant Assurance – Management have reviewed the recommendations from the last two audits on Bank and Agency controls. Is it confirmed they have all been implemented. This is a key part of the Trust being able to monitor and manage its bank and agency effectively. Work is carrying on via People Committee and F&P to drive reductions in agency staff, and it was noted that the controls in Nursing bank/ agency were more mature than in medical, and work was ongoing to improve this. e) **Risk Management & BAF – Significant Assurance -** ARC reviewed the year-end report, the routine risk report and the current BAF, and was bearing in mind comments from our auditors. It was agreed the systems in place were much strengthened from earlier in 2024, and this needed to be maintained.	a) ARC reviewed and APPROVED the Risk Management Policy, subject to minor amendments suggested and agreed at the Committee to clarify the frequency of the Risk register and BAF being brought to Committees and Board.

2509 - E INFORMATION

13:00

2509 - E1 2024/25 INFECTION, PREVENTION & CONTROL ANNUAL REPORT

Information Item | Karen Jessop, Chief Nurse | 13:00

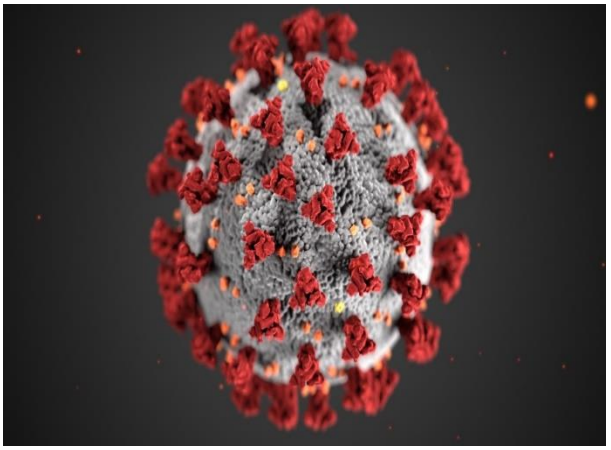
REFERENCES

Only PDFs are attached

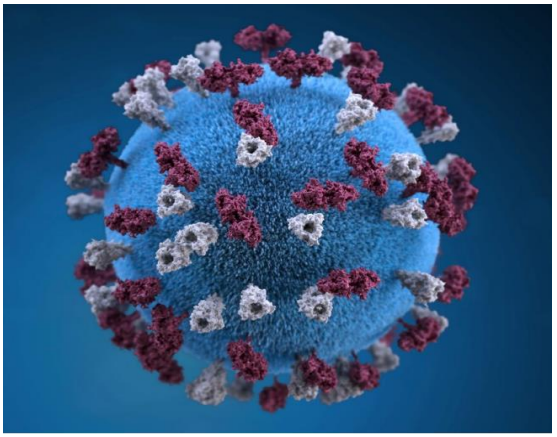
E1 - 2024-25 IPC Annual Report.pdf

NHS

Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust



Measles virus (CDC)



Sars-Cov 2 (WHO)

Dr Ken Agwuh - Director of Infection Prevention and Control.
Miriam Boyack – Lead Nurse Infection Prevention and Control.

DBTH Infection Prevention and Control Team

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This report outlines a summary of the key infection prevention and control initiatives and activities in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) during the year April 2024 to March 2025. Delivering the values – We Care, some of our achievements in the last twelve months, include:

We always put the patient first.

- We continue to support the COVID and Flu vaccination for Healthcare workers in the Trust.
- We continue to support the use of point of care testing (in addition to confirmatory PCR tests) for diagnosis of COVID-19 and Influenza for all patients admitted with respiratory symptoms and for all patients if they developed respiratory symptoms during their admission.
- We provided 8439 POCT tests for COVID, and 6562 POCT for Flu A/B in 2024/25

Everyone Counts – we treated each other with courtesy, honesty, respect and dignity.

- Our Escherichia coli bloodstream infections increased by 3.1% in 2024/25 compared with figures in 2023/24 (96 cases). We reported 99 cases, which was our E coli bloodstream infection threshold for Healthcare associated *E coli* bloodstream infection.

Committed to quality and continuously improving patient experience.

- We achieved our *Clostridioides difficile* trajectory by reporting 68(1.5%) reduction against a threshold of 69 cases. There was no evidence of cross-infection despite the prevalence of a number of ribotypes.
- We achieved 360 days of zero MRSA bloodstream infection towards the end of the financial year. We are committed to exceeding this achievement in 2025/26.
- Trust continues to participate in Infection in Critical Care Quality Improvement – Blood Stream Infection (ICCQIP-BSI) surveillance.
- The Infection Prevention and Control Team have commenced Surgical Site Infection Surveillance in other surgical specialties including Breast surgery, vascular surgery and gastro-intestinal surgery.

Always caring and compassionate.

- We continued promoting hand hygiene compliance of greater than 97%.
- Achieving improved ward environmental cleanliness scores of >97% in all patient care areas.
- The Trust participates yearly in the Point Prevalence Surveillance (PPS). The Trust HCAI rate, which fell to 3.2% in 2023, has now risen to 4.6 in 2024 but this remains below the National average of 8.0% (2023) for all Acute NHS Trusts.

Responsible and accountable for our actions – taking pride in our work.

- We missed our target to maintain our blood culture contamination rate of <3% as recommended by Department of Health. The Trust average was 4.1% down from 4.5% in 2023/24, a challenge we are working to improve.
- We continue to update our Trust antimicrobial guidelines based on NICE clinical guidelines, to effectively manage sepsis/infections, encourage antimicrobial stewardship (AMS) and reduce antimicrobial resistance (AMR)
- Better compliance with Water Quality for *Legionella spp* and *Pseudomonas aeruginosa* monitoring Trust-wide.

Encouraging, valuing our diverse staff, and rewarding ability.

- Continued development of IPC teaching packages for all staff within Trust.
- Maintain regular Infection Prevention communication during the COVID pandemic & other learning resources.
- We continue to work with the UKHSA and the Doncaster and Bassetlaw Places to manage effectively, the ongoing measles cases presenting to the Trust.

Challenges:

Continued promotion of good Infection Prevention and Control practices within the context of the resolving pandemic and living with COVID.

- The NHS Standard Contract for 2025/26 is yet to be released officially but we are working with our trajectory figures for 2024/25 to further reduce our Trust *Clostridioides difficile* and Gram-negative bloodstream infections. This further brings the challenge of improving on our performance from previous years.
- Working to reduce the incidence of nosocomial COVID and other respiratory viruses within the Trust. Attributed to the poor ventilation within our Trust old wards.
- Work with our health economy partners to reduce the incidence of Gram-negative bloodstream infections.
- Maintaining MRSA bacteraemia against a zero case threshold and working with our UKHSA and CCG colleagues to investigate a growing prevalence of PVL MRSA infection/colonisation amongst intravenous Drug users within the health economy.
- Reducing the Trust acquired MRSA colonisation rate from last year.
- Improve teaching and training on blood cultures no touch technique to reduce our contamination rate to <3%
- Managing effectively the dental chairs water quality located at Mexborough Hospital.
- Managing the measles outbreak which is currently having significant impact in IPC within the region.

Introduction

The purpose of this report is to inform patients, members of the public, staff, the Trust Board of Directors, Council of Governors and South Yorkshire Integrated Care Board (Doncaster Place-Based partnership) and Nottingham & Nottinghamshire Integrated Care System (Bassetlaw Place – Based partnership), of the infection prevention and control work undertaken in 2024-25 and to provide assurance that the trust remains compliant with the Health and Social Care Act 2008 – Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance which sets out the criteria against which a registered provider demonstrates compliance with requirements relating to cleanliness and infection prevention and control.

This report is a record of activities relating to prevention and control of healthcare associated infection (HCAI) in Doncaster & Bassetlaw Teaching Hospitals NHS Trust (DBTH) during the year April 2024 to March 2025. The control of healthcare associated infection remains a top priority for the public, patients and staff; and remains one of the Trusts strategic objectives. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources, and affect antimicrobial resistance. Investment in infection prevention and control remains both necessary and cost effective in the long term.

1. Purpose

The Trust has a statutory responsibility to be compliant with The Health and Social Care Act 2008 (DH, 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). This report details the Infection Prevention and Control Team (IPCT) activity from April 2024 to March 2025. Performance targets/thresholds generally set for the year were taken from the NHS Standard Contract 2024/25: Minimising *Clostridiodes difficile* and Gram-negative bloodstream infections (version 2) published in June 2024 by NHS England.

Key Points:

- The Trust considers itself to be compliant with The Health and Social Care Act 2008 (DH, 2015) and the team continue to monitor this through the Infection Control governance processes.
- There was one Trust-apportioned methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases reported against the national zero tolerance.
- There were 47 HOHA and 21 COHA *Clostridium difficile* toxin (CDT) cases reported in total this year against a threshold of 69 cases.
- There were 41 HOHA and 18 COHA Trust-apportioned methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia. An increase by 9 cases compared to 2023/24 cases (59 cases in total for year 2023-2024)
- The Trust reported 99 *Escherichia coli* (*E. coli)* bacteraemia cases in total against a threshold of 99 cases. Of cases reported, 52 were HOHA and 47 cases of COHA. We increased our numbers by 3 cases when compared to submission in 2023/24.
- We reported between 1st April 2024 to 31st March 2025, 629 cases of confirmed COVID-19
- We reported between 1st April 2024 to 31st March 2025, 428 cases of influenza A, 87 cases of Influenza B admitted to hospital. We also reported 231 cases of confirmed Respiratory Syncytial Virus (RSV)
- There have been 3 confirmed Norovirus cases that has resulted in three Norovirus outbreaks involving 43 patients and 25 members of staff.
- We reported 42 Vancomycin-resistant Enterococci (VRE) cases this year (10 from clinical samples, 32 from screening samples.
- We reported zero cases of Mpox in the Trust in 2024/25
- There were 14 cases of carbapenemase-producing *Enterobacteriaceae* (CPE) in the Trust this year (3 from clinical samples and 10 from screen samples). We carried out 567 screens for CPE in 2024/25 compared with 1876 screens for CPE in 2023/24.
- We ensured all Trust antimicrobial policies are up to date
- Hand hygiene and bare below the elbow compliance has previously been audited on a monthly basis by the infection control link practitioners, Ward Managers and Matrons as well as the Infection Prevention and

Control Team. The Trust target for hand hygiene compliance remains at 97% (green). At the end of 2024/2025 we were reporting compliance at 97.58%.

- The Trust participates in the Surgical Site Infection Surveillance system (SSIs) for Trauma and Orthopaedic. We reported two cases of deep SSI involving the total knee revision (TKR), one each at Bassetlaw and Doncaster sites throughout 2024/25. One case of deep SSI for total hip revision (THR) was reported at Bassetlaw site and none at DRI site for 2024/25. There was no reported SSI for the Trust Mexborough site.

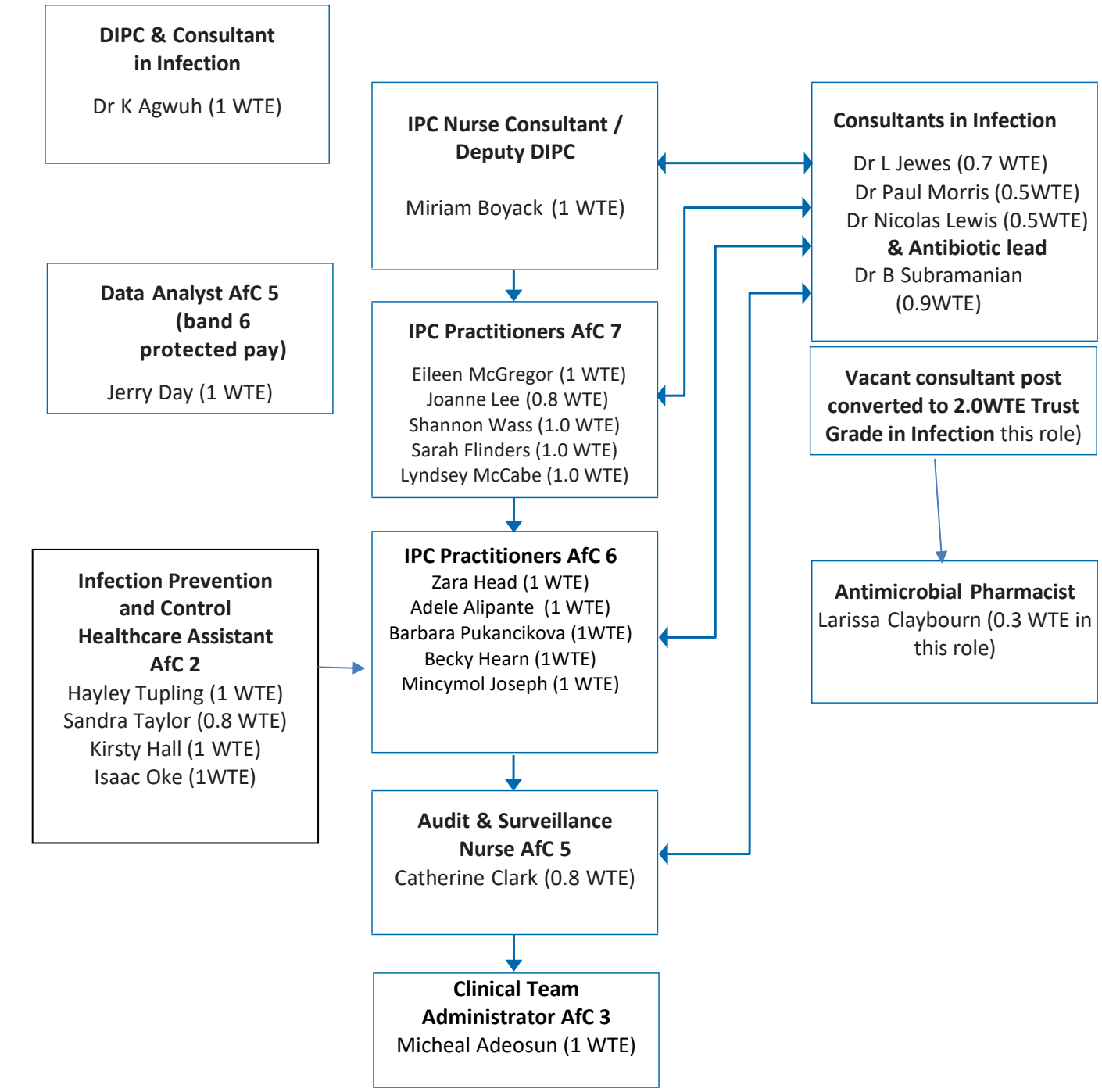
2. Infection Prevention & Control Arrangements

During 2022-2023, the proposed plan for a PLACE based Infection Prevention and Control Team was confirmed. With a collaborative approach to providing a service across organizational boundaries that would serve not only those patients in hospital, but wider members of the local population, funding was agreed and the Infection Prevention and Control Team was uplifted. This service has continued during 2024/2025:

IPC Team	WTE	
Band 8b	**1.0**	**Nurse Consultant & Deputy DIPC**
Band 8a	**1.0**	**Infection Prevention and Control Lead Nurse**
Band 7	**4.8**	**Infection Prevention and Control Practitioner**
Band 6	**5.0**	**Infection Prevention and Control Nurse Specialist**
Band 5	**0.8**	**Audit and Surveillance Nurse**
Band 6	**1.0**	**Data Analyst**
Band 3	**1.0**	**Infection Prevention and Control Administrative Assistant**
Band 2	**3.8**	**Infection Prevention and Control Assistant**
Microbiology Team		
Consultant in Infection Dr K Agwuh	**1.0**	**DIPC**
Consultant in Infection Dr L Jewes	**0.7**	
Consultant in Infection Dr B Subramanian	**0.9**	**Antimicrobial Lead**
Consultant in Infectious Disease & GIM/Infectious Diseases Dr P Morris	**0.5**	
Consultant in Infectious Disease & GIM/Infectious Diseases Dr N Lewis	**0.5**	
Trust grade doctors in Infection Dr A Abdulghani & Dr F Abraham	**2.0**	**Fixed term posts**

The Consultants in Infection work closely with the IPC nursing team to deliver the infection control service at DBTH. In addition to their work for the Trust, the Consultants in Infection provide specialist advice to Rotherham, Doncaster and South Humber Mental Health Trust (RDASH).

Infection Prevention & Control Team



INFECTION PREVENTION & CONTROL STRATEGIC STEERING GROUP MEETING ATTENDANCE 2024-2025

Title	Apr 18th	Jun 20th	Aug 15th	Oct 24th	Dec 12th	Feb 20th	% Attendance
Antimicrobial Pharmacist	✓	×	×	×	×	×	16.67%
Bassetlaw ICB	✓	✓	✓	✓	✓	✓	100%
CCDC UKHSA (Yorkshire and Humber)	✓	×	×	×	×	✓	33%
CCDC UKHSA (North Notts)	×	×	✓	×	×	✓	33%
Consultant In Infection (Antimicrobial Lead)	✓	✓	×	✓	✓	✓	83.33%
Director of Infection Prevention and Control	✓	×	✓	✓	✓	✓	83.33%
Chief Nurse (Executive Lead for IPC)/ Deputy Chief Nurse (Representing Executive team) / Quality and Governance	✓	✓	✓	✓	✓	✓	100%
Doncaster ICB	✓	×	×	✓	✓	✓	66%
Facilities Manager /Estates Manager	✓	✓	✓	✓	✓	✓	100%
Lead Nurse for Infection Prevention and Control	✓	✓	✓	✓	✓	✓	100%
Trust Decontamination Manager	✓	×	×	×	×	×	16.67%
Occupational Health	✓	×	×	×	×	✓	33%
Medical Division	✓	✓	×	✓	✓	✓	83.33%
Clinical Specialties Division	✓	✓	✓	×	✓	✓	83.33%
Surgery Division	✓	✓	✓	✓	✓	✓	100%
Children and Families Division	✓	✓	✓	✓	✓	✓	100%
Urgent and Emergency Care Division	✓	✓	✓	✓	✓	✓	100%

AP = apologies

The Infection Control Committee (CCM) now transformed into the Infection Prevention & Control Strategic Steering Group (IPCSSG) and the Trust Infection Control Operational Group (ICOG). The IPCSSG is held bimonthly and is responsible for ensuring appropriate implementation of national guidance and for monitoring of standards and that infection prevention and control policies are in place, regularly reviewed and compliance audited.

The IPCSSG membership includes representatives from the Health and Wellbeing, Consultants in Infection, Senior Infection Prevention and Control Practitioners, Senior Divisional Matrons and/or representatives, Pharmacist, ICB representatives, Estates and Facilities, Medical director or deputy, Deputy Chief Nurse and others co-opted as required. The ICOG on the other hand is the operational arm of infection control and the work streams are monitored through this committee. The ICOG meets runs every alternate month but odd months to the IPCSSG.

1. **There are systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.**

Surveillance of Healthcare Associated Infection

One of the main elements of Infection Prevention work stream is undertaking active surveillance. Surveillance is more than just recording or reporting of infections. Data is collected in accordance with strict definitions and protocols to ensure consistency. Some surveillance data are only reported internally and other data are reported externally either as part of mandatory or voluntary surveillance schemes. All mandatory surveillance has continued to take place with the addition of Breast Surgery, C-Section, Vascular and Gastrointestinal Surgery Surveillance.

However, the most important element of surveillance is feedback to clinicians. Feedback prompts review of, and where necessary, planned improvements to clinical practice.

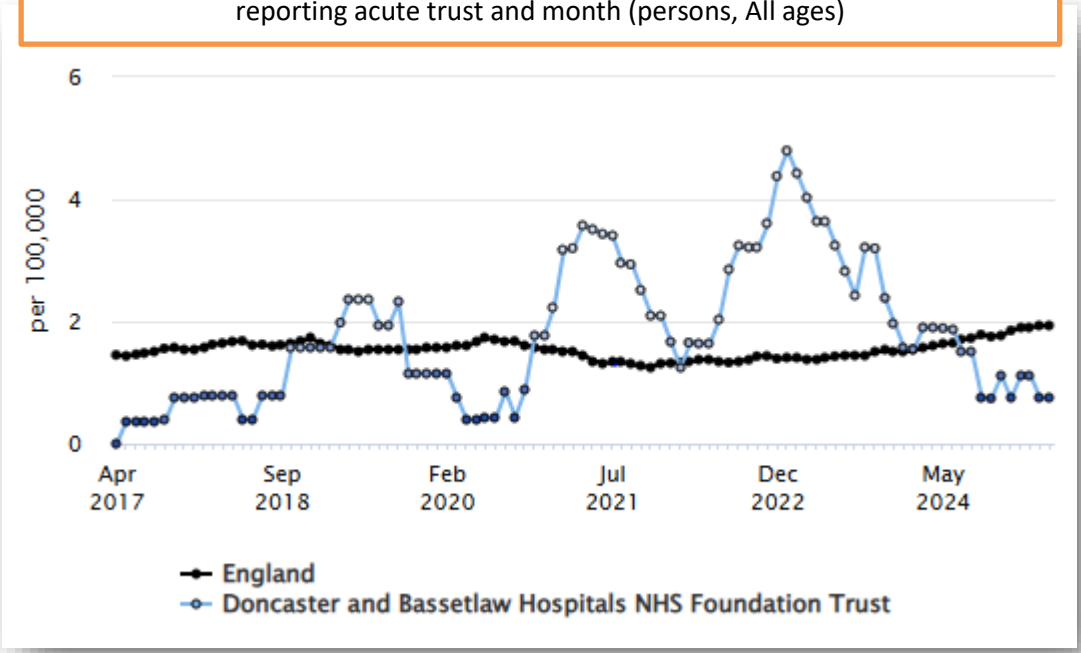
MRSA bacteraemia

Nationally, there remains a zero tolerance for preventable MRSA bacteraemia cases. As in previous years, every case of MRSA bacteraemia must undergo a rigorous Post Infection Review process to help identify any obvious root causes and to identify and learning.

In 2024/25 we recorded one case of Trust attributed MRSA Bloodstream infection in February 2025 more than a year from the last recorded case in February 2024. The Incident management review identified some learning, including lack of admission screen and multiple attempts at venepuncture.

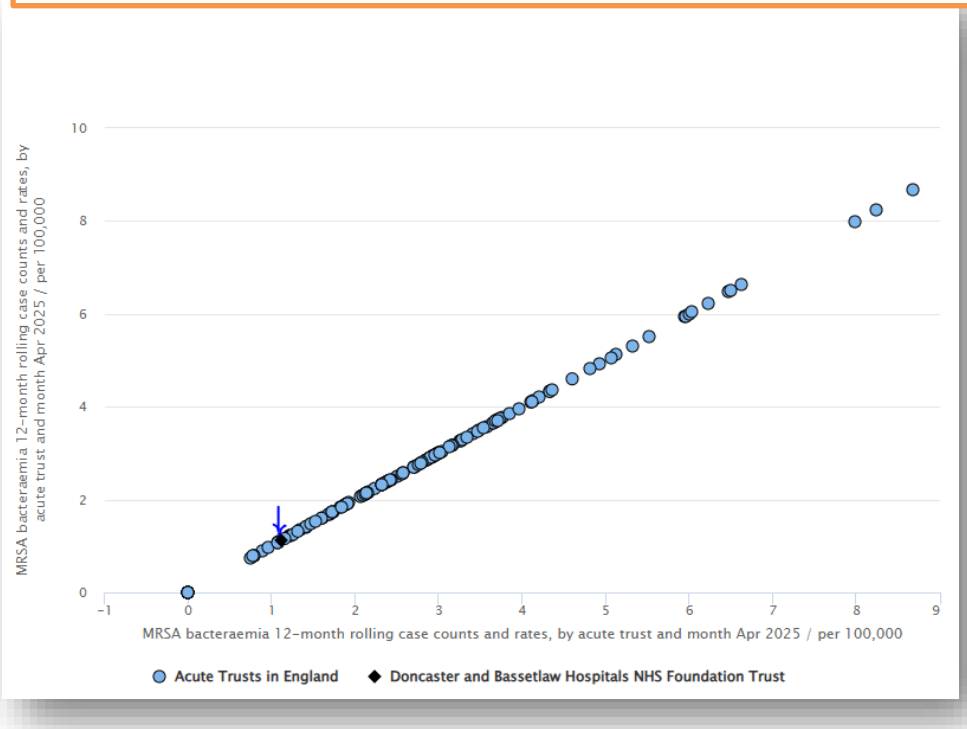
According to UKHSA review, the rate of community-onset community-associated (COCA) MRSA bacteraemia cases per 100,000 population in Doncaster and Bassetlaw was, 0.7 cases per 100,000, and was lower than the national average (1.9 cases per 100,000) at March 2025. While the MRSA bacteraemia cases counts of hospital-onsets as reported by the Trust as of March 2025 was 0.4 per 100,000 compared with national average of 1.0 per 100,000 population.
We have embarked on our ambition to continue to implement the 'Zero Tolerance to MRSA bacteraemia: 'Search and Destroy' campaign.

MRSA bacteraemia 12-month rolling case counts and rates of community-onset, by reporting acute trust and month (persons, All ages)



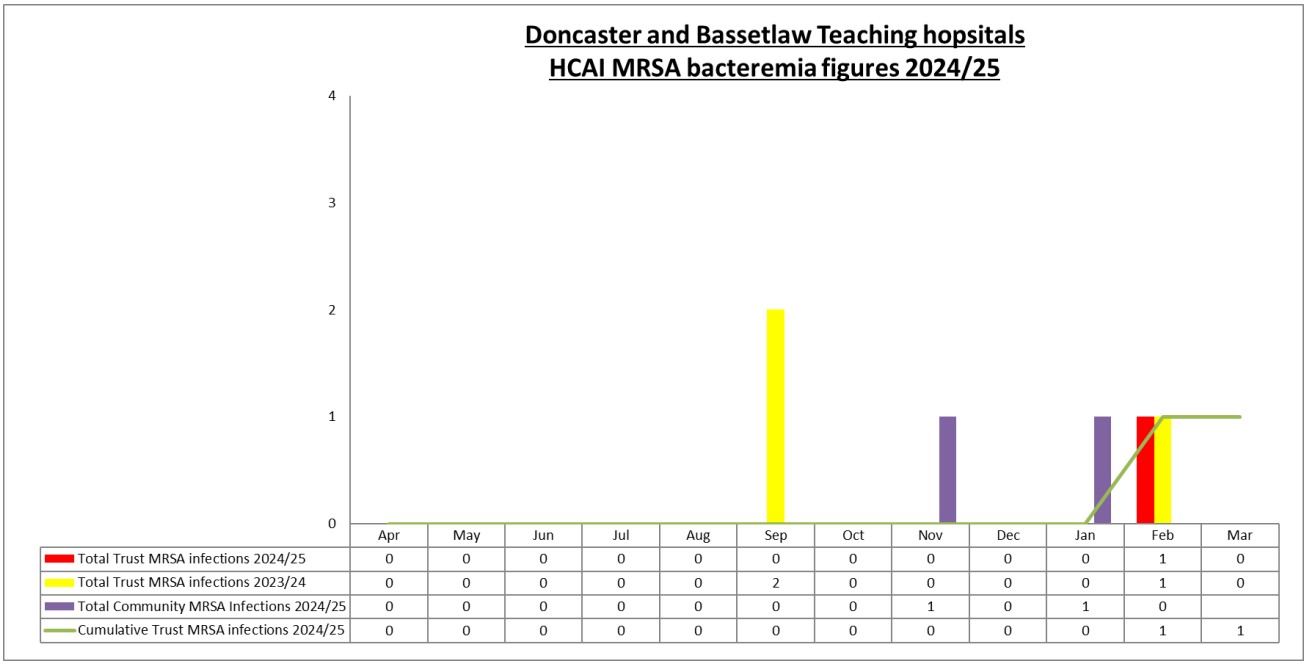
Within Doncaster and Bassetlaw we recorded higher than average MRSA bacteraemia rates during the COVID pandemic and post-pandemic period, this has significantly improved in the last year, with the Trust now in 12-month rolling rate among the lowest in England.

MRSA bacteraemia 12-month rolling case counts and rates, by acute trust and month April 2025 Crude rate – per 100,000.



Work continues to minimise the risk of MRSA Bacteraemia incidents through one to one specialist advice on decolonisation and risk reduction between the members of Infection Prevention and Control team and patients. Admitting teams are advised to perform a full sepsis screen on patients who are requiring antibiotics where they are from the high risk intravenous drug using group within Doncaster. The Consultants in Infection have a low threshold for advising anti-MRSA antibiotics for this groups of patients to minimise the risk of MRSA Bacteraemia developing.

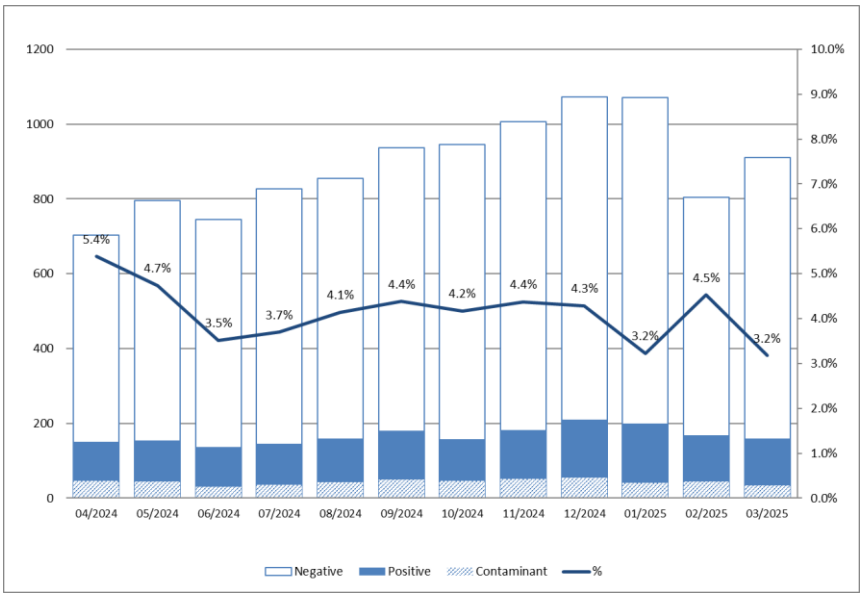
MRSA bacteremia cases 2024-25



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust MRSA infections 2024/25	0	0	0	0	0	0	0	0	0	0	1	0
Total Trust MRSA infections 2023/24	0	0	0	0	0	2	0	0	0	0	1	0
Total Community MRSA Infections 2024/25	0	0	0	0	0	0	0	1	0	1	0	
Cumulative Trust MRSA infections 2024/25	0	0	0	0	0	0	0	0	0	0	1	1

Blood culture contamination rates

Average Blood culture contamination rate for 2024/25 was 4.1%, greater than the 3% national target but down from 4.5% from 2023/24. Overall, the number of blood cultures taken has doubled from 5,578 in 2021/21 to greater than 12,679 in 2024/25. Despite this increase in number of blood cultures taken the contamination rate have remained stable and now on a down trend from previous years. This figure is still low as our blood culture sets performed by the Trust is up from 56.8 to 59.6 per 1,000 bed-days compared to an England average of 73.3 per 1,000 bed-days as of Q3 in 2024/25.



Education programs continue to target high-risk areas on improving blood culture techniques. A seven-minute video is shown at Doctors induction demonstrating the aseptic non-touch technique to use when obtaining blood cultures. Divisional directors are sent copies of blood cultures reported as contaminants. If staff on their units are involved in more than two episodes of blood cultures contaminants, they are observed and if necessary referred for refresher training and assessment by the clinical skills team.

In November 2024, the Infection Prevention and Control team employed a Band 7 Antimicrobial Stewardship Nurse who has commenced work with the Trust Sepsis Nurse on blood culture standards to improve sepsis screening and reduce contaminant rates. The work has focused in the Emergency Department on taking two sets of blood cultures with increased volume of samples and the time from taking blood cultures samples from the patient, to the laboratory putting the samples on to the analyser. In addition, educational colleagues within the ED department have worked on ensuring that those staff who are taking the samples are specifically trained to do so (have completed the clinical skills package) and that they have revalidated the training within 3 years.

This work will be built on going forward to next year focusing on diagnostic stewardship with nursing staff, improved antibiotic stewardship and data collection to inform areas for intervention. There will be further analysis of the site that blood cultures are taken from (new cannula or venepuncture site) to understand the impact that this has on contamination rates and identifying areas to focus on.

***Clostridioides difficile* infections**

Clostridioides difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in the elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. The NHS has made great strides in reducing the number of CDIs, but the rate of improvement has slowed over recent years and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

CDI reporting algorithm for this financial year continue are:

- Adding prior healthcare exposure element for community onset cases
- Reducing the number of days to apportion hospital-onset healthcare associated cases from three or more to two or more days following admission. This year, the time is taken from the 'decision to admit', even if the patient is in ED for a very short period of time.

- Virtual Ward patients are newly classified this year, being counted as if the patient is in hospital.
- The cases are reported onto the data capture system as:
    - **Hospital onset healthcare associated:** cases that are detected in the hospital two or more days after admission (HOHA)
    - **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)
    - **Community onset indeterminate association**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)
    - **Community onset community associated**: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA).

The acute trusts objectives use just two of these categories HOHA and COHA. The Trust had an increased trajectory in the year 2024/2025 from 42 cases to 69 which was reflective of the national increase of CDI cases in 2023/24. DBTH ended the year on 68 cases (one below trajectory). Despite the rise in number of cases reported by the Trust for hospital onset-healthcare, associated cases, the rate of *C. difficile* overall for DBTH NHS FT was 21.7 per 100,000 bed days compared to an England average of 21 cases per 100,000 at the end of March 2024. Of interest is the significant reduction of *C. difficile* infection counts due to community onset-healthcare associated cases of 3.4 per 100,000 compared to an England average of 7.2 cases per 100,000 bed days.

The most common findings following review of the CDI cases are as follows:

- Antibiotic Exposure
- Failure of treatments (previously identified and relapsed outside the timeframe).
- Patients on prolonged proton pump inhibitors (PPI)

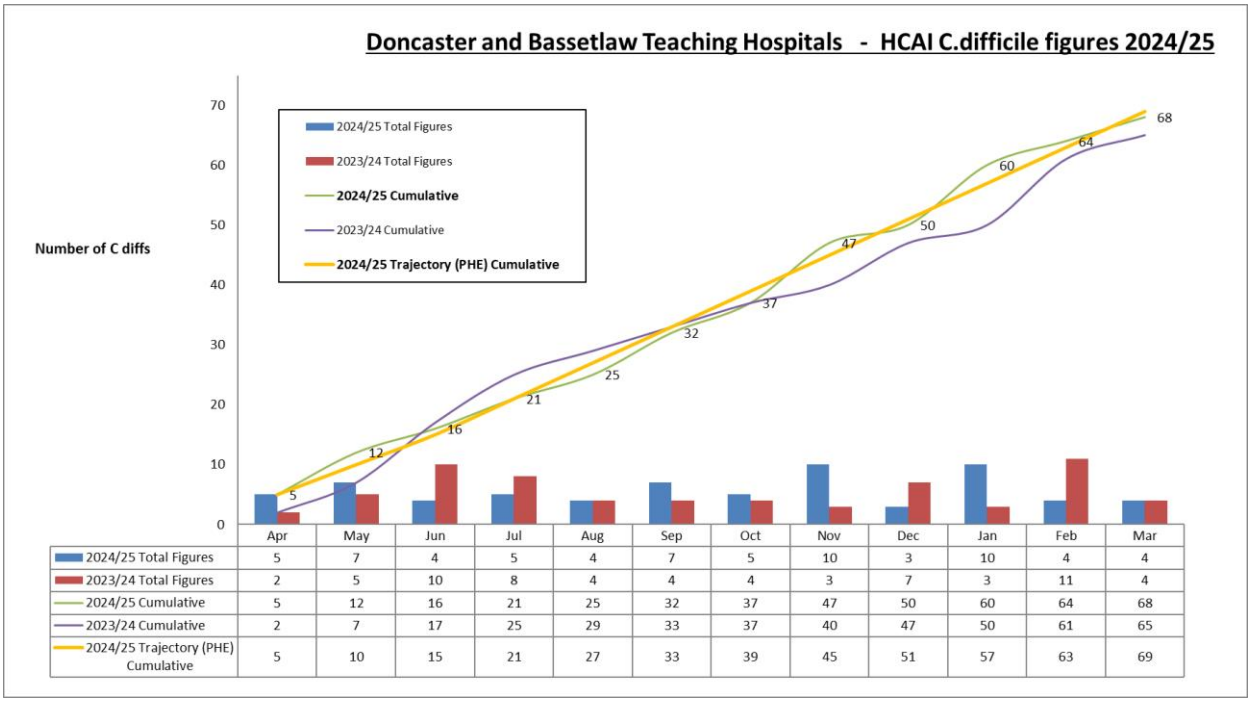
Other themes of learning identified, but which had no impact on the acquisition of CDI are as follows:

- Stool chart completion
- Delays in isolation
- Delays in sampling

Initiatives taken to reduce the risk of infection including CDI.

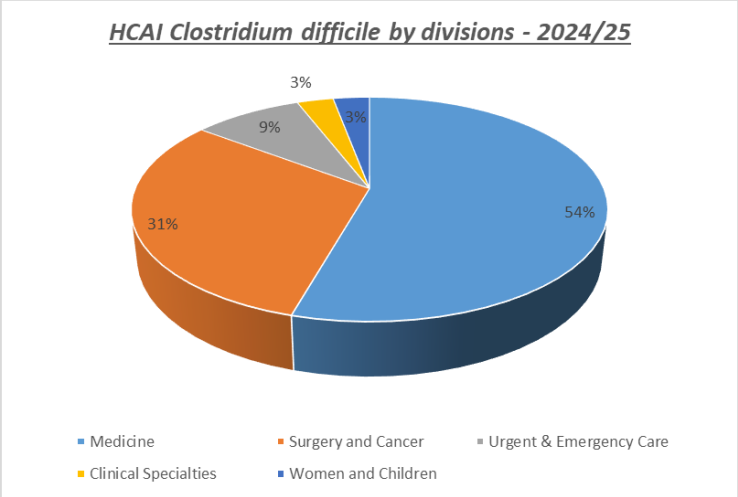
- Point prevalence surveillance (PPS), to identify any issues with invasive devices, antimicrobials and infection related issues
- Development of a RAG cleaning classification
- Continued monitoring of standards through Audit.
- Production and delivery of C Difficile teaching package in inpatient areas.
- Completion and introduction of Decontamination of a bay following identification of GDH/CDI cases.
- QI project, aiming to find carriers of CDI to ensure timely infection prevention and control interventions and optimum antimicrobial stewardship along with improvement in risk assessment for isolation and documentation.
- Weekly CDI reviews by the Consultant in Infection/DIPC and Nurse Consultant/Deputy DIPC in addition to three time's weekly reviews by the Infection Prevention and Control Team.

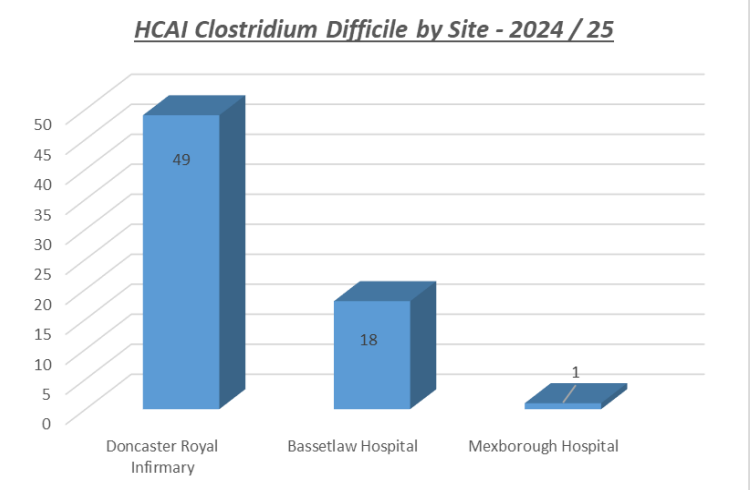
The Trust has moved towards the Patient Safety Incident Response Framework (PSIRF) that sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purposes of learning and improving patient safety.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25 Total Figures	5	7	4	5	4	7	5	10	3	10	4	4
2023/24 Total Figures	2	5	10	8	4	4	4	3	7	3	11	4
2024/25 Cumulative	5	12	16	21	25	32	37	47	50	60	64	68
2023/24 Cumulative	2	7	17	25	29	33	37	40	47	50	61	65
2024/25 Trajectory (PHE) Cumulative	5	10	15	21	27	33	39	45	51	57	63	69

Trust-Attributed *C. difficile* cases by ward and divisions are shown in Appendix 3. Most infections occurred in the division of medicine, where there were 37 cases in the year, Women and Children Division and Clinical Specialties recorded 2 cases each for 2024/25. The vast majority (49 cases) of the healthcare associated *C. difficile* occurred at DRI.



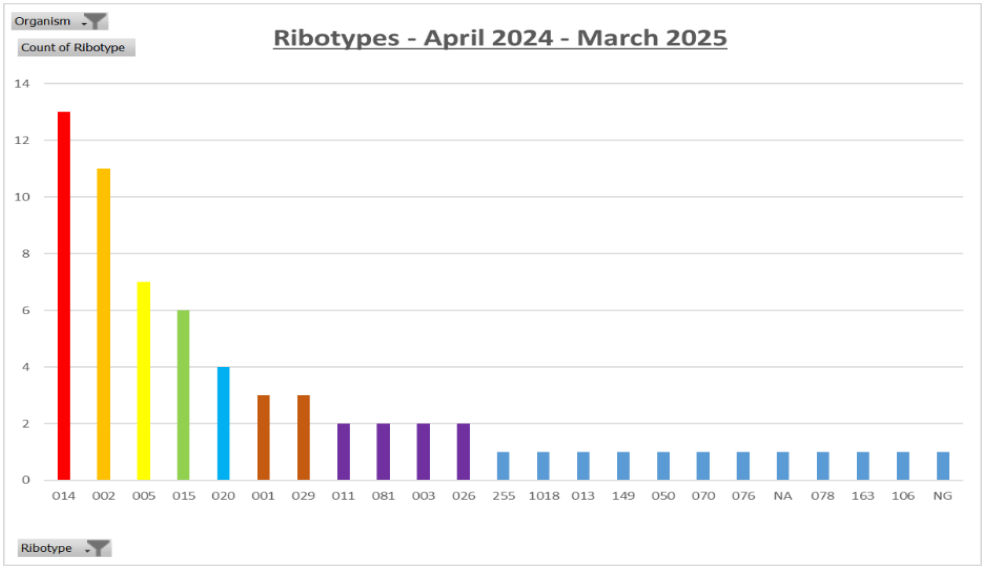


Ribotyping on *Clostridioides difficile* isolates from patients with *C. difficile* infection allows for the identification of certain strains such as 027 that can be difficult to control when causing outbreaks and/or may be associated with poor clinical outcomes. Ribotyping allows for identification of possible cross infection.

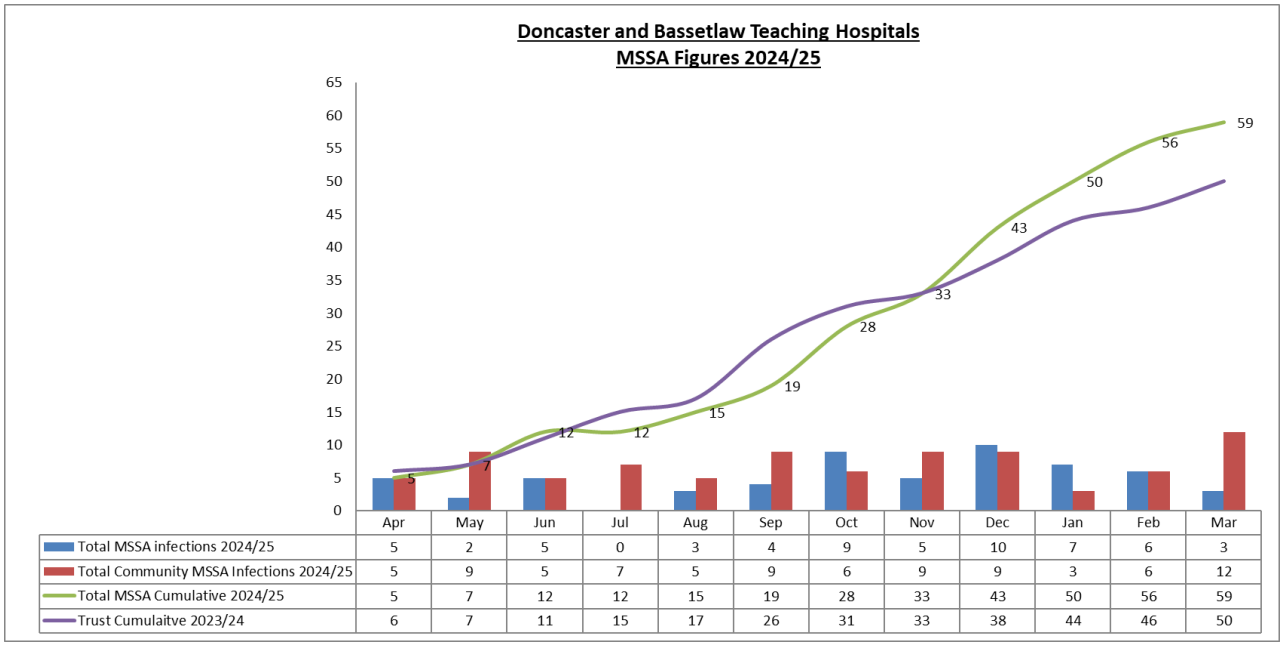
Common ribotypes at DBTH:

CE014 was the most frequently isolated 13(21%) ribotype in 2024/25. The CE002 accounted for second highest in last two consecutive years 11(16.2%) of the total Trust cases. Other common ribotypes include CE005 – 7 times, CE015 – 6 times, CE020 – 4 times, CE001 and CE029 – 3 times respectively. We also recorded 2 cases each of CE011, 081, 003 and 026. There was no direct evidence of cross-infections despite the recurring ribotypes.

Ribotypes identified from samples submitted to reference laboratory



Methicillin sensitive *Staphylococcus aureus* bloodstream infection (MSSA BSI)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total MSSA infections 2024/25	5	2	5	0	3	4	9	5	10	7	6	3
Total Community MSSA Infections 2024/25	5	9	5	7	5	9	6	9	9	3	6	12
Total MSSA Cumulative 2024/25	5	7	12	12	15	19	28	33	43	50	56	59
Trust Cumulaitve 2023/24	6	7	11	15	17	26	31	33	38	44	46	50

Methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia has been included in the mandatory surveillance scheme since January 2011, with cases occurring more than 2 days after admission apportioned to acute Trusts. There were 144 MSSA BSI in 2024/25, an increase from 140 cases reported in 2023/24. We reported 59 cases attributed to the Trust for 2024/25 compared to 50 cases in 2023/24. There is an overall downward trend in MSSA bacteraemia cases counts for hospital-onset from 15.8 in 2023/24 to 14.8 versus 10.9 per 100,000 bed-days, while we recorded an upward trend in community on-set cases of 38.2 versus 27.1 per 100,000 bed-days community on-set compared with England averages.

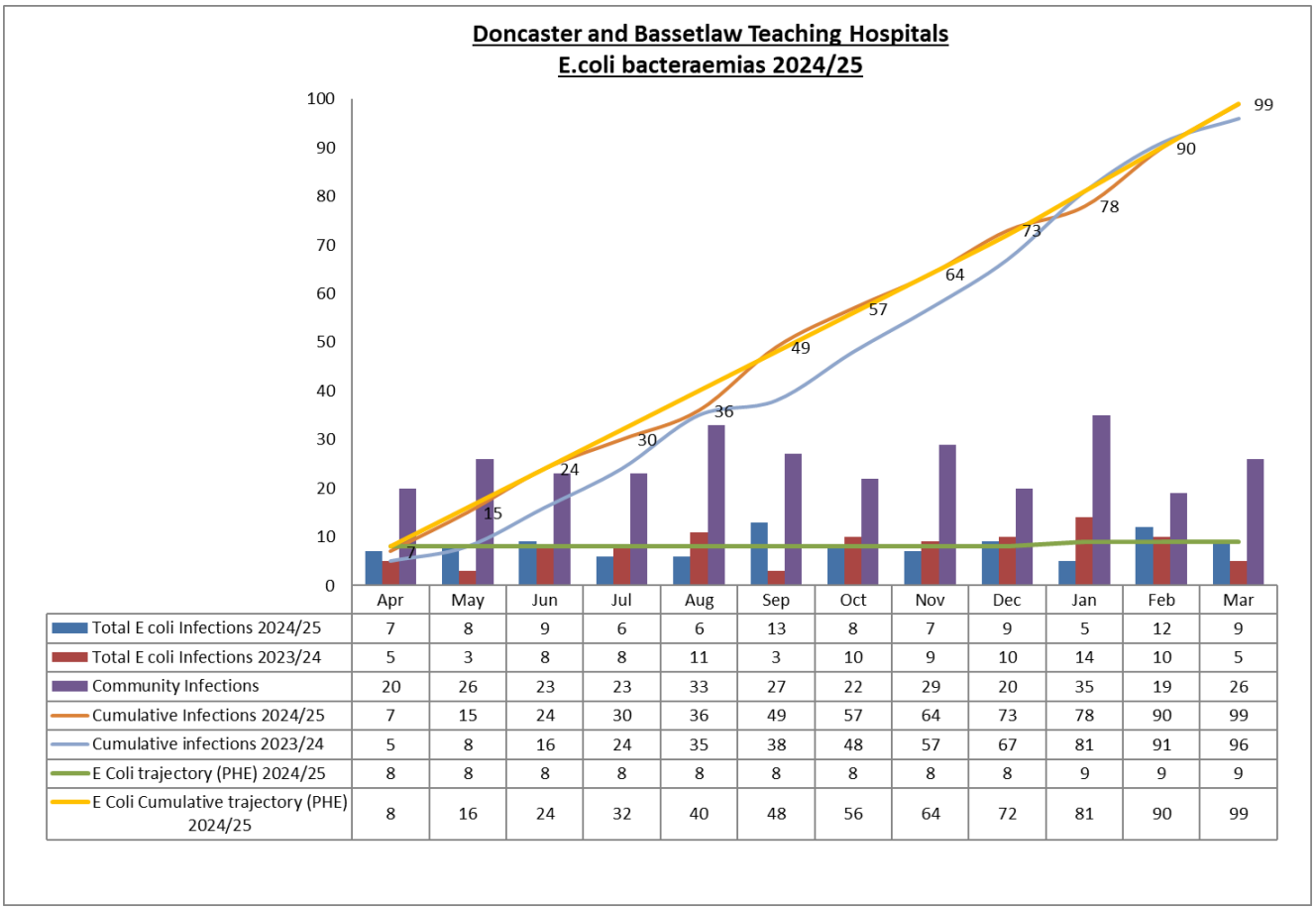
However, the Trust acknowledges that further improvement can be achieved in this infection as significant number of Trust attributed cases were catheter associated and increased emphasis on clinical practices using the VIP score and initiation of post infection reviews will assist in case reduction. Overall, Trust attributed MSSA by ward and Division are shown in Appendix 2.

Gram-negative bloodstream infections surveillance

Public Heath England, in April 2017, introduced additional Gram-negative bloodstream infections surveillance. This was to enable NHS Trusts to report cases of bloodstream infections due to *Pseudomonas aeruginosa* and *Klebsiella spp,* on the Healthcare Associated Infections Data Capture System (HCAI DCS).

This was further expanded by HM government publication in January 2019, tackling antimicrobial resistance 2019-2024: the UK's five-year national action plan. This includes the aim to reduce the incidence of specified drug-resistant infections in humans in the UK, halve the number of healthcare associated Gram-negative blood stream infections, reduce UK antimicrobial use in humans by 15% and report on the percentage of prescriptions supported by use if a diagnostic test or decision support tool. This surveillance is expected to be in line with the existing *E. coli* bacteraemia surveillance.

***E. coli* bloodstream infection (*E. coli* BSI)**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total E coli Infections 2024/25	7	8	9	6	6	13	8	7	9	5	12	9
Total E coli Infections 2023/24	5	3	8	8	11	3	10	9	10	14	10	5
Community Infections	20	26	23	23	33	27	22	29	20	35	19	26
Cumulative Infections 2024/25	7	15	24	30	36	49	57	64	73	78	90	99
Cumulative infections 2023/24	5	8	16	24	35	38	48	57	67	81	91	96
E Coli trajectory (PHE) 2024/25	8	8	8	8	8	8	8	8	8	9	9	9
E Coli Cumulative trajectory (PHE) 2024/25	8	16	24	32	40	48	56	64	72	81	90	99

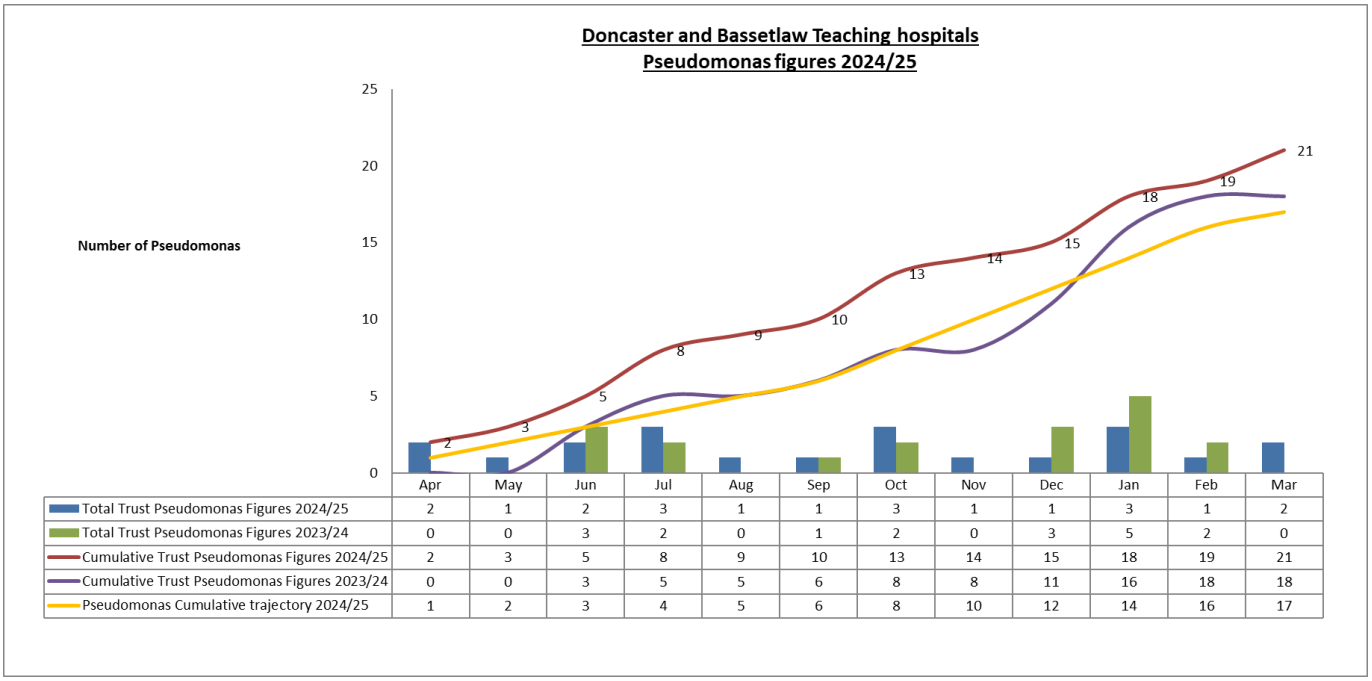
There were 402 *E. coli* bloodstream infections of which 99 occurred in patients more than two days after admission to hospital. The overall Trust attributed *E. coli* BSI cases have increased by 3 cases from 2023/24 submission.

There is an overall downward trend in E coli bacteraemia cases counts for hospital-onset from 24.5 in 2023/24 to 19.7 in 2024/25 versus 23.2 per 100,000 bed-days, while we recorded an upward trend in community on-set cases of 38.2 versus 27.1 per 100,000 bed-days community on-set compared with England averages.

Doncaster & Bassetlaw Teaching Hospitals N HS Trust has been working with Doncaster Place-Based partnership in South Yorkshire Integrated Care Board and Nottingham & Bassetlaw Place – Based partnership in Nottinghamshire Integrated Care System to minimise rates of Gram-negative bloodstream infections so they are no higher than the threshold levels set by NHS England. Cases occurring more than two days after admission are shown by ward and Divisions in Appendix 5. Most E coli bacteremia occurred in patients aged 65 or over, with a median age of 76 years for hospital associated cases. The majority of *E. coli* BSI relate to urinary tract or hepato-biliary infection, which account for around three-quarters of infections.

Over the last decade there has also been an increase in extended-spectrum beta- lactamase (ESBL) producing E. coli and other antibiotic resistant strains. There were 10 (10.4%) ESBL-producing or other multi-resistant E coli in 96 blood cultures attributed to Trust as healthcare associated and 19 (8.2%) in 245 blood cultures taken after the second day of admission to hospital and with no recent admission within 28 days to hospital.

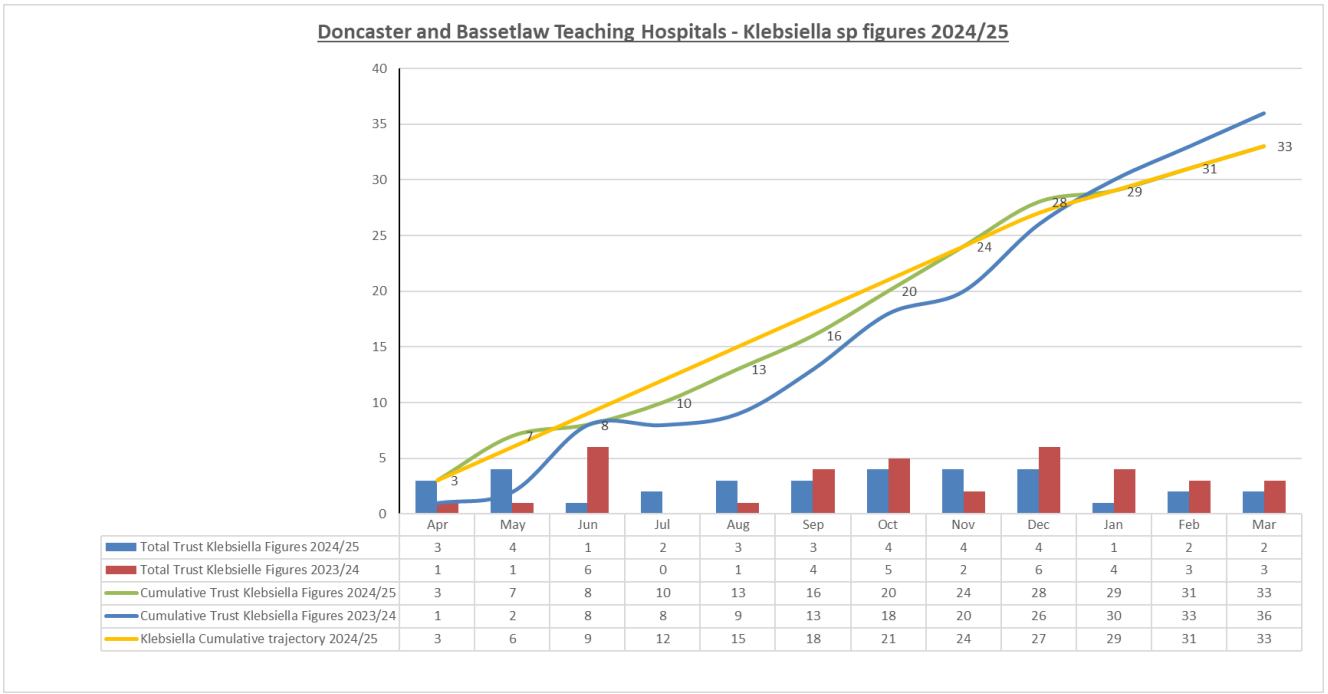
Pseudomonas aeruginosa & Klebsiella spp



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Pseudomonas Figures 2024/25	2	1	2	3	1	1	3	1	1	3	1	2
Total Trust Pseudomonas Figures 2023/24	0	0	3	2	0	1	2	0	3	5	2	0
Cumulative Trust Pseudomonas Figures 2024/25	2	3	5	8	9	10	13	14	15	18	19	21
Cumulative Trust Pseudomonas Figures 2023/24	0	0	3	5	5	6	8	8	11	16	18	18
Pseudomonas Cumulative trajectory 2024/25	1	2	3	4	5	6	8	10	12	14	16	17

Forty one *Pseudomonas aeruginosa* bloodstream infections, an increase of fourteen case from 2023/24, were reported to the HCAI DCS for 2024/28. 21 were in patients greater than 48 hours from admission, demonstrating an increase from 18 cases reported as healthcare associated infection in 2023/24.

We exceeded our trajectory of 17 by four cases of *P. aeruginosa* BSI.
There is an overall upward trend in the last few years in *Pseudomonas aeruginosa* bacteraemia cases counts, the hospital-onset and community on-set cases of *P. aeruginosa* bacteraemia of 4.4 versus 4.8 per 100,000 bed-days and 10.8 versus 7.6 per 100,000 bed-days respectively for hospital on-set and community on-set compared with England averages in 2024/25.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Trust Klebsiella Figures 2024/25	3	4	1	2	3	3	4	4	4	1	2	2
Total Trust Klebsielle Figures 2023/24	1	1	6	0	1	4	5	2	6	4	3	3
Cumulative Trust Klebsiella Figures 2024/25	3	7	8	10	13	16	20	24	28	29	31	33
Cumulative Trust Klebsiella Figures 2023/24	1	2	8	8	9	13	18	20	26	30	33	36
Klebsiella Cumulative trajectory 2024/25	3	6	9	12	15	18	21	24	27	29	31	33

Of the 100 *Klebsiella spp* bloodstream infections reported, an increase of 8% to the HCAI DCS for 2023/24 from previous financial year. The Trust reported 64 and 36 cases for community associated & hospital associated *Klebsiella* infections respectively. We exceeded our threshold of 33 cases by 9.1%. The vast majority approximately 75% of these being *Klebsiella pneumoniae*.
There is a downward trend in *Klebsiella spp* bacteraemia cases counts for hospital-onset versus England average of 9.5 per 100,000 bed-days in 2023/24 to 5.6 per 100,000 bed-days in 2024/25 compared to a national average of 11.6 per 100, 000 bed-days. While we observed an upward trend for community, on-set cases of *Klebsiella spp bacteraemia* of 30.8 versus 25.4 per 100,000 bed-days in 2023/24 to 36.7 versus 25.5 per 100,000 bed-days for community on-set compared with England averages.

Cases occurring more than two days (for *Pseudomonas aeruginosa and Klebsiella spp*) after admission are shown by ward and Divisions in Appendix 3.

Surgical site infection surveillance:

The United Kingdom Health Security Agency (UKHSA) Surgical Site Infection (SSI) surveillance service assesses specialty specific surgical site infections, on a quarterly basis. The Trust participates in this surveillance using the standard case definitions and surveillance methodology.

The reporting of Orthopaedic SSI cases became compulsory in 2006. Other components of the scheme remain voluntary.

The reports produced by the UKHSA enable Trusts to benchmark their performance against other hospitals. Information is extrapolated from Bluespier, patient's notes, discussion with clinicians, patients and post-discharge telephone surveillance within 30 days of the procedure is conducted, or via follow-up appointments or on readmission.

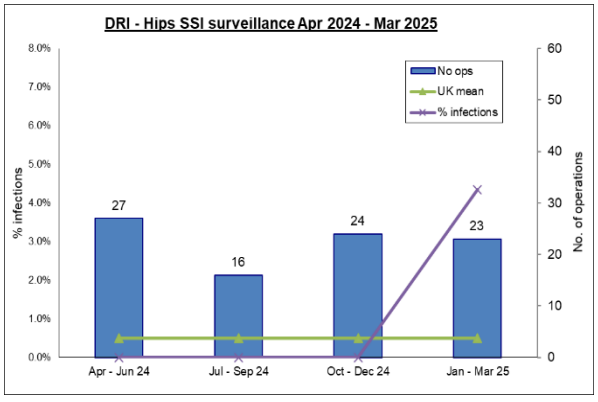
Infection rates are reported monthly to the board through the Trust Patient Safety Review Group (PSRG), Patient Safety Group (PSG) and governance processes. The SSI rate of infection for Primary Knee Surgery at DRI and BH was 1% and 0.3% respectively against a UK mean of 0.4%. While the SSI rate for Primary Hip Surgery for 2024/25 at DRI and BH was, 1.1% and 0.6% respectively against a UK mean of 0.5%.

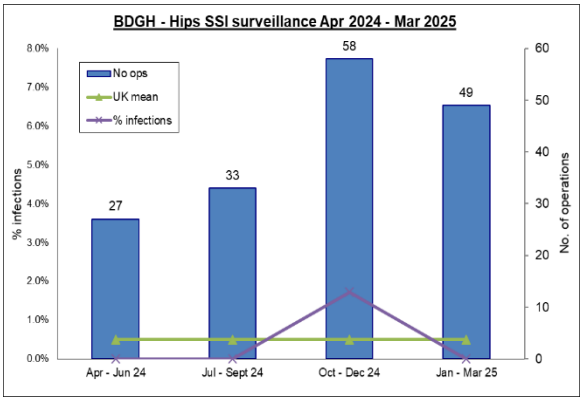
The SSI rate of infection for MH at MEOC continues to remain at 0% for both hips and knees. MEOC is a shared venture, utilised by Barnsley, Bassetlaw, Doncaster and Rotherham.

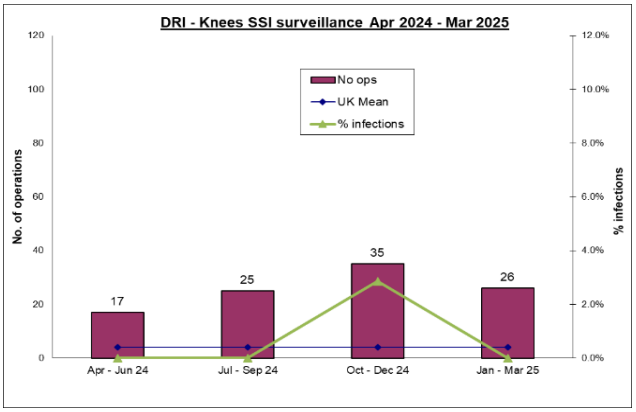
The SSI rate of infection for Breast at DRI and BH was 0.3% and 0.0% respectively, against a UK mean of 0.7%.

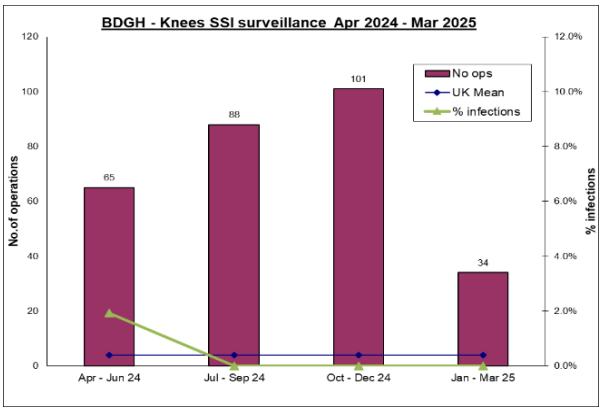
The SSI rate of infection for Vascular at DRI was 2.6%, against a UK mean of 2.1%.

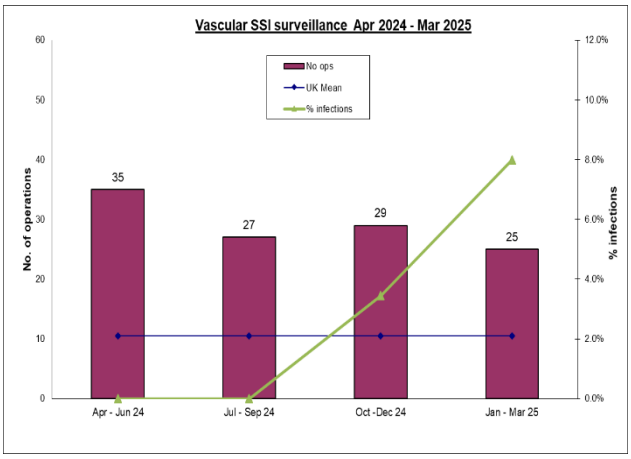
The graphs below show surgical activities and deep infection cases compared with national averages.

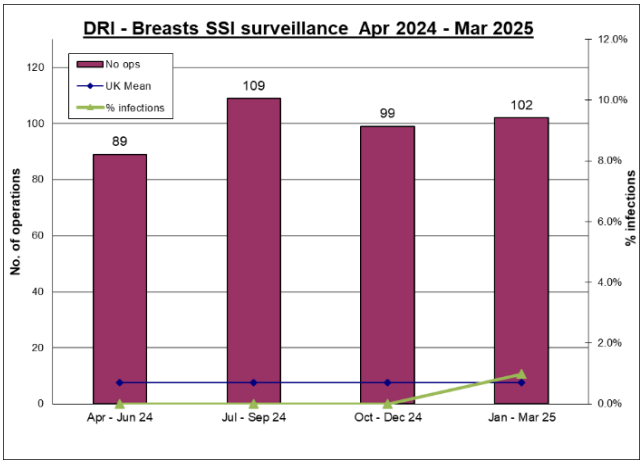


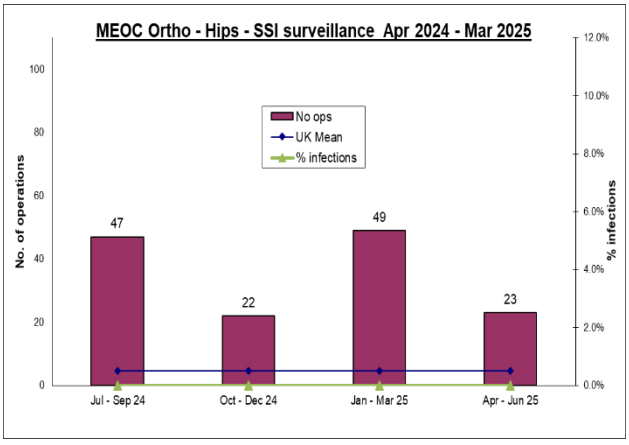


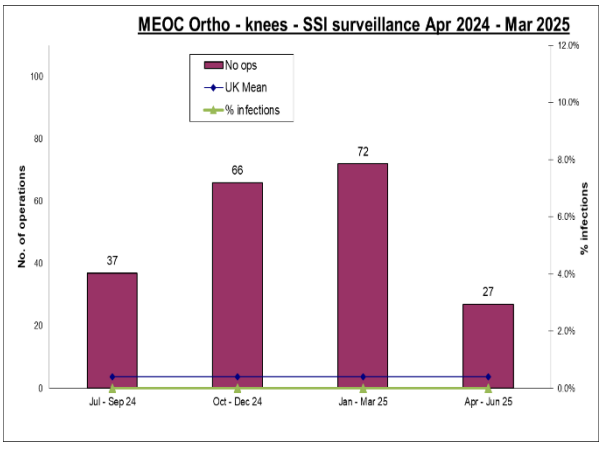

DRI - Knees SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No. of operations
% infections
17
25
35
26
Apr - Jun 24
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25

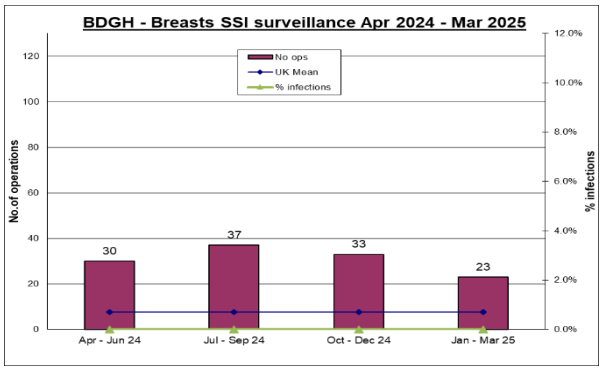

BDGH - Knees SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No.of operations
% infections
65
88
101
34
Apr - Jun 24
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25


Vascular SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No. of operations
% infections
35
27
29
25
Apr - Jun 24
Jul - Sep 24
Oct -Dec 24
Jan - Mar 25


DRI - Breasts SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No. of operations
% infections
89
109
99
102
Apr - Jun 24
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25


MEOC Ortho - Hips - SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No. of operations
% infections
47
22
49
23
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25
Apr - Jun 25

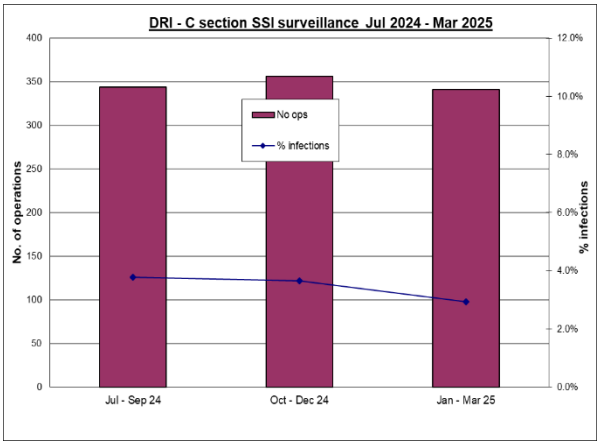

MEOC Ortho - knees - SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No. of operations
% infections
37
66
72
27
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25
Apr - Jun 25

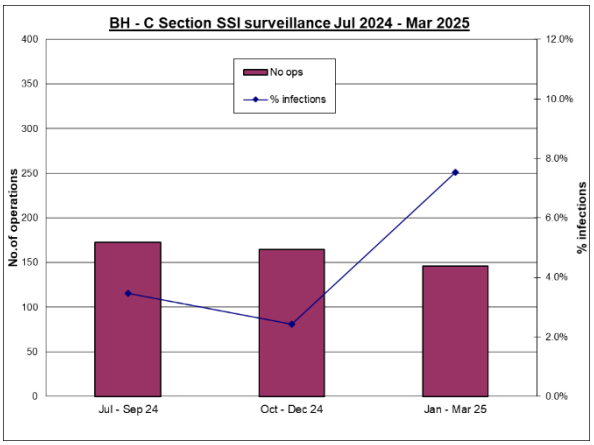

BDGH - Breasts SSI surveillance Apr 2024 - Mar 2025
No ops
UK Mean
% infections
No.of operations
% infections
30
37
33
23
Apr - Jun 24
Jul - Sep 24
Oct - Dec 24
Jan - Mar 25

In July 2024 the IPC team began an in-house surveillance programme to ascertain and monitor the infection rate of Caesarean sections within the Trust.

The SSI rate of infection for Caesarean section at DRI and BH was 3.5% and 4.3% respectively, with a Trust average 3.7%. When including patient reported infections this increases our Trust rate of infection to 12.1%.

While there is no current UK national average for rate of infection, a pilot scheme of four hospitals in the West of England, overseen by UKHSA, offers an indication of 2.1%, increasing to 4.4% when patient reported infections are included.





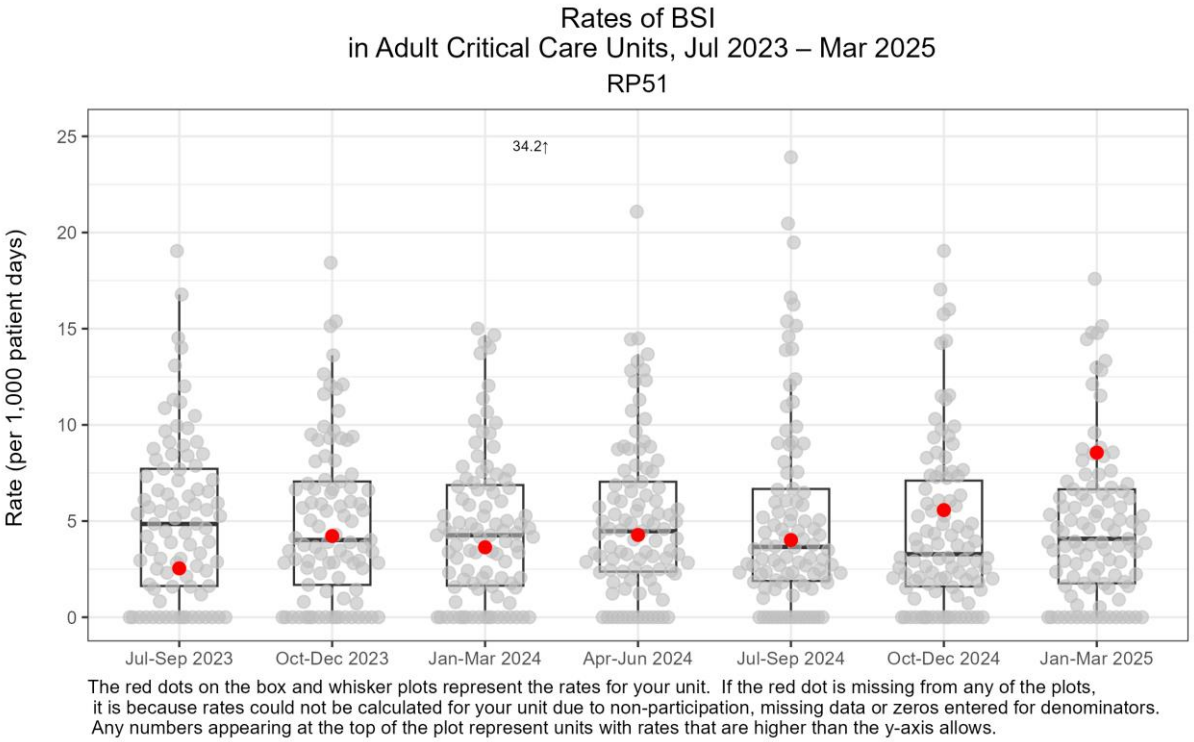
Infection in Critical Care Quality Improvement Programme (ICCQIP):

The Trust joined the Infection in Critical Care Quality Improvement Programme, which carries out ICU bloodstream infection surveillance in England. The graph below shows the progress made by our Adult critical care unit at the Doncaster Royal Infirmary in reducing our ICU-associated bloodstream infection and catheter associated bloodstream infection respectively. We will be extending the surveillance and any learning to the Bassetlaw Hospital Intensive care unit.

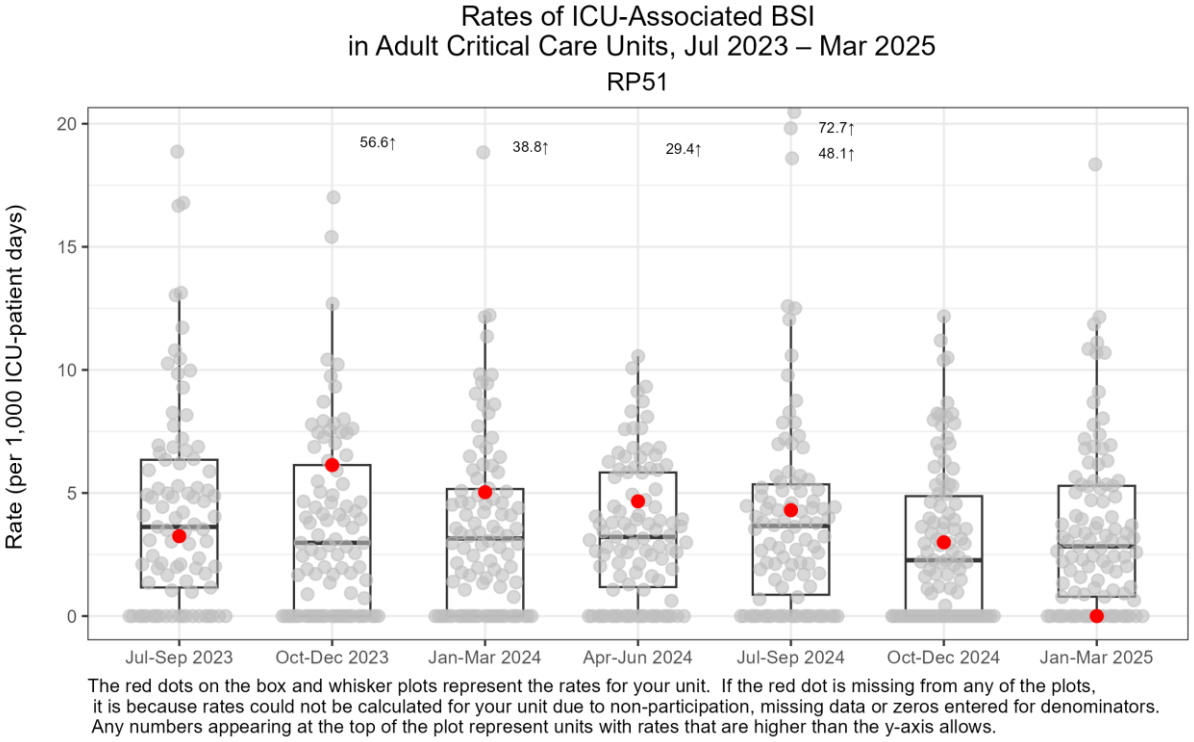
Central Venous Line Infection in Critical Care, referred to as Catheter related blood stream infections (CRBSI), are monitored and reported via Public Health England (now known as the UKHSA). This is mandatory surveillance for all critical care units in England.

The infection rate peaked during the COVID pandemic and has remained higher than baseline nationally as well as at DBTH. This is likely due to higher morbidity in the case mix in critical care, in hospital and in the population generally.

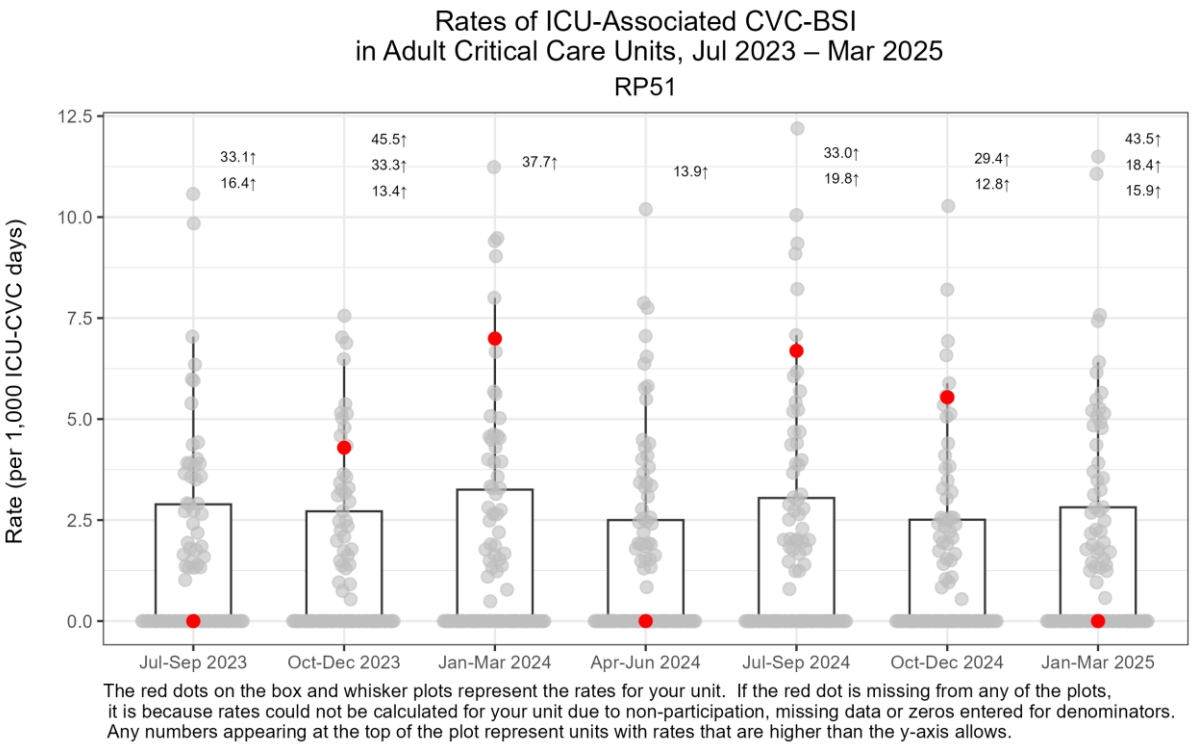
Below are data obtained for Trust participation in the ICCQIP for 2024/2025:



The rate of BSI in Adult Critical Care Units overall good improvement, with a spike in Jan-Mar 2025 probably due to number of cases out-side of the ICU and not CVC-related or ICU-associated BSI for same periods.



The Trust DCC unit has shown all through 2024/25 improvement in our BSI rates (especially in Jan – Mar 2025), and relatively stable performance otherwise a couple of higher-than-average quarters.



The Trust DCC infection rates fluctuated across the quarters in 2024/25 we had two quarters Apr-Jun 2024 and Jan – Mar 2025 with zero rates of infections and the other two quarters with higher than average rates but not extreme outliers.

Influenza virus infection

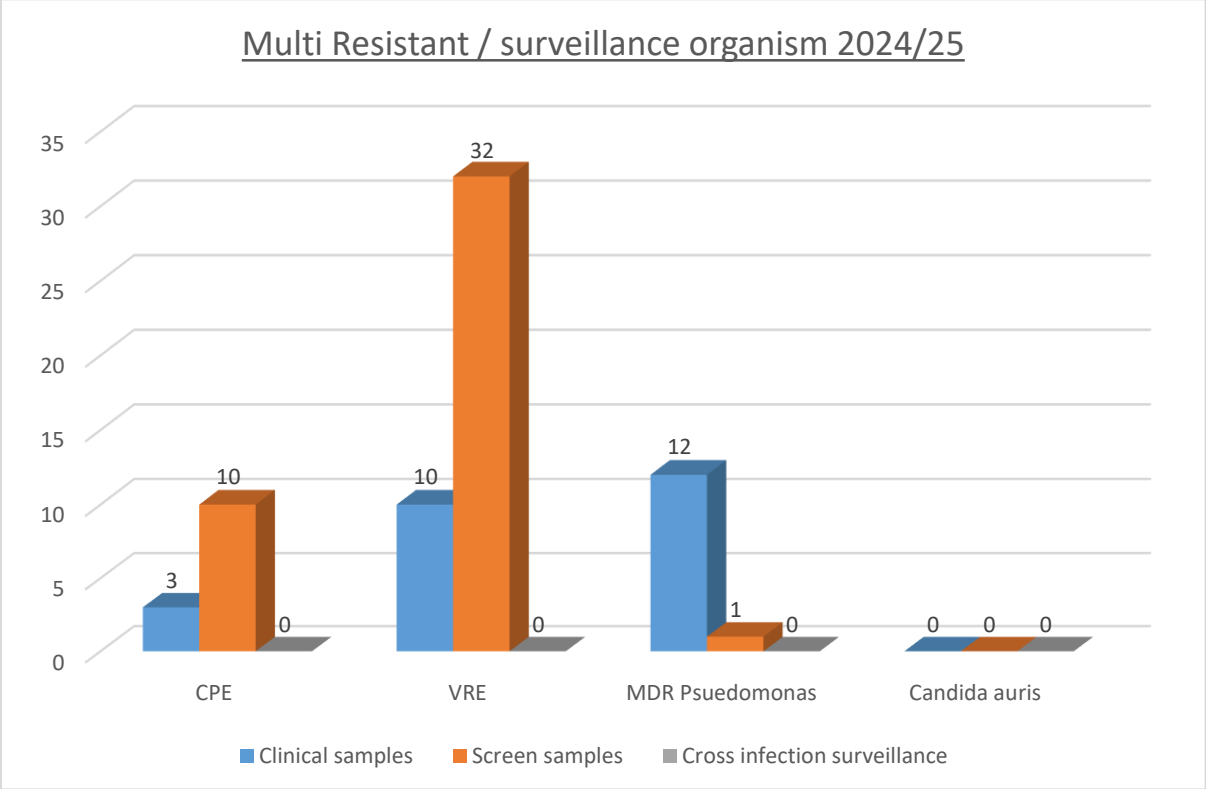
Influenza season this year saw significant number of cases, with 428 cases of Flu A and 87 cases of Flu B, which was reduction in total Influenza cases when compared to 2022/23 where we recorded 605 confirmed Flu A and 42 Flu B. Most cases were seen between November 2024 and February 2025.

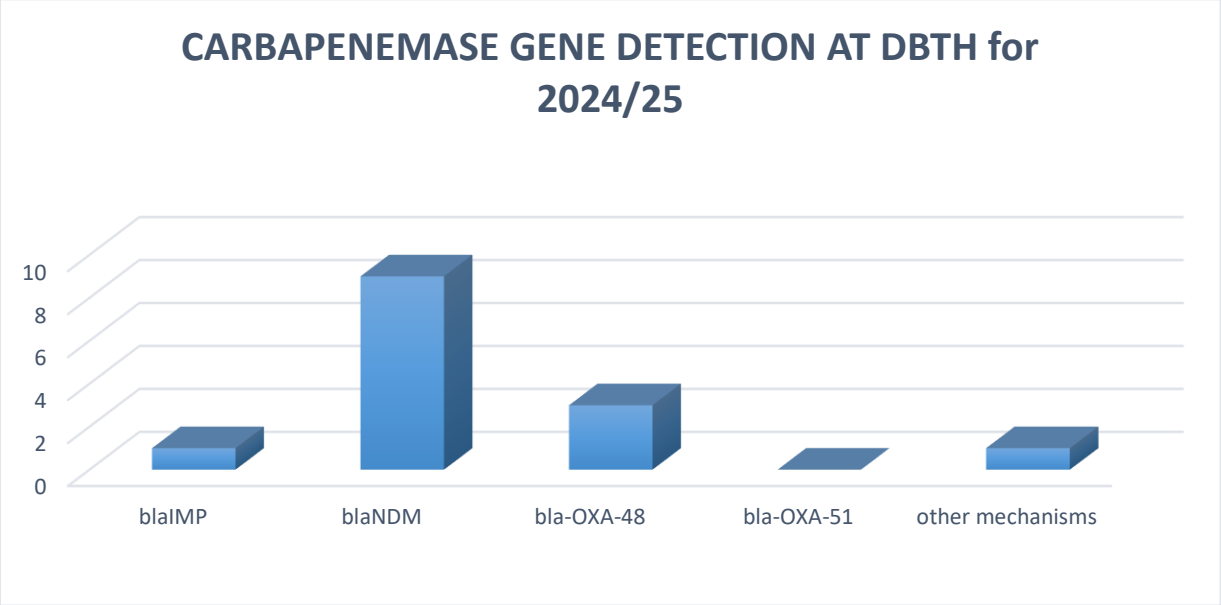
Month	Influenza A	Influenza B
April 2024	1	0
May 2024	3	0
June 2024	1	2
July 2024	1	0
August 2024	0	0
September 2024	2	2
October 2024	5	2
November	22	0

2024		
December 2024	202	11
January 2025	158	29
February 2025	26	28
March 2025	7	13

The statistics highlighted that 28.3% of all frontline staff received the influenza vaccine against all NHS Trust average in England of 37.9%. This was a reduction from 47% uptake at DBTH the previous year (2023/2024). It is acknowledged that more work is needed within DBTH to increase the vaccination rate and improve the Flu vaccine uptake across the Trust in 2025/2026. There are plans in place to improve this in the coming year.

Multi-resistant organisms & Carbapenemase-Producing Organisms





Carbapenemase-producing Enterobacteriaceae (CPE) is a group of bacteria that are highly resistant to many antimicrobials, including Carbapenems (Meropenem, Imipenem). Some isolates are resistant to all currently available antibiotics. Many of these bacteria usually live harmlessly as part of the gut flora and play an important role in the digestion of food. In September 2020 Public Health England (now UKHSA), issued a framework of actions to contain Carbapenemase-producing Enterobacterales; these organisms spread rapidly in healthcare settings and lead to poor clinical outcomes due to limited antimicrobial options available to treat. The recommendations from this updated framework include active screening for CPE, surveillance systems required for rapid detection and monitoring, standard infection control and contact precautions, antimicrobial stewardship, laboratory methods to enable early detection of the four major types (KPC, OXA-48-like, NDM and VIM), effective outbreak and cluster management and organizational responsibilities.

We reported fourteen cases of CPE for 2024/25 compared to thirteen cases of CPE in 2023/24, this is partly due to an increase in CPE screening due to the updated guidelines. Of the cases identified in the Trust 9 of the screens were identified as blaNDM, and the other screens identified 3 cases each of the blaOXA-48, and one case of blaIMP and one of other carbapenemase activities. The devastating impact of CPE in these health economies highlights the importance of the Trust having robust infection prevention and control practices in place consistently to prevent the spread of these bacteria.

We have continued to isolate multi-drug resistant *Pseudomonas aeruginosa* (MDR – Pseudomonas), we reported in 2024/25, twelve cases isolated from clinical samples such as urine, sputum, tissue and wound swabs and one case from a screen sample.

We reported 42 cases of Vancomycin Resistant Enterococcus (VRE) in 2024/25, which was a significant decline from 119 cases reported in 2023/24. Ten of the reported cases were identified from clinical samples, while thirty-two were from screening samples, there was zero case related to cross-infection, which was identified in our trauma and Orthopaedic wards in previous couples of years. The vast majority of these isolates were Glycopeptide resistant.

We have not reported or isolated *Candida auris* in 2024/25 as was the case in previous years.

Point Prevalence Survey

National Point Prevalence Survey (PPS) of Healthcare-Associated Infections

The Trust participated in the National Point Prevalence Survey (PPS) on Healthcare-associated infections (HCAIs), Antimicrobial Use (AMU), and Antimicrobial Stewardship (AMS) 2024 in England.

The 2023 survey is the sixth national point prevalent survey (PPS) on healthcare-associated infections (HCAI) and the third national PPS on antimicrobial use (AMU). This PPS is the first national PPS post-COVID survey and will provide important information on prevalence of HCAI and AMU following the pandemic. DBTH NHS FT was one of the 124 Trusts / independent sector providers who contributed to the 2023 PPS with data on more than 55,000 patients.

The survey included all three major sites of the Trust, Doncaster Royal Infirmary, Bassetlaw District General Hospital and Montagu Hospital.

A total of 779 patients were surveyed, there were 25 patients with HCAIs, 253 patients having AMU, 40 patients with a CVC and 154 patients with a urinary catheter in situ.

There are now eight years of data – National PPS November 2016, local PPS September 2018, 2019, and 2020, November 2021, 2022 and 2023 and October 2024 upon which to benchmark for improvement.

The Infection prevention and Control Team carried out a PPS in October 2024 across in-patient wards over a two week period.

572 patients were surveyed, with an age range between 16 and 100 years old, with a gender split of 51.7% female and 48.3% male. There were 25 patients with HCAIs. These consisted of:

13 Pneumonia

4 Urinary Tract Infections

1 Gastrointestinal infection

3 Cellulitis, wound, deep tissue infection

3 Lab confirmed bacteraemia

2 Other

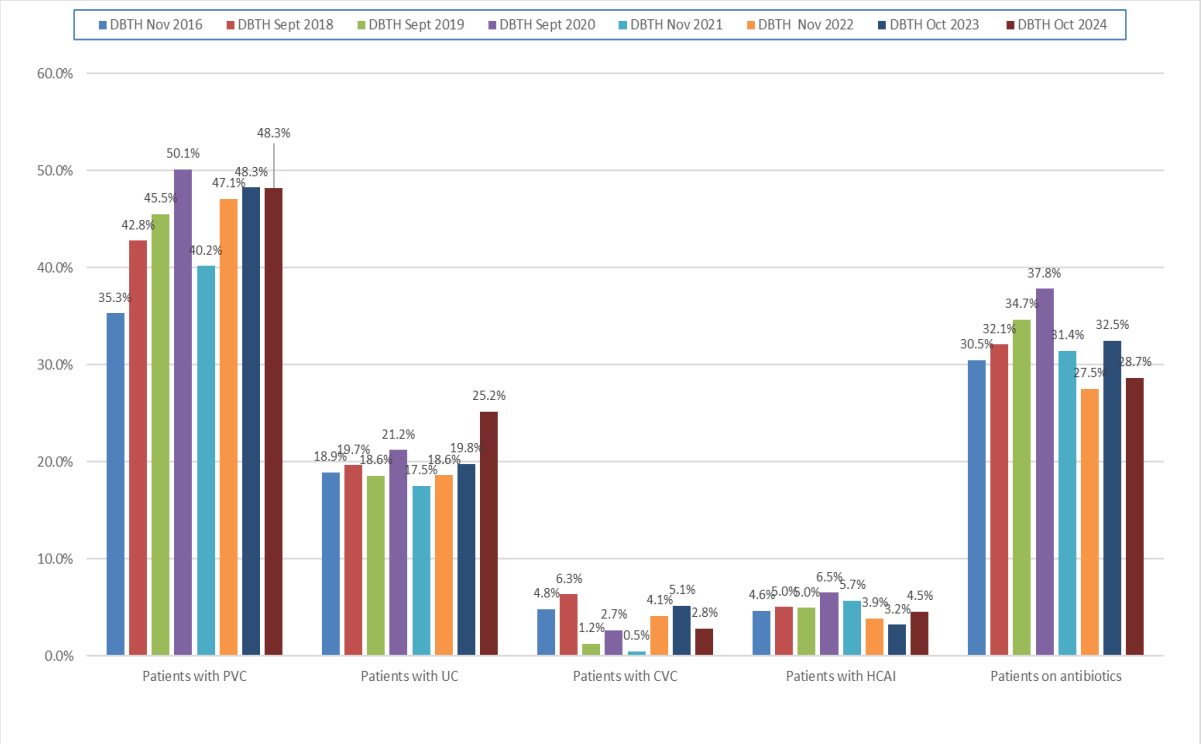
HCAI prevalence has increased to 4.5% compared to 3.2% last year and is below the national average of 6.6% in 2016, we are still awaiting National averages from the 2023 National PPS.

Year on year HCAI prevalence in DBTH from 2016 to 2024

Measure	DBTH Oct 2024		DBTH Sep 2023		DBTH Nov 2022		DBTH Nov 2021		DBTH Sept 2020		DBTH Sept 2019		DBTH Sept 2018		DBTH Nov 2016	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Patients surveyed	572		779		414		423		415		404		458		476	
Patients with PVC	276	48.3%	376	48.3%	195	47.1%	170	40.2%	208	50.1%	184	45.5%	196	42.8%	168	35.3%
Patients with UC	144	25.2%	154	19.8%	77	18.6%	74	17.5%	88	21.2%	75	18.6%	90	19.7%	90	18.9%
Patients with CVC	16	2.8%	40	5.1%	17	4.1%	2	0.5%	11	2.7%	5	1.2%	29	6.3%	23	4.8%
Patients with HCAI	26	4.5%	25	3.2%	16	3.9%	24	5.7%	27	6.5%	20	5.0%	23	5.0%	22	4.6%
Patients on antibiotics	164	28.7%	253	32.5%	114	27.5%	133	31.4%	157	37.8%	140	34.7%	147	32.1%	145	30.5%

	DBTH Nov 2016	DBTH Sept 2018	DBTH Sept 2019	DBTH Sept 2020	DBTH Nov 2021	DBTH Nov 2022	DBTH Oct 2023	DBTH Oct 2024	
Patients with PVC	35.3%	42.8%	45.5%	50.1%	40.2%	47.1%	48.3%	48.3%	
Patients with UC	18.9%	19.7%	18.6%	21.2%	17.5%	18.6%	19.8%	25.2%	
Patients with CVC	4.8%	6.3%	1.2%	2.7%	0.5%	4.1%	5.1%	2.8%	
Patients with HCAI	4.6%	5.0%	5.0%	6.5%	5.7%	3.9%	3.2%	4.5%	
Patients on antibiotics	30.5%	32.1%	34.7%	37.8%	31.4%	27.5%	32.5%	28.7%	

Year on year comparison of main elements of Point Prevalence Survey



2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Facilities

Enhanced Cleaning

During the course of 2024/25 our Facilities teams provided a number of enhanced cleaning across acute wards due to outbreaks relating to Norovirus, Influenza and COVID-19.

National Standards of Healthcare Cleanliness

A revision to the National Standards of Healthcare Cleanliness (NSOHC) 2021 were published in February 2025, however this revision is aimed more at GP's and Ambulance operators. The 2021/25 standards reflect modern methods of cleaning, changes in infection prevention and control and important considerations for cleaning services during a pandemic. The new standards focus on a need for a collaborative approach to cleaning and aim to emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

As part of compliance with the new cleaning standards, all organisations are required to display the commitment to cleanliness charter. The charter demonstrates that the organisation is serious about providing a safe, clean environment by referencing the new star rating which reflects the cleanliness of the whole area.

All areas within the Trust have been assessed in partnership with IPC and assigned one of six functional risk categories. The functional risk categories then apply the frequency of cleaning, the cleaning standards to be achieved, the monitoring and auditing frequency, and audit target scores that will then be reflected in the star rating.

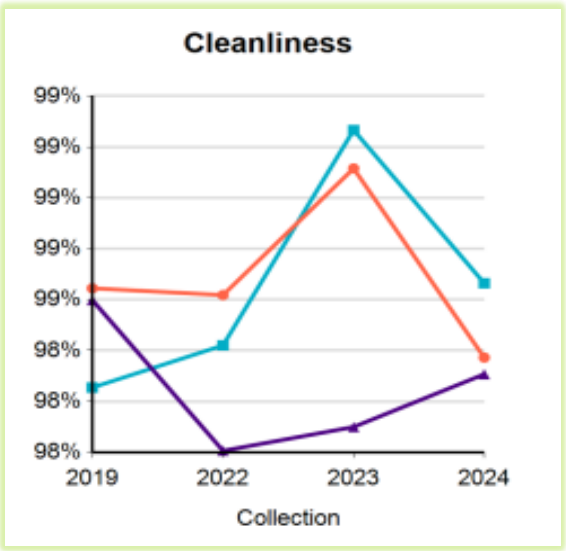
The Trust approved the funding to enable DBTH Facilities Management services to comply with the NSOHC requirements in November 2024 and an operation delivery project is being followed to ensure we are able to fully comply with the input requirements and cleanliness outcomes during the course of the first quarter of 2025/26. The Commitment to Cleaning posters and the Star Rating posters will be displayed following the delivery of operational compliance.

A new window cleaning partner for the Trust's sites was secured following a competitive tender process. The cleaning of external window will be undertaken every 6 months and the first clean from our new provider was completed in February 2025.

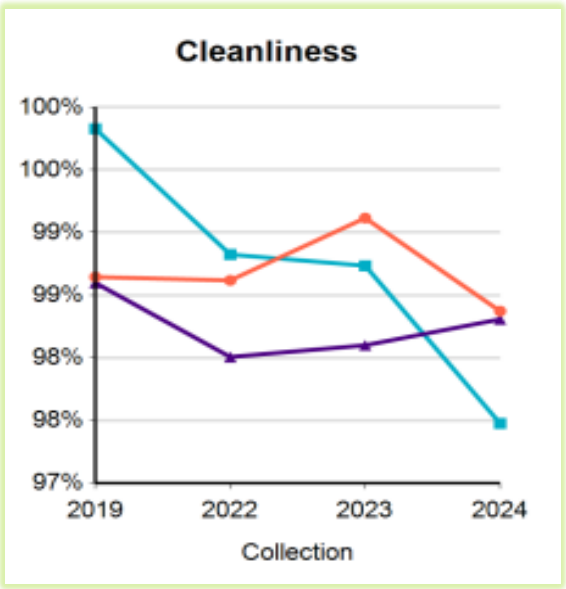
PLACE inspections

The Facilities teams supported the Patient Led Assessment of the Care Environment (PLACE) data collection exercise undertaken in September 2024. The three main sites of the Trust were assessed in the various domains of the inspection including cleanliness. The Trust achieved an organisational cleaning score of 98.37%, which was above the national average of 98.31%.

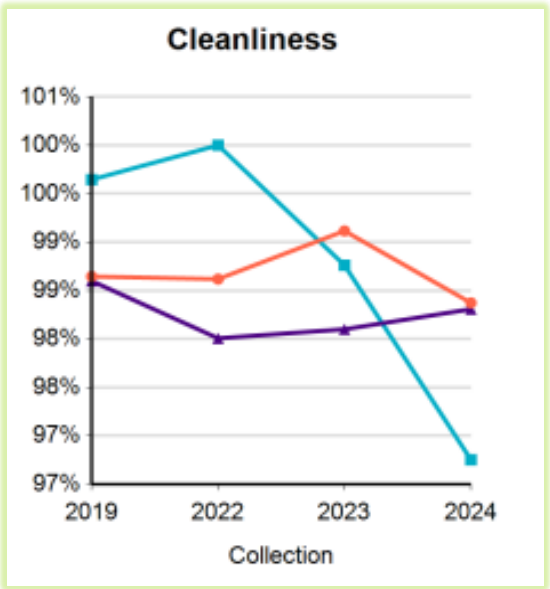
DRI Site PLACE Cleanliness Score



BDGH Site PLACE Cleanliness Score



MMH Site PLACE Cleanliness Score



Site Scores Organisation Average National Average

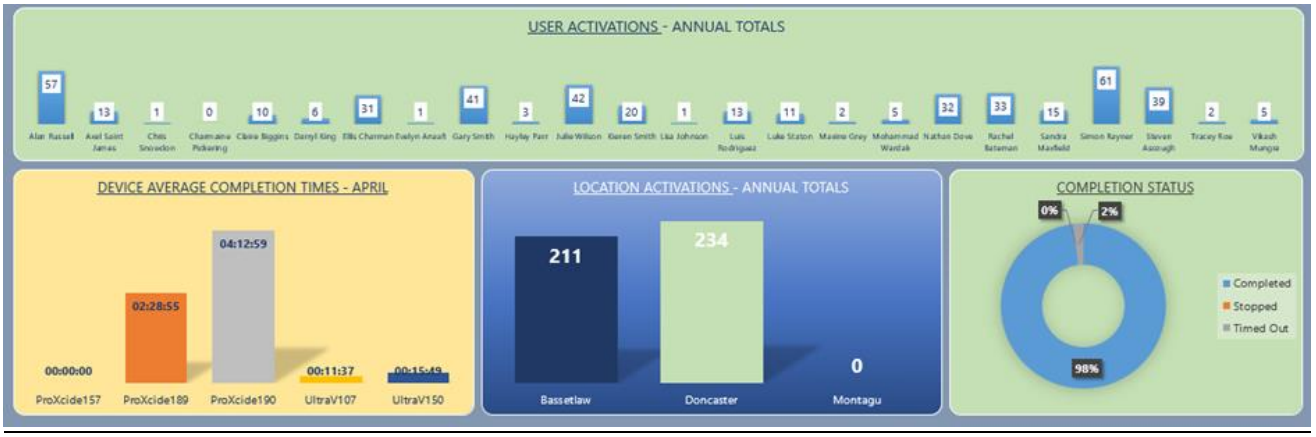
Deep Clean Update 24-25

The Deep Clean program has had success in working through a pre-planned annual schedule which has been supported by the IPC team, Head of Patient Flow, and the Deputy Chief Nurse.

Where access has not been possible due to activity or patient capacity issues, the team have looked at opportunities outside of the schedule – for example Theatres, communal areas, pro-active preventative treatments and at functional areas on other sites.

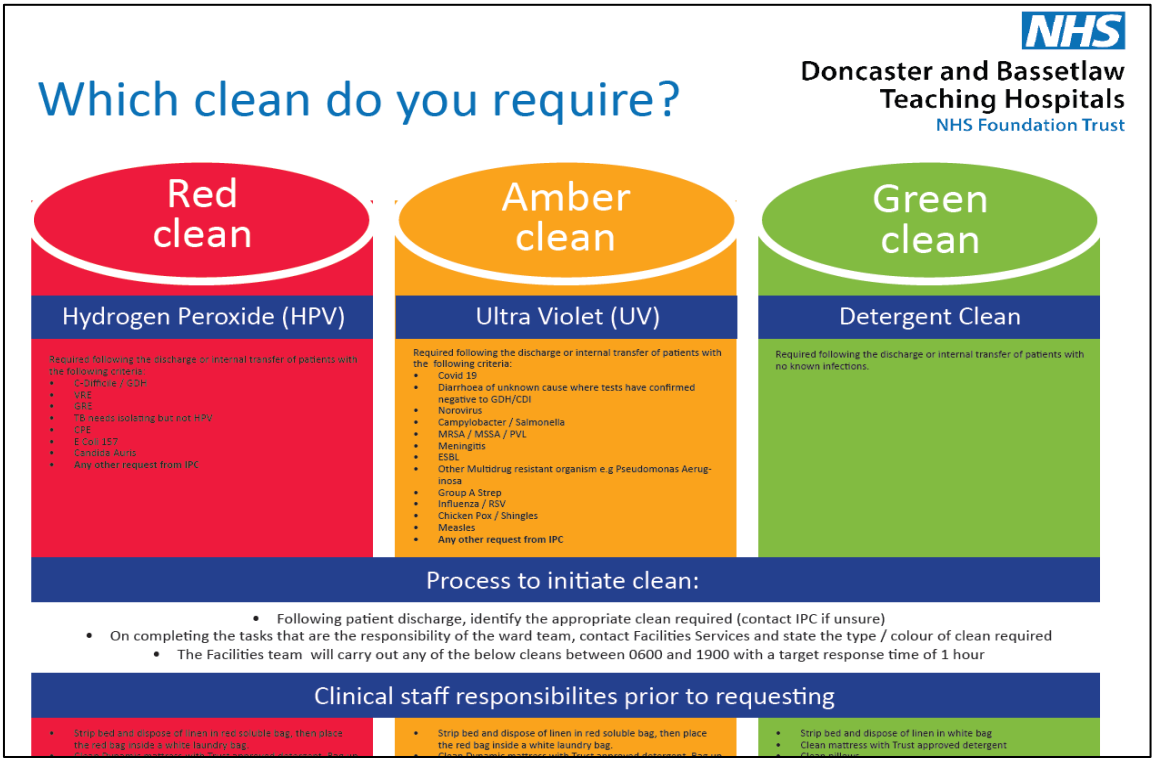
Whilst some HCA infections have risen in the Trust during 2024/25, the teams have strived to deliver decontamination services to affected functional areas prior to admitting new patients without limiting patient flow.

A deep clean dashboard has been developed by the Facilities team to track every aspect of the delivery of disinfecting services including the schedule, usage, location, disinfection type etc. Excerpts of the dashboard are shown below for information.



Machine	Operator	Hospital	Location	Start Date	Start Time	Finish Date	Finish Time	Process Duration	Process Status
ProXcide190	Sandra Maxfield	Doncaster Royal Infirmary	dri A&E bay 9 r0028	01/04/2025	09:36 AM	01/04/2025	01:49 PM	04:12:59	Completed
UltraV150	Steven Ascough	Doncaster Royal Infirmary	ward a m u room7 ro202	01/04/2025	03:36 PM	01/04/2025	03:49 PM	00:13:20	Completed
UltraV107	Gary Smith	Bassetlaw Hospital	A&E room 9	02/04/2025	11:19 AM	02/04/2025	11:36 AM	00:17:36	Completed
UltraV107	Alan Russell	Bassetlaw Hospital	A&E room 13	02/04/2025	05:08 PM	02/04/2025	05:21 PM	00:12:52	Completed
UltraV107	Alan Russell	Bassetlaw Hospital	ward amu room 1	03/04/2025	06:08 PM	03/04/2025	06:17 PM	00:08:48	Completed
UltraV107	Alan Russell	Bassetlaw Hospital	ward amu room 1	03/04/2025	06:21 PM	03/04/2025	06:28 PM	00:07:48	Completed
UltraV107	Alan Russell	Bassetlaw Hospital	ward winter room 1	03/04/2025	07:26 PM	03/04/2025	07:30 PM	00:04:04	Completed
UltraV107	Alan Russell	Bassetlaw Hospital	ward winter room 1	03/04/2025	07:35 PM	03/04/2025	07:44 PM	00:08:24	Completed
UltraV150	Steven Ascough	Doncaster Royal Infirmary	ward25 room21 ro101	04/04/2025	07:11 PM	04/04/2025	07:21 PM	00:10:20	Completed
ProXcide189	Alan Russell	Bassetlaw Hospital	ward amu room 15	04/04/2025	03:22 PM	04/04/2025	05:55 PM	02:32:41	Completed
ProXcide189	Alan Russell	Bassetlaw Hospital	ward c4 room 7	04/04/2025	06:24 PM	04/04/2025	08:38 PM	02:14:13	Completed
ProXcide189	Julie Wilson	Doncaster Royal Infirmary	ward ccu sideroom b	05/04/2025	05:51 AM	05/04/2025	07:52 AM	02:00:36	Completed
UltraV150	Evelyn Anaafi	Doncaster Royal Infirmary	dri ward 27 room r102 bed 18	06/04/2025	04:02 PM	06/04/2025	04:09 PM	00:07:36	Completed
UltraV150	Claire Biggins	Doncaster Royal Infirmary	dri ward27 room r102 bed 18	06/04/2025	04:24 PM	06/04/2025	04:33 PM	00:09:08	Completed
UltraV150	Claire Biggins	Doncaster Royal Infirmary	dri ward27 room r102bed 18	06/04/2025	04:38 PM	06/04/2025	04:48 PM	00:09:52	Completed
UltraV150	Claire Biggins	Doncaster Royal Infirmary	dri ward16roomr0039 bed16	06/04/2025	06:00 PM	06/04/2025	06:13 PM	00:12:40	Completed
UltraV107	Gary Smith	Bassetlaw Hospital	a2 room 2	06/04/2025	04:14 PM	06/04/2025	04:24 PM	00:09:44	Completed
UltraV107	Gary Smith	Bassetlaw Hospital	A&E cubicle 2	06/04/2025	05:11 PM	06/04/2025	05:17 PM	00:06:04	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri theatre 1 r 0112	07/04/2025	08:37 AM	07/04/2025	08:53 AM	00:15:32	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri theatre 1 r 0112	07/04/2025	08:57 AM	07/04/2025	09:18 AM	00:20:24	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri theatre1 r0113	07/04/2025	09:24 AM	07/04/2025	09:36 AM	00:11:40	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri theatre1 r0114	07/04/2025	09:40 AM	07/04/2025	09:48 AM	00:07:20	Completed
UltraV107	Gary Smith	Bassetlaw Hospital	labour room 6	07/04/2025	07:29 PM	07/04/2025	07:42 PM	00:13:36	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri kingfisher ward room18 r0077	08/04/2025	11:29 AM	08/04/2025	11:42 AM	00:12:44	Completed
UltraV107	Gary Smith	Bassetlaw Hospital	a2 room 1	08/04/2025	05:52 PM	08/04/2025	05:59 PM	00:06:20	Completed
UltraV107	Rachel Bateman	Bassetlaw Hospital	c1 sideroom b	08/04/2025	07:11 AM	08/04/2025	07:27 AM	00:16:16	Completed
UltraV150	Simon Rayner	Doncaster Royal Infirmary	mallard ward room8 ro128	09/04/2025	02:42 PM	09/04/2025	02:58 PM	00:15:36	Completed
UltraV150	Steven Ascough	Doncaster Royal Infirmary	amu room15 roo46	09/04/2025	06:56 PM	09/04/2025	07:17 PM	00:20:36	Completed
UltraV107	Julie Wilson	Bassetlaw Hospital	ward c4 sideroom b	09/04/2025	07:22 PM	09/04/2025	07:41 PM	00:19:04	Completed
UltraV150	Ellis Charman	Doncaster Royal Infirmary	dri ward g5 wc r0073	10/04/2025	11:31 AM	10/04/2025	11:35 AM	00:04:44	Completed
UltraV150	Simon Rayner	Doncaster Royal Infirmary	ward f a u room 6 ro171	10/04/2025	04:19 PM	10/04/2025	04:32 PM	00:12:16	Completed
UltraV150	Simon Rayner	Doncaster Royal Infirmary	ward a m u room40 roo81	10/04/2025	05:27 PM	10/04/2025	05:45 PM	00:18:04	Completed

The FM team in collaboration with the IPC team introduced a reference RAG poster to advise which type of clean to request for individual circumstances. An excerpt of the poster is shown on the next page. This was in production during 2023-2024 and has been rolled out and embedded in 2024-2025.



Cleanliness Audits

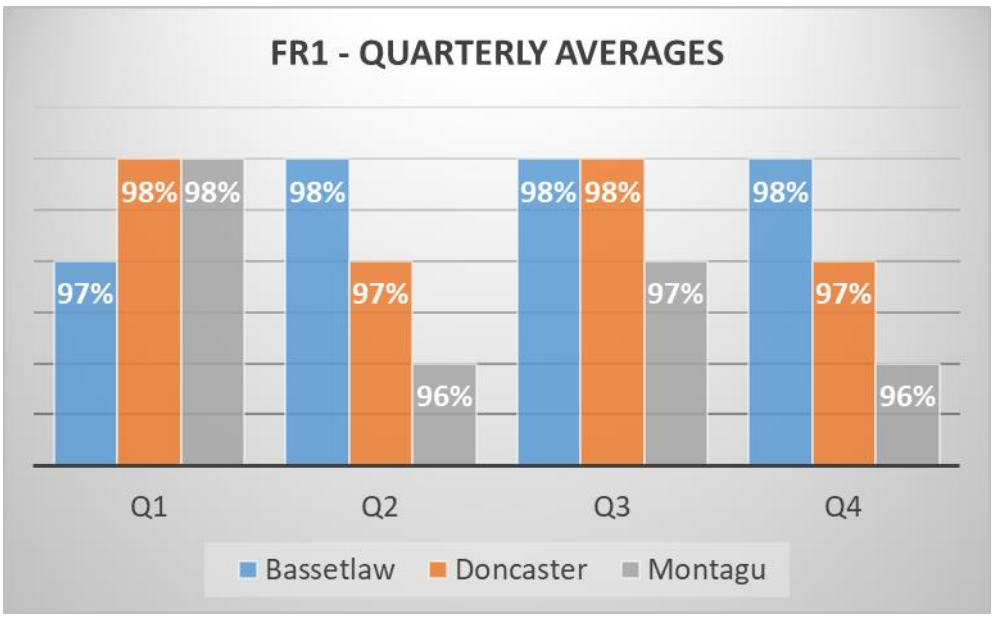
The Facilities team currently audit cleanliness outcomes based on the requirements of the National Specification of Cleanliness 2007 – soon to be to the new standards. In addition, following CQC Feedback, at least one audit per month has the divisional matron in attendance. This occurs across the organisation.

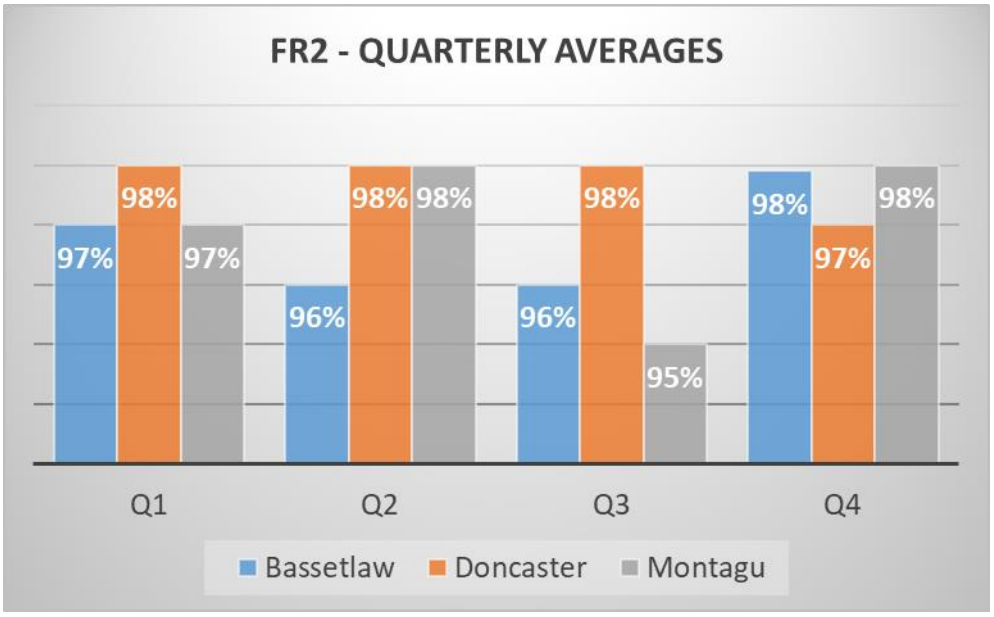
During 2024/25 the service audited 1756 functional areas with the highest risk rating.

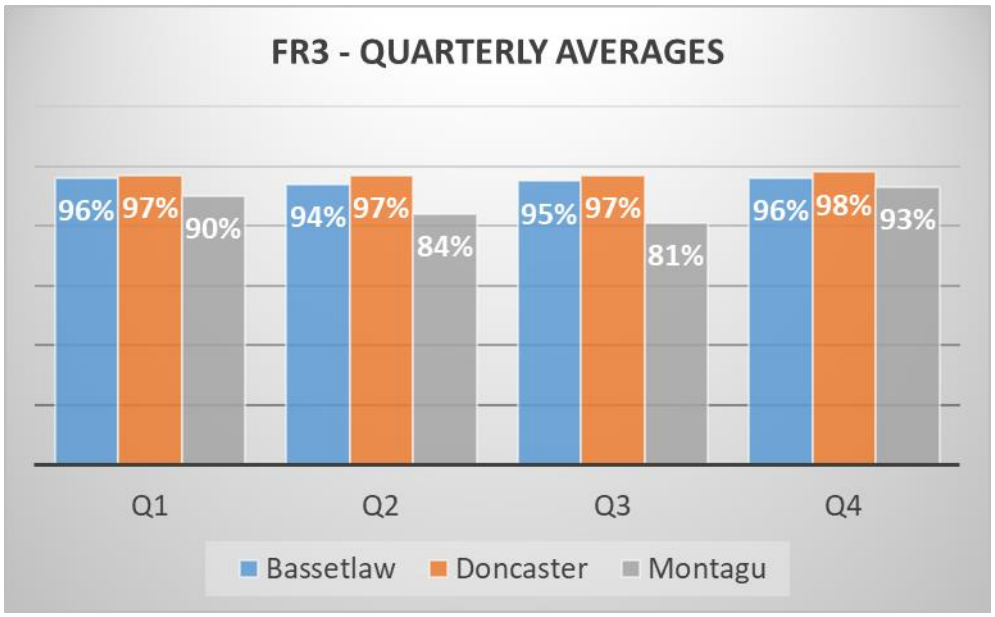
The service audits in excess of 3000 wards and departments every year.

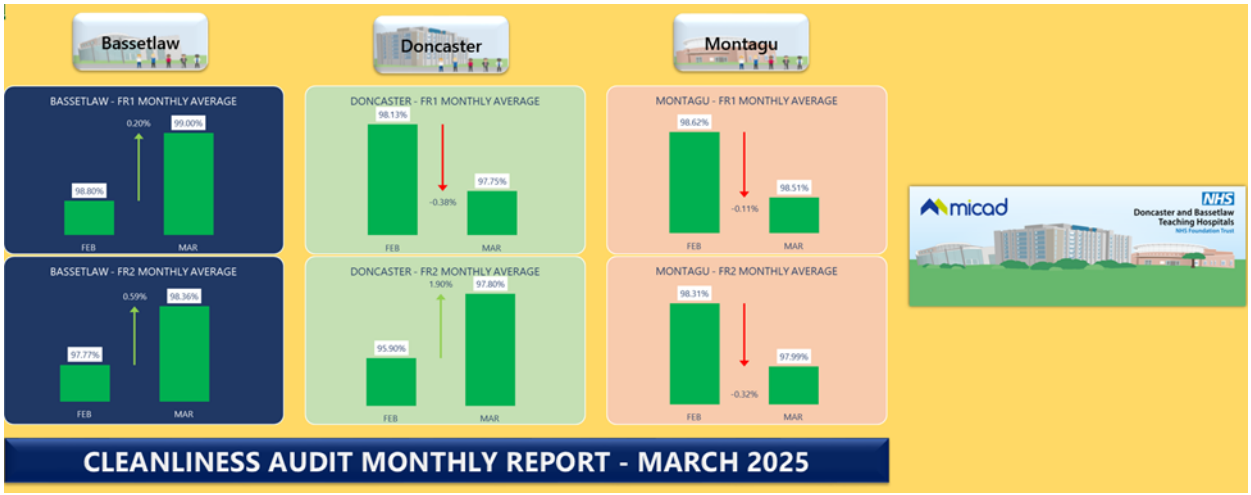
We report our performance monthly to our internal POSM meetings for assurance.

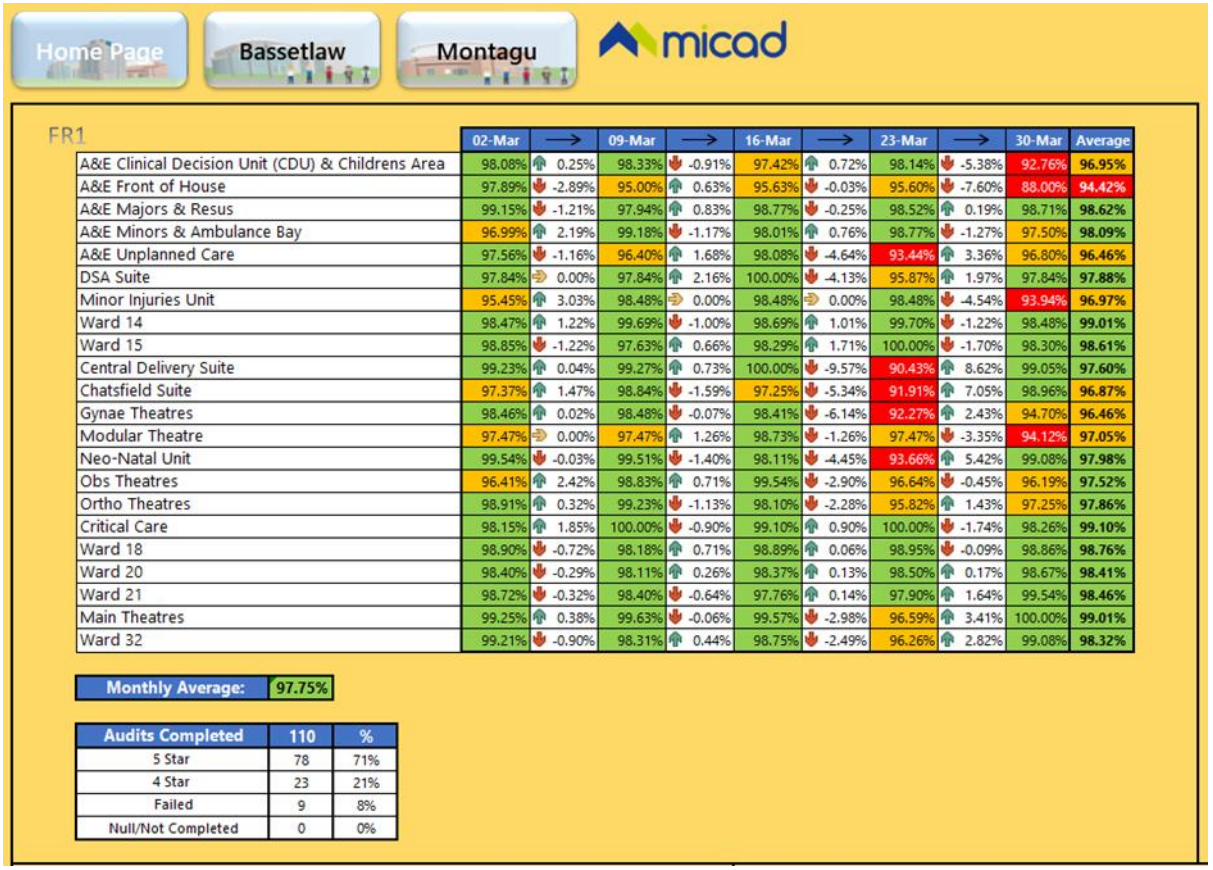
The development of dashboards and management information designed to improve operational outcomes, are key tools for the management team and for providing assurance of oversight. Examples of our dashboards for reporting are below.


FR1 - QUARTERLY AVERAGES
97%
98%
98%
98%
97%
96%
98%
98%
97%
98%
97%
96%
Q1
Q2
Q3
Q4
Bassetlaw
Doncaster
Montagu


FR2 - QUARTERLY AVERAGES
97%
98%
97%
96%
98%
98%
96%
98%
95%
98%
97%
98%
Q1
Q2
Q3
Q4
Bassetlaw
Doncaster
Montagu


FR3 - QUARTERLY AVERAGES
96%
97%
90%
94%
97%
84%
95%
97%
81%
96%
98%
93%
Q1
Q2
Q3
Q4
Bassetlaw
Doncaster
Montagu


Bassetlaw
Doncaster
Montagu
BASSETLAW - FR1 MONTHLY AVERAGE
98.80%
99.00%
0.20%
FEB
MAR
DONCASTER - FR1 MONTHLY AVERAGE
98.13%
97.75%
-0.38%
FEB
MAR
MONTAGU - FR1 MONTHLY AVERAGE
98.62%
98.51%
-0.11%
FEB
MAR
BASSETLAW - FR2 MONTHLY AVERAGE
97.77%
98.36%
0.59%
FEB
MAR
DONCASTER - FR2 MONTHLY AVERAGE
95.90%
97.80%
1.90%
FEB
MAR
MONTAGU - FR2 MONTHLY AVERAGE
98.31%
97.99%
-0.32%
FEB
MAR
micad
NHS
Doncaster and Bassetlaw Teaching Hospitals
CLEANLINESS AUDIT MONTHLY REPORT - MARCH 2025

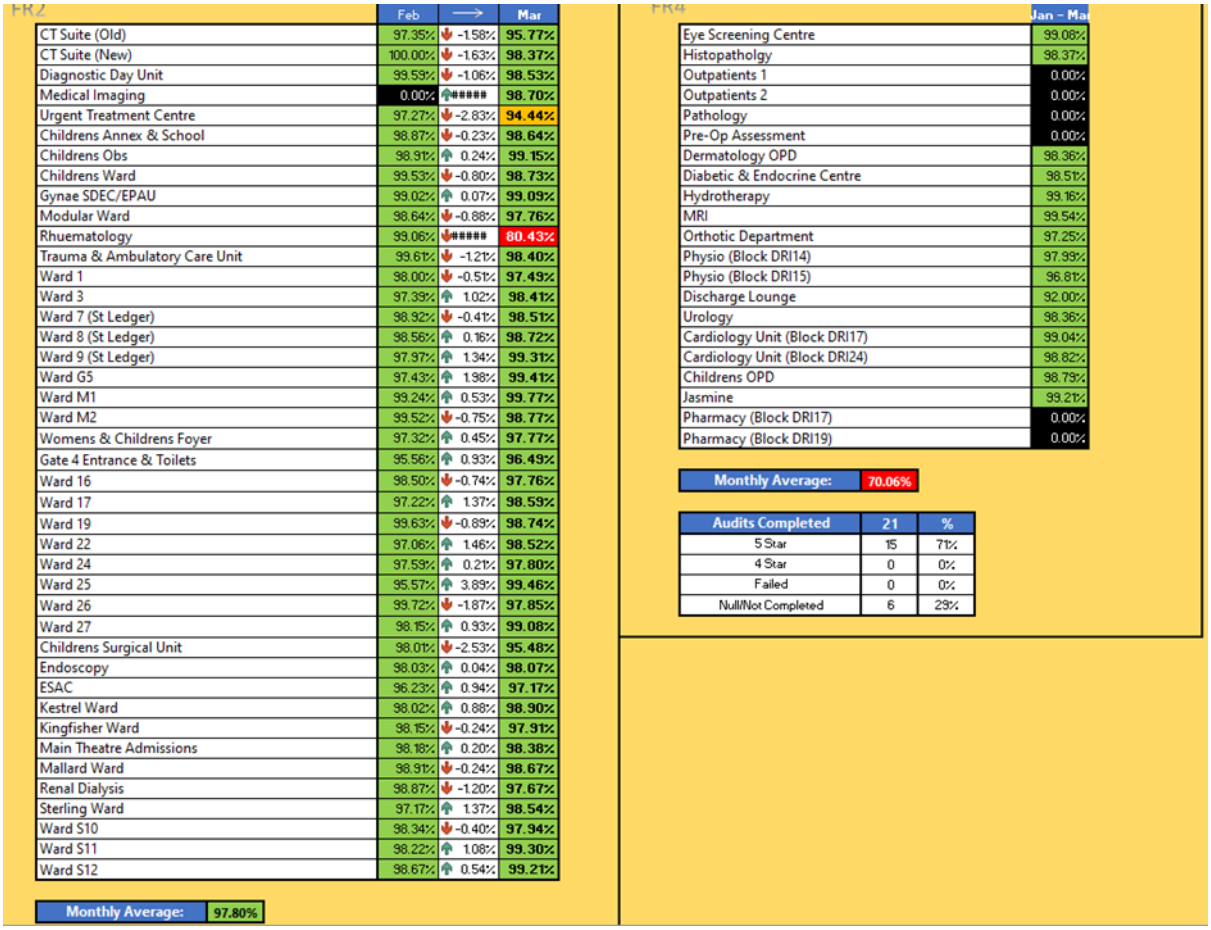


FR1

	02-Mar		09-Mar		16-Mar		23-Mar		30-Mar	Average
A&E Clinical Decision Unit (CDU) & Childrens Area	98.08%	0.25%	98.33%	-0.91%	97.42%	0.72%	98.14%	-5.38%	92.76%	**96.95%**
A&E Front of House	97.89%	-2.89%	95.00%	0.63%	95.63%	-0.03%	95.60%	-7.60%	88.00%	**94.42%**
A&E Majors & Resus	99.15%	-1.21%	97.94%	0.83%	98.77%	-0.25%	98.52%	0.19%	98.71%	**98.62%**
A&E Minors & Ambulance Bay	96.99%	2.19%	99.18%	-1.17%	98.01%	0.76%	98.77%	-1.27%	97.50%	**98.09%**
A&E Unplanned Care	97.56%	-1.16%	96.40%	1.68%	98.08%	-4.64%	93.44%	3.36%	96.80%	**96.46%**
DSA Suite	97.84%	0.00%	97.84%	2.16%	100.00%	-4.13%	95.87%	1.97%	97.84%	**97.88%**
Minor Injuries Unit	95.45%	3.03%	98.48%	0.00%	98.48%	0.00%	98.48%	-4.54%	93.94%	**96.97%**
Ward 14	98.47%	1.22%	99.69%	-1.00%	98.69%	1.01%	99.70%	-1.22%	98.48%	**99.01%**
Ward 15	98.85%	-1.22%	97.63%	0.66%	98.29%	1.71%	100.00%	-1.70%	98.30%	**98.61%**
Central Delivery Suite	99.23%	0.04%	99.27%	0.73%	100.00%	-9.57%	90.43%	8.62%	99.05%	**97.60%**
Chatsfield Suite	97.37%	1.47%	98.84%	-1.59%	97.25%	-5.34%	91.91%	7.05%	98.96%	**96.87%**
Gynae Theatres	98.46%	0.02%	98.48%	-0.07%	98.41%	-6.14%	92.27%	2.43%	94.70%	**96.46%**
Modular Theatre	97.47%	0.00%	97.47%	1.26%	98.73%	-1.26%	97.47%	-3.35%	94.12%	**97.05%**
Neo-Natal Unit	99.54%	-0.03%	99.51%	-1.40%	98.11%	-4.45%	93.66%	5.42%	99.08%	**97.98%**
Obs Theatres	96.41%	2.42%	98.83%	0.71%	99.54%	-2.90%	96.64%	-0.45%	96.19%	**97.52%**
Ortho Theatres	98.91%	0.32%	99.23%	-1.13%	98.10%	-2.28%	95.82%	1.43%	97.25%	**97.86%**
Critical Care	98.15%	1.85%	100.00%	-0.90%	99.10%	0.90%	100.00%	-1.74%	98.26%	**99.10%**
Ward 18	98.90%	-0.72%	98.18%	0.71%	98.89%	0.06%	98.95%	-0.09%	98.86%	**98.76%**
Ward 20	98.40%	-0.29%	98.11%	0.26%	98.37%	0.13%	98.50%	0.17%	98.67%	**98.41%**
Ward 21	98.72%	-0.32%	98.40%	-0.64%	97.76%	0.14%	97.90%	1.64%	99.54%	**98.46%**
Main Theatres	99.25%	0.38%	99.63%	-0.06%	99.57%	-2.98%	96.59%	3.41%	100.00%	**99.01%**
Ward 32	99.21%	-0.90%	98.31%	0.44%	98.75%	-2.49%	96.26%	2.82%	99.08%	**98.32%**

Monthly Average:	97.75%

Audits Completed	110	%
5 Star	78	71%
4 Star	23	21%
Failed	9	8%
Null/Not Completed	0	0%



FR2	Feb		Mar
CT Suite (Old)	97.35%	-1.58%	95.77%
CT Suite (New)	100.00%	-1.63%	98.37%
Diagnostic Day Unit	99.59%	-1.06%	98.53%
Medical Imaging	0.00%	#####	98.70%
Urgent Treatment Centre	97.27%	-2.83%	94.44%
Childrens Annex & School	98.87%	-0.23%	98.64%
Childrens Obs	98.91%	0.24%	99.15%
Childrens Ward	99.53%	-0.80%	98.73%
Gynae SDEC/EPAU	99.02%	0.07%	99.09%
Modular Ward	98.64%	-0.88%	97.76%
Rhuematology	99.06%	#####	80.43%
Trauma & Ambulatory Care Unit	99.61%	-1.21%	98.40%
Ward 1	98.00%	-0.51%	97.49%
Ward 3	97.39%	1.02%	98.41%
Ward 7 (St Ledger)	98.92%	-0.41%	98.51%
Ward 8 (St Ledger)	98.56%	0.16%	98.72%
Ward 9 (St Ledger)	97.97%	1.34%	99.31%
Ward G5	97.43%	1.98%	99.41%
Ward M1	99.24%	0.53%	99.77%
Ward M2	99.52%	-0.75%	98.77%
Womens & Childrens Foyer	97.32%	0.45%	97.77%
Gate 4 Entrance & Toilets	95.56%	0.93%	96.49%
Ward 16	98.50%	-0.74%	97.76%
Ward 17	97.22%	1.37%	98.59%
Ward 19	99.63%	-0.89%	98.74%
Ward 22	97.06%	1.46%	98.52%
Ward 24	97.59%	0.21%	97.80%
Ward 25	95.57%	3.89%	99.46%
Ward 26	99.72%	-1.87%	97.85%
Ward 27	98.15%	0.93%	99.08%
Childrens Surgical Unit	98.01%	-2.53%	95.48%
Endoscopy	98.03%	0.04%	98.07%
ESAC	96.23%	0.94%	97.17%
Kestrel Ward	98.02%	0.88%	98.90%
Kingfisher Ward	98.15%	-0.24%	97.91%
Main Theatre Admissions	98.18%	0.20%	98.38%
Mallard Ward	98.91%	-0.24%	98.67%
Renal Dialysis	98.87%	-1.20%	97.67%
Sterling Ward	97.17%	1.37%	98.54%
Ward S10	98.34%	-0.40%	97.94%
Ward S11	98.22%	1.08%	99.30%
Ward S12	98.67%	0.54%	99.21%

Monthly Average:	97.80%

FR4	Jan - Mar
Eye Screening Centre	99.08%
Histopatholgy	98.37%
Outpatients 1	0.00%
Outpatients 2	0.00%
Pathology	0.00%
Pre-Op Assessment	0.00%
Dermatology OPD	98.36%
Diabetic & Endocrine Centre	98.51%
Hydrotherapy	99.16%
MRI	99.54%
Orthotic Department	97.25%
Physio (Block DRI14)	97.99%
Physio (Block DRI15)	96.81%
Discharge Lounge	92.00%
Urology	98.36%
Cardiology Unit (Block DRI17)	99.04%
Cardiology Unit (Block DRI24)	98.82%
Childrens OPD	98.79%
Jasmine	99.21%
Pharmacy (Block DRI17)	0.00%
Pharmacy (Block DRI19)	0.00%

Monthly Average:	70.06%

Audits Completed	21	%
5 Star	15	71%
4 Star	0	0%
Failed	0	0%
Null/Not Completed	6	29%

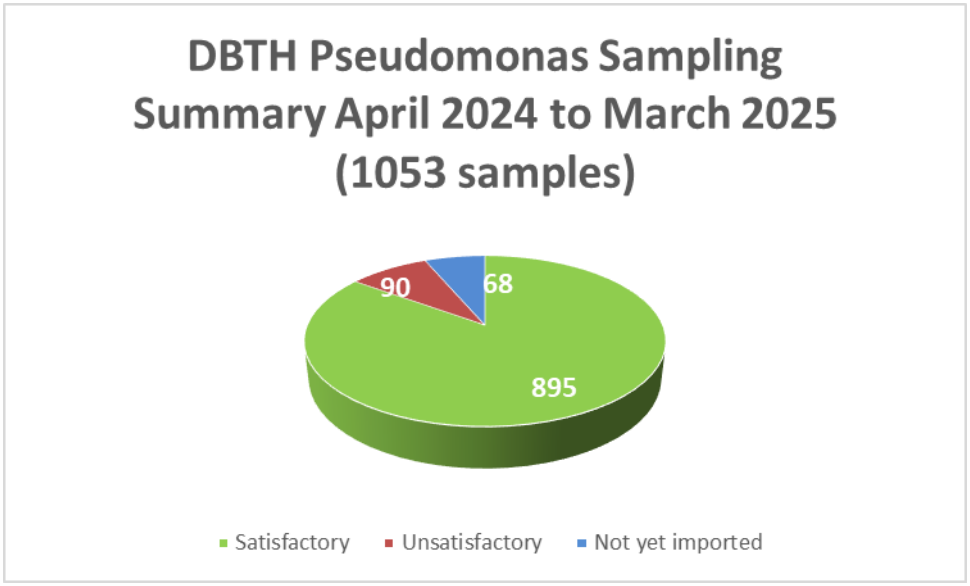
Water Safety Group:

Water hygiene sampling for Pseudomonas Aeruginosa and Legionella species is carried out proactively to monitor water quality within Trust premises. Sampling is also implemented reactively in response to any potential failures in water quality control strategies for assurance.

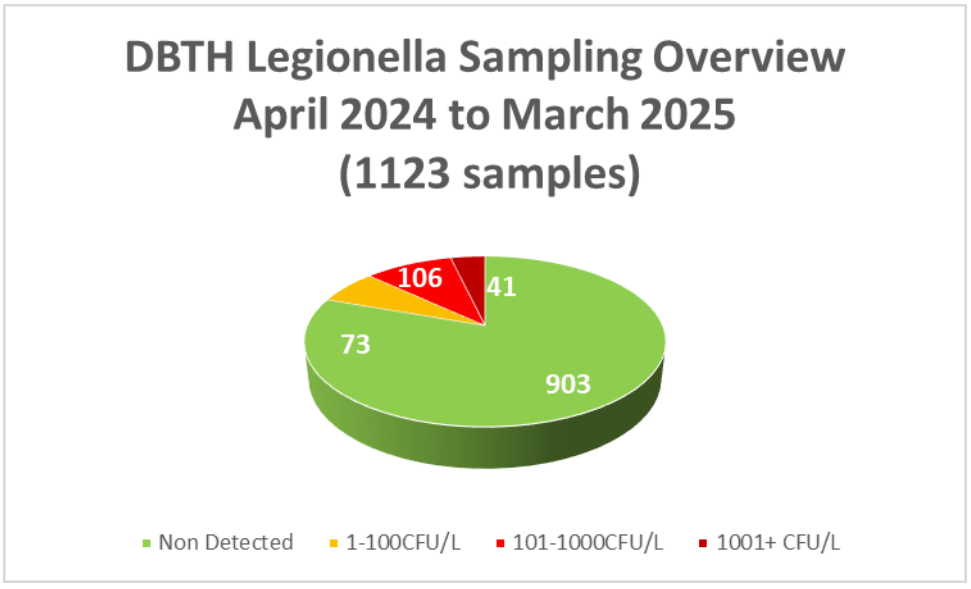
Routine sampling is carried out on a monthly basis across the 3 sites, the sampling is made up of repeat testing of any failures from the previous month and a set of samples. The sampling strategy is agreed jointly between IPC and the Estates team at the Water Safety Group (WSG) which meets every 3 months.

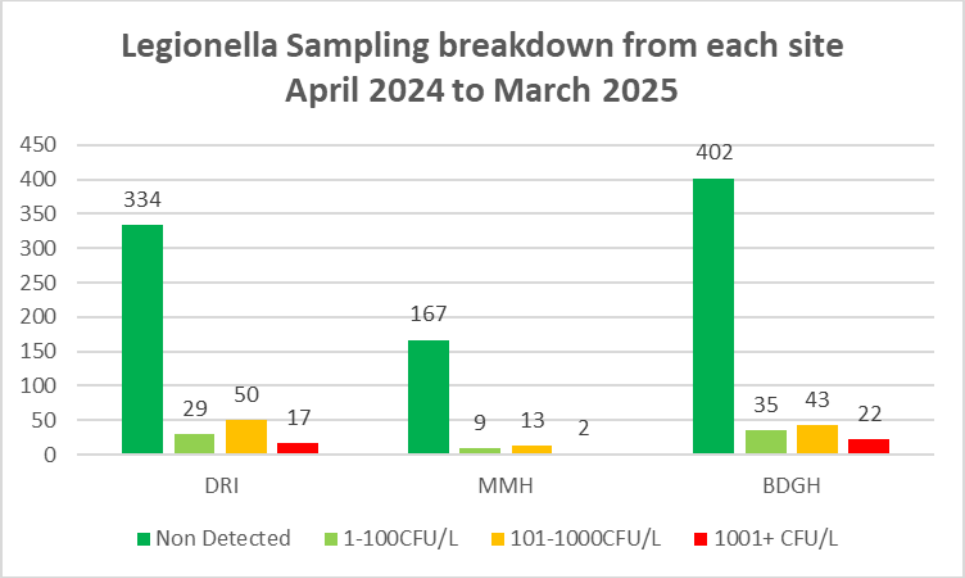
HTM 04-01 'Safe Water in Healthcare Premises' advises that all outlets in augmented care areas should be sampled for Pseudomonas Aeruginosa on a 6 monthly basis. A third party water quality service provider is contracted to conduct this sampling on behalf of the Trust they carry out a number of samples across the sites for Pseudomonas. Below are the Pseudomonas results for 2024/25

Over this period, Pseudomonas Aeruginosa sampling has slightly increased, with 1053 samples taken, representing a 148-sample increase following an audit of augmented care areas. The vast majority of results were clear, with only 90 positive samples identified. Where positives were detected, appropriate action was taken to address and resolve any issues.



Legionella sampling similarly has remained relatively constant in 2024/25 with 1123, the vast majority of sample returned a satisfactory result, and any unsatisfactory results are investigated for non-conformities and rectified and resampled.





IPC and Estates continue to work in close collaboration to monitor sampling data and coordinate responses to positive sample results as required. Water sampling data is also reported to the Trust Water Safety Group and Infection Control Committee routinely for assurance. Any trends, themes or concerns emerging from this data are then discussed so that actions to manage the risk may be agreed accordingly.

Ventilation

Poor ventilation remains a significant challenge across the Trust's estate. This issue is actively managed by the Ventilation Safety Group, which meets every six months to review the latest ventilation reports for both critical and non-critical ventilation systems.

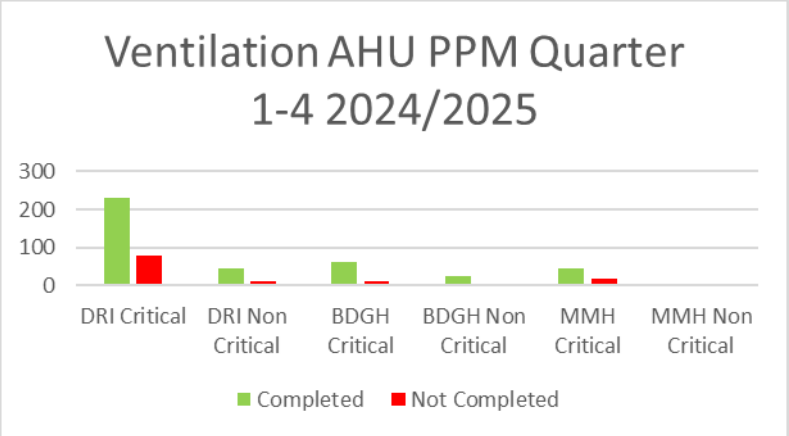
Due to limited capital funds, the Trust has prioritised ventilation improvements where they will have the greatest impact. In the last financial year, the Ventilation Safety Group allocated funds to begin replacing the main supply and extract fans in the two tower blocks, East Ward and Women's & Children's, as this project is expected to deliver the most significant improvements to clinical areas, including the Department of Critical Care and Respiratory, both classified as critical ventilation zones under the Health Technical Memorandum.

All fans were procured within the last financial year, and installation has progressed well during the current year. The clean and dirty extract systems have already been successfully replaced in both the East Ward and Women's Block.

In addition, the Ventilation Safety Group has agreed to collect and store all unused air scrubbers purchased during the COVID-19 pandemic. These units are now held by the Estates department and will be deployed as required under the direction of the Infection Prevention and Control team.

The table below summarises the PPM performance over the past year. An average completion rate of 76.71% was achieved for critical ventilation PPM, and 78.87% for non-critical ventilation PPM. While achieving full compliance remains a challenge due to workforce capacity, as highlighted in the recent Estates Review robust processes are in place to mitigate this. Any missed PPMs are identified through the Estates KPI meeting and are actioned independently to ensure they are completed in a timely manner.

Importantly, all critical verifications are carried out externally by a specialist contractor, supporting our continued commitment to maintaining compliance wherever possible.



2024-25	CRITICAL	Completed	NON CRITICAL	Completed
DRI	309	74.43%	56	80.36%
BDGH	73	83.56%	32	81.25%
MMH	61	72.13%	4	75.00%

3. Provide suitable accurate information on infections to service users and their visitors.

Patient information

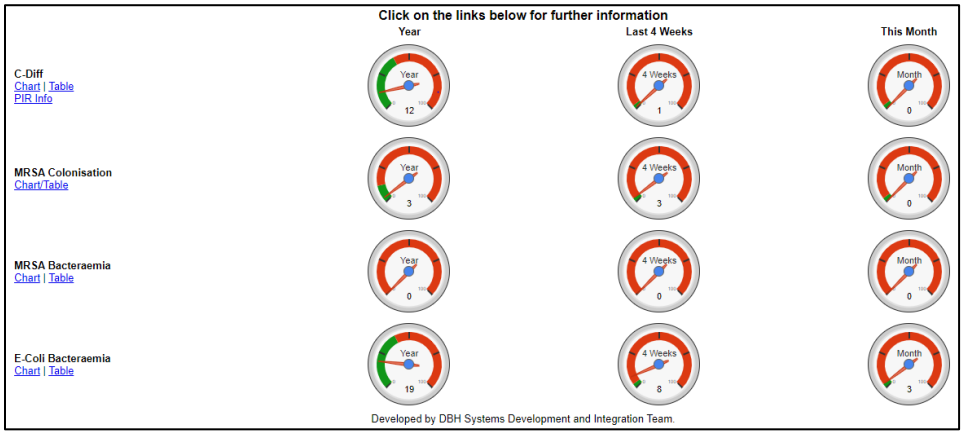
General patient information is available on the Trust's internet site, which includes up to date information on respiratory viral infection following advice from UKHSA (UK Health Security Agency) and access to Hospital services. This information is updated when required through the year. Patient information leaflets are available on different organisms, explaining what they are and what measures may be put in place while the patient is in hospital and what that means for the patient and their families.

4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

Performance dashboard

The intranet site for most of the year displayed a number of key clinical indicators available to managers and clinical staff.

These dials provided a quick visual assessment on how the Trust is performing against key performance indicators, and clicking on the dials gave access to further detailed information.



The performance dials are also interactive allowing Divisions to visually review their performance against key IPC indicators. The processes of accessing these HCAI dials involves taking multiple steps on the Trust HIVE system and are thus, not as accessible as they were with the previous intranet site.

There has been a recognition over the past year that the current Intranet site is outdated. As the Trust moves to using Nerve Centre, the IPC team have worked with the Digital Transformation team to develop an IPC profile on Nerve Centre to provide live information that can be inputted remotely and seen by the clinical teams immediately on the hand held devices in the clinical area and on Desktops. However, Nerve Centre only provides a snapshot of patients with infectious organisms who are inpatients at the time of viewing. The system does not provide a cumulative view across the year.

The current IPC information dashboard is not supported, is not fit for purpose and has reoccurring technical issues. This has been recorded on the trust Risk Register since 2022. Financial constraints within the organization has prevented the purchase of an appropriate IPC IT system.

5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

Covid-19

Over the year 2024-2025, the organisation continued to see activity in relation to SARS-CoV-2 and COVID-19 although cases have been much reduced. In accordance with national guidance and the National Infection Prevention and Control Manual, COVID-19 has been group with other acute respiratory illnesses with changes to acquisition classifications to reflect hospital acquired cases where illness occurs on or after day 5 of admission (where day of admission is 0).

Key elements of the IPCT continued response over the year 2024-2025 are listed below:

- PPE regimes reinforced. General wearing of masks have been stepped down throughout the year, with mask wearing in place when caring for patients with infectious respiratory illness. Protocols also reflected the requirement to wear masks where colleagues have been well enough to attend work but where they have some respiratory symptoms.
- Frequent close contact with clinical services to support clinical practice and patient management in terms of IPC practices and in clinical aspects by Consultants in Infection and the Infection Prevention and Control Team.
- Continued provision of the IPC service across the Trust and across the Doncaster borough covering all CQC registered older persons care homes, Learning Disabilities care homes, Supported Living facilities, two Specialist Healthcare Placements, five Extra Care facilities and the team are also a point of contact for domiciliary care providers as and when required.
- COVID-19 outbreak management within the DBTH and in community services covered by the team.

Patient Management/cohorting

There have been 323 patients who have acquired COVID-19 within DBTH from day 5 of their admission onwards during 2024-2025. There have been 341 cases of COVID 19 in patients admitted to the organization having been exposed whilst in the community. In order to identify patient with COVID, Flu and RSV when they present to DBTH, point of care testing has been place, facilitating a result within ten minutes of the test being taken which allows for appropriate segregation from patients who are not known to have an infectious viral respiratory illness.

Patients who are known to have been admitted with any confirmed or suspected infectious illness, continue to be isolated or cohorted during their infectious period to minimise the risk of transmission of infection.

The IPC team have participated daily in the Operational meetings, where senior leaders support patient flow through services as safely as possible with advice given by the IPC team and Consultants in Infection where required. The infection prevention and control team have provided a service at weekends during 2024-25 to support with patient flow and management of patients with infectious illnesses.

The Infection Prevention and Control Team have worked to identify protocols and separate areas through which to receive patients who may have a High Consequence Infectious Disease (HCID).

PPE

Mask Fit testing remains a key priority for DBTH as it now forms part of the Emergency Preparation Resilience and Response (EPRR) Core standards which mandates that any member of staff that is likely to be exposed to patients who may have an infection where FFP3 masks are required (e.g Influenza, COVID-19, TB) must be Fit tested on at least two masks every two years. Fit tests should be carried out by a competent person in accordance with Health and Safety Executive.

The resource required to meet the standard is not in place. The IPC team have provided ad hoc FIT testing on staff, supporting Paediatrics in particular this year to support staff in meeting the needs of patients with Measles this year. The Education Team are Fit testing new starter staff during induction, if the staff member's role means that they may come into close contact with a patient with an infection that requires the wearing of FFP3 masks.

In late 2024, Mpox Clade 1b (initially classified as a HCID) became a recognized risk in the UK, with the first UK case being identified in October 2024. Although, there were no known cases in Doncaster, on notification by the UKHSA, preparations were made to ensure a level of preparedness, procuring elements of PPE required when caring for patients with a HCID. Whilst stocks have been put in place, accompanying training has not been available. Training has been planned for the coming year, with HCID donning and doffing competence expected to become part of the EPRR core standards going forward.

Response to Suspected Infectious cases

The infection Prevention Control Team have responded to minimize the risk of spread of infectious organisms conducting investigations and contact tracing in relation to; 41 suspected cases of
Measles, 9 of which were confirmed as being positive, 4 suspected Pertussis cases and 4 cases of Pulmonary Tuberculosis.

Outbreaks

Outbreaks that have occurred throughout 2024-2025 are listed below. On identification of an outbreak the IPC Team have deployed, rapidly reviewing the areas and identifying areas for improvement. The IPC Team have also audited PPE use and IPC practice proactively outside of outbreaks situations. Themes of learning identified through outbreak control reviews have been exposure of unknown origin, resulting in spread across the wards. Prior to the outbreak occurring there have been no COVID related restrictions, no restriction to visitors. Ventilation may also have had an impact as well as general clutter of environments.

Date	Department	Causative Organism	Number of patients involved	Number of staff involved	Outcome	Comments
April 2024	Gresley	COVID-19	19	12	Resolved within a month	Visitors confirmed COVID positive after visiting
May/June 2024	Ward 16/17	Norovirus	17	16	Resolved within a month	Unknown source
June 2024	Rehab 2	COVID-19	12	3	Resolved within 2 weeks	Initial patient had been moved to ED for a short period time which may have been

						the source of exposure
Nov 2024	Gresley	Norovirus & COVID 19	8 Noro 12 COVID	2 Noro 3 Respiratory	Resolved within a month	Unknown source
Jan 2025	Ward 17	Norovirus	20	6	Resolved within a month	Unknown source

ANTIMICROBIAL MANAGEMENT

The DBTH antimicrobial stewardship activity in 2024/2025 has focused on a number of key priorities –

I. Antibiotic audits and feedback to wards and clinicians
II. Improving the blood culture pathway in ED
III. Specialty ward rounds and MDTs
IV. Stewardship in Surgery
V. Regional and local Paediatric antibiotic stewardship activities
VI. IVOS CQUIN (non-mandatory)
VII. Review of fluoroquinolone use
VIII. Reducing MSSA bacteraemia in renal dialysis patients
IX. Updating antimicrobial guidelines
X. Virtual wards for complex antibiotic regimens/monitoring
XI. Educational activities including WAAW 2024
XII. Participation in regional AMS committees

AMS team and service

The AMS agenda is delivered through teamwork from Consultants in Infection, Trust grade doctors, Antimicrobial Pharmacist and IPC nurse team. From January 2025, we have also recruited an AMS Nurse to our team to assist in expanding AMS activity and education within the Trust. Our clinical service comprises of phone consults, e-consults from GPs, bacteraemia reviews, infectious disease consults, daily ICU ward rounds and specialty antibiotic ward rounds in a number of specialties. We work closely with our IPC team – they regularly identify high risk patients for C.difficile, MRSA or those with antibiotic stewardship concerns.

I. Antibiotic Ward round audits

We developed an antibiotic ward round data collection tool for use by the AMS team and IPC teams to be able to provide real time data and feedback to clinicians regarding key performance indicators for AMS – in particular, appropriate antibiotic indication, choice based on guideline or discussion with microbiology, evidence of 48 hour review and outline of antibiotic plan/stop date. This data tool is now being used by the whole team to provide verbal and written feedback to clinical teams regarding performance and areas that require improvement. In addition, we are collecting data on proportion of community onset vs hospital onset infections, whether appropriate de-escalation of antibiotics is being undertaken, whether diagnostic samples and sepsis screen is being sent, whether source control is considered and whether patient is on a concurrent PPI.

We have aimed to alternate between medical and surgical specialties to capture data on current prescribing practice and areas that require further intervention. Data from AMS ward rounds and IVOS CQUIN has been shared periodically at IPCSSG meetings to raise awareness and trigger improvement. The audit data is also emailed to relevant stakeholders for wider dissemination and learning within clinical teams.

Our Trust performance in infection audits, point prevalence studies and antibiotic consumption data is shared at the bimonthly IPC Strategic Steering Group (IPCSSG) meetings. The previous AMT group has been stood down due to engagement lacking from some of the specialty areas. This has been replaced with engaging individually with teams and ward areas to address pertinent issues.

II. Blood culture pathway in DRI ED

2024/2025 has seen more networking with key stakeholders within the Trust to improve AMS/sepsis. We initiated a Qi to improve the blood culture pathway, focusing on reducing transport times, increasing blood culture volumes and reducing blood culture contamination. This involved collaborating with ED colleagues, sepsis nurses within the Trust, laboratory management, Estates and facilities and colleagues in Education department. Baseline data has been collected to look at transport times from ED to the lab and times from lab receipt to uploading onto the blood culture incubators. We have raised awareness of the blood culture pathway in ED through posters, new guidelines and meetings. We have introduced a 'blue light box' in ED to identify blood cultures as urgent samples requiring urgent transport. In regard to blood culture contamination, we are collecting data on potential issues that may be contributing, such as skin decontamination and method of obtaining blood cultures. This piece of work is still underway and will continue into the new financial year. We aim to extend this work to Bassetlaw ED in due course.

III. Specialty Ward Rounds & MDTs

The Consultants in Infection conduct regular antibiotic ward rounds and provide input at governance meetings for a number of specialties within DBTH. This includes weekly haematology, orthopaedics, renal and vascular MDTs. In addition, we participate in regular MDTs for prosthetic joint infections, spinal infections/discitis and ad hoc presence at regional South Yorkshire infective endocarditis. The Infection team meets on a weekly basis to discuss complex cases around the hospital and review stewardship issues.

IV. Stewardship in Surgery

a) We undertook AMS audits in Urology in Quarter 2 and shared feedback with Urology Consultant governance lead. Discussions included:

- Shared antibiotic audit data for ward 19 from April – June 2024
- Shared learning from recent C.difficile case
- Discussed way to improve AMS on ward 19 including encouraging 1st line gentamicin use (versus Cefuroxime) where possible, avoid 'reflex' prescribing of IV Cefuroxime, avoid combining Cefuroxime and Gentamicin, ensure previous urine culture results and microbiology are reviewed prior to prescribing antibiotic (e.g. previous ESBL)
- Shared Nottingham guideline for recurrent UTI – option of 1st line use of methenamine for recurrent UTI rather than low dose antibiotic strategy.
- To avoid overuse of trimethoprim as 'prophylaxis' post urological procedures unless recent urinary isolate which is trimethoprim sensitive. Consider pivmecillinam as alternative
- Information regarding MHRA alerts for fluoroquinolones and restricting use unless there is no safe alternative. Need for providing patient information leaflet.

In the next financial year, we plan to write a local DBTH guideline in conjunction with Urology team for management of recurrent UTI, and to consider methenamine hippurate (as opposed to prophylactic antibiotics) earlier in the treatment pathway.

b) In Quarter 3 we met with Surgery AMS lead and Deputy Divisional Nurse to discuss AMS benchmarking and activities within the surgical division

Data shared and discussed included:

- Rates of hospital acquired infections (including C.difficile, MSSA, MRSA, E.coli, Klebsiella and Pseudomonas bacteraemia)
- Hand hygiene compliance rates
- IVOS CQUIN
- Reducing antibiotic use in UTI by improving hydration and catheter care (IPC audit)
- Antimicrobial ward round data for AMS quality indicators.
- Specific issues identified during antimicrobial ward rounds including
  - Use of triple antimicrobial therapy outside of Trust policy (amoxicillin, flucloxacillin and metronidazole)
  - Use of ciprofloxacin for ERCP prophylaxis
  - Prescriptions for extended prophylaxis

The AMS Nurse and IPC team plan to subsequently complete focus weeks within surgery. A further update for the above will provided to the surgery division in the new financial year.

V. ***Paediatric AMS***

We have a local DBTH Paediatric AMS group and we link in with the regional paediatric South Yorkshire group (SYB pAMS) on a quarterly basis. The SYB pAMS network has been shortlisted for a national award – the prescribing and stewardship category of the Antibiotic Guardian Shared Learning and Awards Event.

The DBTH paediatric teams are enthusiastic about AMS and have initiated a number of AMS activities in 2024/25:

- Bimonthly data collection on antibiotic prescribing practices – including appropriate indication, choice of agent, duration/review,
- Daily discussion regarding AMS at handover and huddles
- Addition of a 'Microbiology' column in the patient handover sheet to prompt doctors to review antibiotic appropriately
- Introduction of IVOS sticker on drug kardex
- Education for resident doctors on current guidelines and treating common infections
- Qi project to improve blood culture pathway in paediatrics with an emphasis on increasing blood culture volumes and ensuring the correct blood culture bottles are used depending on the child's age. This project has just been initiated and work will carry on into the next financial year.
- Qi project to improve diagnostic stewardship around urine sampling methods. We have removed 'bag urines' from ICE requesting to avoid contaminated samples and unnecessary antibiotic use. This project is also ongoing.

VI. ***IVOS CQUIN***

We continued to work on IVOS strategy and improvement to build on the work done last year. IVOS CQUIN was non-mandatory in 2024/2025. The CQUIN target had been set at less than 15% of patients still being on IV antibiotics at the point of meeting UKHSA IVOS criteria and the CQUIN was extended to include paediatric patients. This target had been tightened compared to 2023/2024 when it had been set at 40% or less. We audited a random selection of medical, surgical and paediatric wards in DBTH – 102 cases in Quarter 1, 100 cases in Quarter 2, 100 cases in Quarter 3 and 52 cases in Quarter 4. See Figure 1 for performance figures.

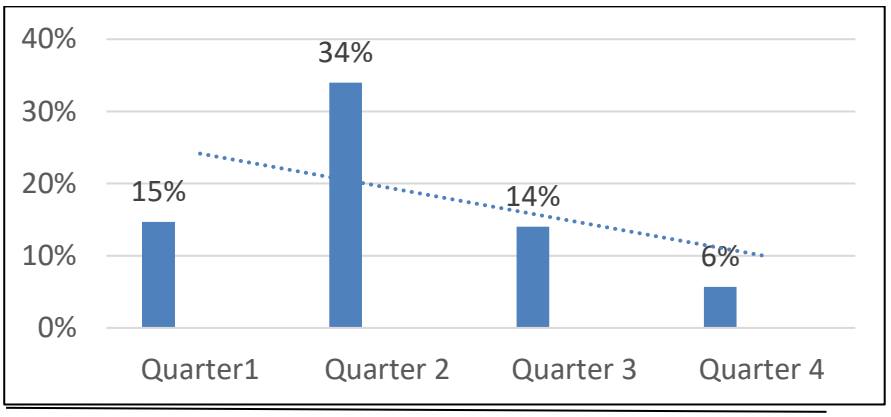


Figure 1 Proportion of DBTH patients still on IV antibiotics at point of meeting IVOS switching criteria (Target < 15%)

VII. ***Restricting fluoroquinolone use***

On the back of the MHRA warnings in January 2024, we have reviewed antibiotic policies to minimise fluoroquinolone use and replace with alternative antibiotics where possible.

Use of fluoroquinolone antibiotic is already restricted at DBTH. Microbiology authorisation is required for most fluoroquinolone prescriptions which are outside of our Trust policy. This is to ensure appropriateness, given the side effect profile, and to advise that discussions occur between the prescribing doctor and patient about the risks and benefits of the antibiotic selected.

In the next financial year, we are aiming to conduct surveillance audits on a weekly basis and feedback to clinicians regarding inappropriate use.

VIII. ***MSSA bacteraemia in Renal dialysis patients***

Due to high numbers of MSSA bacteraemia within the renal unit in recent years, we have introduced measures to address this:

- IPC presence on renal 3x per week
- Post infection reviews for any cases of MSSA bacteraemia in renal patients
- Emphasis on hand hygiene
- Encouraging the use of Prontoderm foam for patients on dialysis days
- Enhanced MSSA screening to include patients with tunnel lines (as before), now extended to patients with AV grafts and those with buttonhole fistula
- Introduction of topical decolonisation for all patients going for new tunnel line insertion pending swab results
- Qi project introducing BioPatch and Leukomed dressings for patients intolerant of the chlorhexidine dressings (likely due to adhesive rather than chlorhexidine allergy). We have trialled these dressings on 14 patients since 1/2/2025. We have had 3 episodes of MSSA colonisation in the 14 patients to date, none of which were from the line exit site. No cases of bacteraemia in these patients so far. The BioPatch dressings are also being rolled out to satellite dialysis units (Dearne Valley and Bassetlaw). This trial is ongoing and further results will be available in the next financial year.

IX. ***Trust Antimicrobial policies***

The antimicrobial policies are updated and reviewed in monthly Drugs and Therapeutics Committee meetings. See table 2 for overview of guidelines reviewed in 2024/2025.

Table 2 Guideline updated and approved April 2024 – March 2025

Guidelines	Date of approval
Gastrointestinal Tract Infections	April 2024
High dose antimicrobial guideline	June 2024
Treatment of lower respiratory tract infections	September 2024

X. Infection Virtual Wards

In 2024/2025, we have continued and expanded on the 2 x Virtual Ward pathways for Infection Management and Orthopaedic infections. This has been useful in facilitating earlier discharge from hospital and monitoring of complex antibiotic regimens including both IV and PO antibiotics.

XI. *AMS Education during World Antimicrobial Awareness Week 2024*

The theme for WAAW 2024 was 'Educate, Advocate, Act now'. As part of our educational programme we focused on the followed areas:

- UTI – prevention (hydration/catheters)/novel therapies in recurrent UTI
- Watch & reserve antibiotics
- AMS in Paediatrics
- Sepsis and value of diagnostic stewardship

Following the launch of WAAW on 18th Nov 2024, we offered drop in sessions to quiz the Infection and IPC team on AMR related questions, displayed posters and delivered an educational lunchtime lecture.

XII. *Regional committees and networks*

We participate in a number of external AMS network meetings, including SYB AMS/IPC group, South Yorkshire Paediatric AMS (SY pAMS) and Yorkshire & Humber Regional Antimicrobial Pharmacist group.

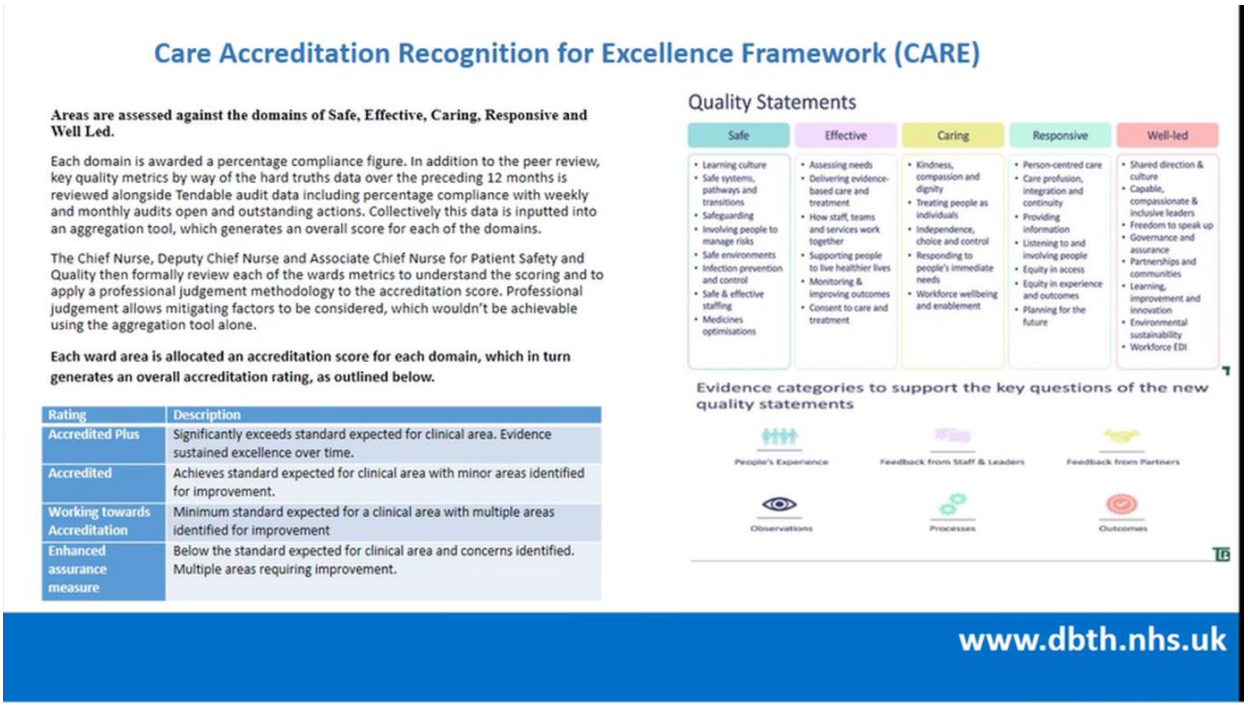
6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

Care Accreditation Recognition for Excellence Framework

It is vital an organisation has systems and structures in place to measure, evaluate and improve the delivery of care to their patients and service users. A governance framework provides a clear structure which enables the organisation to benchmark practice standards, identify areas of concern and most importantly identify sources of support for challenges and blockages which may occur preventing improvement.

The processes within the Care Accreditation Recognition for Excellence framework, allow DBTH to monitor and review concerns or declining performance, celebrate excellence in care, identify sources of support for challenges or blockages that will not be overcome without corporate or wider support.

Wards/Departments are assessed against the domains; Safe, Effective, Caring, Responsive and Well Led. The Infection Prevention and Control elements, sit within the Safe element.



Each Ward/department is allocated an accreditation score for each element, generating an overall accreditation rating.

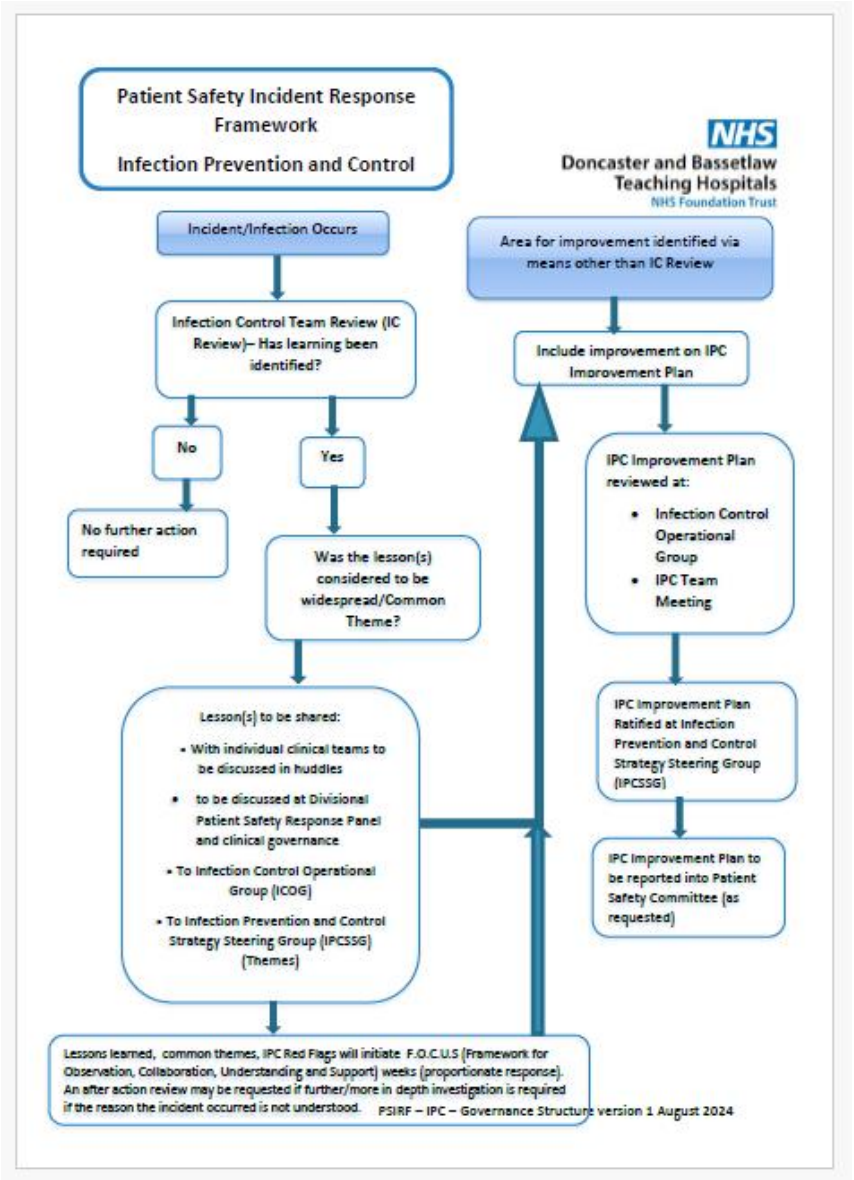
The PSIRF process has been finalised for Infection Prevention and Control this year. This has included implementation of the DBTH FOCUS:

1. General Principles
The following general principles will apply during the F.O.C.U.S week: • The infection prevention and control team will spend an extended period of time on the ward/department across the week. • The visits are designed for the team to provide a supportive service to ward staff and help resolve any IPC-related issues that are identified. • The infection prevention and control team will complete a range of audits and where issues are identified, will provide recommendations for resolution. • Staff will have access to bite sized training in a range of infection prevention and control related subjects. • With the Infection Prevention and Control Team working together with the ward/department colleagues, the aim is to foster supportive relationships that will facilitate open and honest discussion and collaboration, placing the patient at the centre of all that we do together and working to improve Infection Prevention and Control Practice.

FOCUS weeks are initiated on identification of 'Red Flags' and/or where wards/departments are requiring more support. Red flags include:

- Two HOHA C diff cases reported in a one month period
- Two or more cases of C diffs with the same ribotype in one quarter
- 1 MRSA blood stream infection
- 2 hospital acquired MRSA colonisations within one month
- 2 or more MRSA colonisations linked by type in one year
- Failure to improve and sustain improvement past 4 weeks following FOCUS week
- Any serious IPC related incident following discussion and agreement with DIPC/DDIPC, Deputy Chief Nurse and Chief Nurse.

FOCUS weeks have been completed on Gresley Unit, Ward 19, Ward 32 with improvements sustained four weeks post FOCUS weeks. FOCUS weeks are part of the Infection Prevention and Control PSIRF process.



Audit and Surveillance

The wards and department teams are required to achieve defined standards in audits of hand hygiene, patient's environment, Link Practitioner activities and the cascade of information. In addition, appropriate observations and feedback are undertaken which reinforce practical actions that clinical staff must undertake every time they carry out a procedure to reduce the risk of HCAI. These include:

- Preventing surgical site infection
- Urinary Catheter care
- Peripheral line care
- Central Venous Catheter Care
- Ventilator care
- *Clostridioides difficile*.
- *Antimicrobial stewardship*
- *Hand Hygiene*
- *PPE compliance*

Hand Hygiene

Hand hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team have continued to promote hand hygiene compliance incorporating the WHO five moments tool but simplifying the moments to enable staff to concentrate on aspects that can easily influence hand hygiene compliance. Hand hygiene compliance including bare below the elbows is an expectation for all clinical staff.

Hand Hygiene observations are recorded on Tendable.

Where alert infections had been identified, for example, C Difficile and MRSA cases, IPC have monitored compliance with general practices through Snapshot auditing and feedback.

Rapid review by the Infection Prevention and Control team has been completed, using the NHSE Standard Infection Control Precautions Monitoring tool, where an outbreak of infection was being considered, this included environmental audits, hand hygiene compliance, glove wearing and correct PPE. It also included the screening of staff and patients to investigate the extent of the outbreak.

Infection Prevention and Control elements are included in the weekly and monthly auditing undertaken by ward/Department managers and matrons via the Tendable system. The Infection Prevention and Control Team undertake regular auditing of the Environment and elements relating to care via the Tendable System. These include monthly hand hygiene audits, VIP scores, PICC line surveillance, PPE, Urinary catheter care and Antibiotic audits. All clinical areas received an environmental audit in 2024-2025.

Training and education

It is widely recognised that ongoing education in infection control is required in order to improve healthcare workers compliance with infection prevention and control practices.

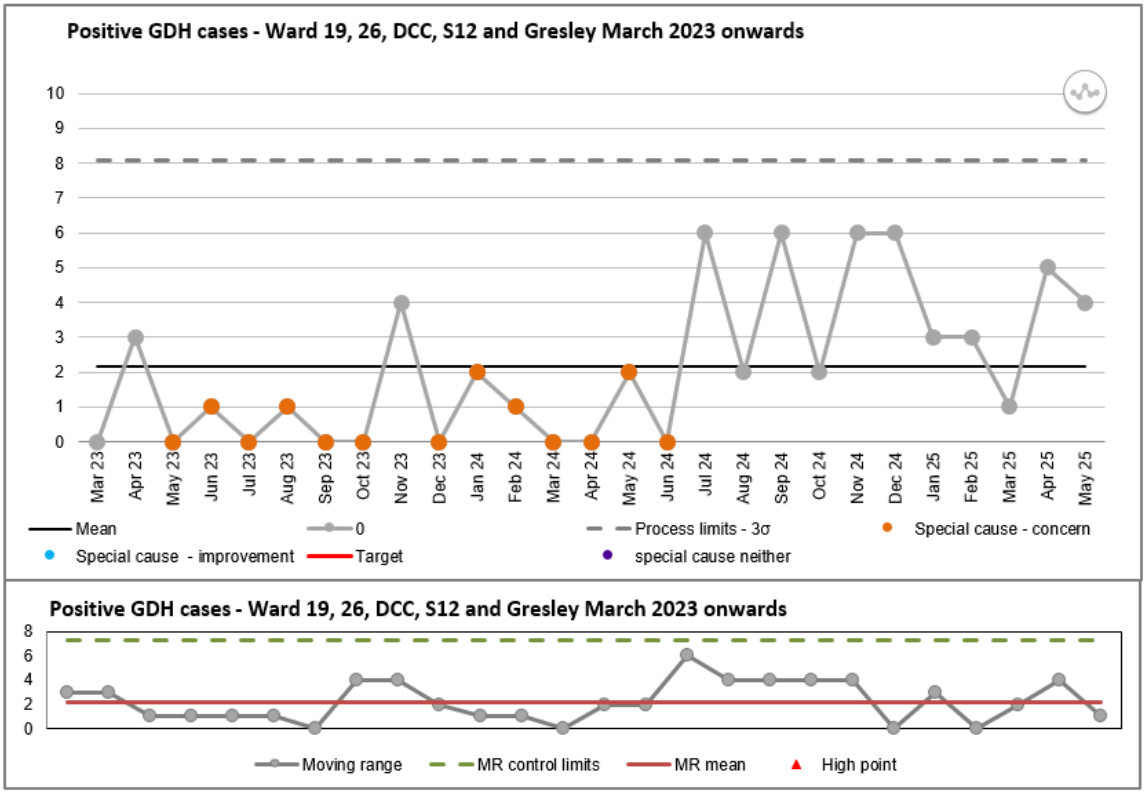
The infection prevention and control computer based learning (SET and eLearning) packages are accessible for all staff via the Trust Intranet site. The Infection Prevention and Control Team have contributed to provide formal and informal teaching sessions within the clinical areas and where appropriate in face to face forums as with the international nurses' induction programme and formal sessions with medical colleagues.

IPC Education has been delivered on the Foundations of Care programme for Healthcare Support Workers, International Nurses programme and the link nurse education/training meetings have continued throughout the year.

Quality Improvement activity

1) The IPC team have supported Trust wide hydration improvement and have supported hydration improvement across the community services that are covered by the service. This is in relation to supporting reduction in gram negative blood stream infections.
2) The CDI project aimed to reduce the number of CDI cases to within trajectory in the financial year 2024 to 2025. It should be noted that this has been against a context of regional and national rises in CDI cases for which a direct cause has not been established.

The teams involved have been actively looking for cases of GDH/CDI and carriers of GDH/CDI. The Infection Prevention and Control team have provided daily support, assisting risk assessments to inform patient placement. The table below indicates the increase in numbers of GDH, since the start of the project in May 2024.



3) The Infection Prevention and Control Team have worked with Renal colleagues to improve line care , MRSA and MSSA screening, to reduce the number of MSSA bloodstream infections within the specialty. Where patients have reported a sensitivity to existing Chlorhexidine dressings for line sites, the team have worked with suppliers to identify alternatives to encourage compliance with dressings which would otherwise be removed by the patient.

Community Infection Prevention and Control

The support and partnership working with Doncaster ICB, Public Health Doncaster, Local authority colleagues, health and social care and the Acute Trust has continued to flourish through 2024-2025.

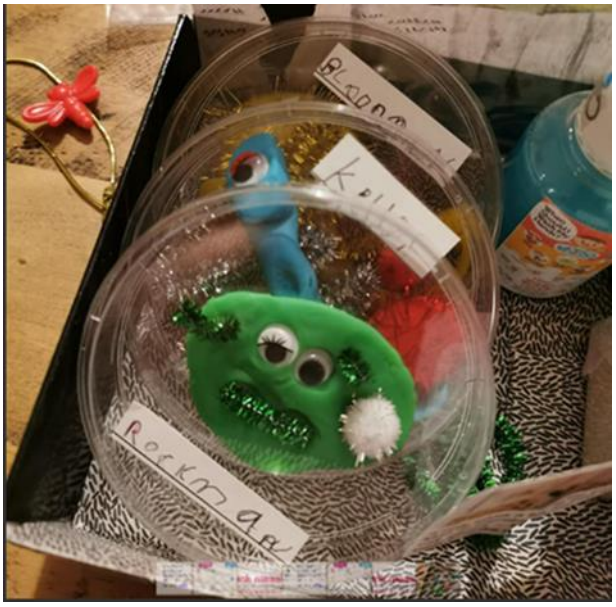
Being visible is at the core of the service we provide, with the aim of providing at least one face-to-face visit to older persons care homes every 4 to 6 weeks. Over the past year, the team have supported facilities in managing 25 Respiratory outbreaks, 24 Diarrhoea and vomiting outbreaks. The team have provided face-to-face support within 48 hours of identification of outbreaks, with additional daily phone call at least and extra support visits face to face as required.

In accordance with the service contract, Learning Disabilities (LD) homes have received at least 1 face to face visit per quarter and all supported living facilities have received a face to face visit twice per year. All older persons care homes and learning disabilities care homes have received a yearly Infection Prevention and Control audit. 10% of Supported Living (SL) facilities within each provider group have received an Infection Prevention and Control audit this year (in accordance with the service contract).

The team have provided 822 routine face-to-face visits throughout the year to facilities covered by the service. The Infection Prevention and Control Team have facilitated monthly education/question and answer sessions via Microsoft teams, involving all facilities. They have also supported local authority colleagues in providing face-to-face infection prevention and control training.

Optimum hand hygiene practices have been supported with the Infection Prevention and Control Team undertaking hand hygiene competency assessments using the hand hygiene light boxes and face-to-face education.

Members of the Infection Prevention and Control Team worked with Public Health colleagues in supporting activities at the ‘Night at the Museum’ event during the learning festival in May 2024 supporting children in understanding how infection spreads and how important hand hygiene is (pictures below).



7. Secure adequate access to laboratory support as appropriate.

Microbiology laboratory

The Microbiology laboratory continues to work closely with the IPC team, to ensure appropriate testing of samples and rapid communication of results, particularly with regard to SARS-COV-2, Influenza virus and RSV, *Clostridioides difficile*, norovirus, Group A Streptococcus, *Mycobacterium tuberculosis,* and MRSA screening and other "alert" organisms such as CPE and VRE. There is a line list of alert organisms generated regularly even before results are authorised to assist the Infection Prevention and Control team to act proactively in managing isolation and thus preventing healthcare associated infection. The microbiology laboratory also assist in facilitating the collection/packaging/forwarding of high risk sample such as measles, pertussis, mpox, viral hemorrhagic fever, CJD to mention but a few to be tested in other specialized reference centers across the United Kingdom, and facilitating results back to the consultants in Infection and IPC team.

The laboratory is fully UKAS accredited, and the laboratory is now providing an extended day service In addition to a seven days working, both of which has improved turnaround of results and prompt action on isolates.

As discussed earlier, resistance in gram-negative organisms continues to evolve and the laboratory has introduced protocols for screening for Carbapenemase-producing Enterobacteriaceae (CPE) to support PHE guidance. Film-Array is now fully validated within the laboratory, as a tool for early identification of bacterial and viral infections in cerebrospinal fluids. Work is completed in ensuing that Communicable Diseases Report (CDR) and Antimicrobial Resistance Reports (AMR) are transferred from the pathology LIMS and sent safely to the Second Generation Surveillance System (SGSS). The consultations within the region for a South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) pathology laboratory network is now completed, as the Microbiology department at DRI is now part of the Sheffield Teaching Hospitals, based at DRI. There is a rollout of the SYB Pathology Oracle Cerner PathNet LIMS expected to commence from April 2024 to completion in February 2026.

The COVID-19 PCR lab in microbiology at Doncaster Royal Infirmary

8. Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.

Infection Prevention and Control Policies

The following policies were updated and approved by the Infection Prevention and Control Strategic Steering Group during 2024-2025.

Policy title	Policy number	Date approved IPCSSG
Standard Infection Prevention and Control Precautions Policy	PAT/IC 19 v.8	April 2024
MRSA Screening and Management of Patients with MRSA	PAT/IC v.11	April 2024
Pathology Specimens – Collection and Handling of Pathology Specimens	PAT/IC 11 v.8	April 2024
Management and Control of Incident/Outbreak of Infection	PAT/IC 20 v.9	April 2024
Management of Respiratory Viruses	PAT/IC 10 v.11	June 2024
Meningococcal Infections - Management of Cases and Contacts	PAT/IC 12 v.6	June 2024
Kitchen Hygiene and Refrigerator Monitoring Policy For Wards and Clinical Areas	PAT/IC 22 v.5	June 2024
Gastroenteritis Minor Outbreak Policy (Diarrhoea and Vomiting)	PAT/IC 27 v.7	August 2024
Management of Patients with Glycopeptide Resistant Enterococci	PAT/IC 27 v.8	October 2024
Sharps Policy - Safe Use and Disposal	PAT/IC 8 v.10	December 2024

9. Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Staff influenza vaccination

The statistics highlighted that 28.3% of all frontline staff received the influenza vaccine against all NHS Trust average in England of 37.9%. It is acknowledged that more work is needed within DBTH to increase the vaccination rate and improve the Flu vaccine uptake across the Trust in 2025 / 2026.

Division or Directorate	Headcount	Vaccination count	Influenza vaccination headcount %
272 Doncaster & Bassetlaw HC Services Ltd	14	8	**57.14%**
272 People & Organisational Directorate	97	51	**52.58%**
272 Nursing Services Directorate	98	46	**46.94%**
272 Education and Research Directorate	99	39	**39.39%**
272 Chief Executive Directorate	37	14	**37.84%**
272 Finance & Healthcare Contracting Directorate	111	41	**36.94%**
272 Clinical Specialties Division	1654	570	**34.46%**
272 Urgent and Emergency Care Division	638	201	**31.50%**
272 Surgery Division	1070	302	**28.22%**
272 Medicine Division	1334	357	**26.76%**
272 Chief Operating Officer	321	73	**22.74%**
272 Digital Transformation Directorate	163	37	**22.70%**
272 Women's & Children's Division	810	183	**22.59%**
272 Mexborough Elective Orthopaedic Centre	55	12	**21.82%**
272 Medical Director Directorate	14	3	**21.43%**
272 Estates & Facilities	697	132	**18.94%**
272 Winter Division	19	2	**10.53%**
272 Executive Team Board	160	16	**10.00%**
Grand total	**7391**	**2087**	**28.24%**

BCG (TB) vaccination summary

BCG Vaccination 24/25	Total Identified	Total attended	DNA letter sent to manager/ employee	Total remaining / no response	% of declined no response
Q1	52	25	10	17	32.6%
Q2	137	64	27	73	53.2%
Q3	N/A				
Q4	N/A				
Total	189	89	37	90	42.9%

Summary

This report has provided the Trust Board with evidence of the measures in place that make a significant contribution to improving infection prevention and control practices across the Trust through a year of increased demand and pressure on the NHS and the Trust. The report has detailed the continuing progress against the Action Plan for 2024/25 in reducing HCAI rates for the Trust and the key priorities include:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices to continue to prevent HCAIs and as we continue to live with COVID-19 and other Acute Respiratory Viruses.
- Continued focus on antimicrobial stewardship (AMS), reducing the impact of antimicrobial resistance (AMR), and ensuring our Trust antimicrobial guidelines are regularly updated in reflects NICE clinical guidelines.
- Continued strategy in reduction in Gram-negative blood stream infections and in particulars those associated with indwelling urinary catheter.
- Continue to implement strategy and effective antimicrobial stewardship geared towards reduction *Clostridioides difficile* infections and risk of contamination of hospital environments.
- Continued to monitor other high risk infectious disease alert pathogens such as *Mycobacterium tuberculosis*, mpox, measles, pertussis, viral hemorrhagic fever, CJD and thus reduce the risk to patients and HCWs
- Monitor decontamination services and reducing the risk of infection or transmission especially with the dental chairs situation at Montagu Hospital.
- Continue to monitor and manage water safety Trust-wide.
- Continue to improve and sustain the works of the ventilation safety group within the trust to meet the challenges of air exchange quality and in preventing transmission of respiratory viruses in clinical care areas and changes in care pathways across the Trust.
- Sustain progress with education, training and audit relating to infection prevention and control practices, and ensure all trust IPC policies are up to date.
- Maintaining a clean and safe environment for patients and staff by collaborative working with Estates and Facilities team to ensure optimal cleaning schedules, deep cleaning, waste management, medical technology, transport, linen services and Health & Safety within the Trust.

Appendix 1: Breakdown of Trust acquired C. difficile cases by ward and division 2024-25

Year	(Multiple Items)
MESS Organi	C.diff

ount of Episo			Mont												
Categor	Division	Location	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	Grand Total
HOHA	Surgery and Cancer	DGB5									1				1
		DR19	1	2				1		2					6
		DR26				1							1		2
		DR27				1									1
		DR7								1					1
		DR8										1			1
		DR9										1	1		2
		DRS11				1			1						2
	Surgery and Cancer Total		1	2		3		1	1	3	1	2	2		16
	Clinical Specialities	DRDCC						1						1	2
	Clinical Specialities Total							1						1	2
	Children and Families	DRG5						1				1			2
	Children and Families Total							1				1			2
	Medicine	CCUC2								1			1		2
		DGA4						1	1						2
		DGA5		2											2
		DGC1	2				1					1			4
		DR16		1											1
		DR17								1		1			2
		DR18			1				1						2
		DR20										1			1
		DR25		1	1			1							3
		DR32			1										1
		DRASSM												1	1
		DRCCU							1						1
		DRKIN				1					1				2
		MALL												1	1
	Medicine Total		2	4	3	1	1	2	3	2	1	3	1	2	25
	Urgent and Emergency Care	DGATC			1								1		2
	Urgent and Emergency Care Total				1								1		2
HOHA Total			3	6	4	4	1	5	4	5	2	6	4	3	47
COHA	Surgery and Cancer	DR1	1												1
		DR19									1				1
		DR26							1			1			2
		DR8					1								1
	Surgery and Cancer Total		1				1		1		1	1			5
	Medicine	DGA4						1							1
		DGA5										2			2
		DGC1								1					1
		DR18								1					1
		DR20					1			2					3
		DRKIN												1	1
		MALL				1									1
		RHB2		1											1
	Medicine Total			1		1	1	1		4		2		1	11
	Urgent and Emergency Care	DGATC								1					1
		DRAE										1			1
		DRASSM	1				1	1							3
	Urgent and Emergency Care Total		1				1	1		1		1			5
COHA Total			2	1		1	3	2	1	5	1	4		1	21
Grand Total			5	7	4	5	4	7	5	10	3	10	4	4	68

Appendix 2: Trust-attributed MSSA BSI cases by ward and division for 2024/25

Year	2024/25
MESS Organism	MSSA

Count of Episode			Mont												
Category	Division	Locati	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	Grand Total
HOHA	Clinical Specialities	DRDCC								1			1		2
	Clinical Specialities Total									1			1		2
	Medicine	CCUC2			1										1
		DGA5							1						1
		DR17												1	1
		DR18		1					1		1				3
		DR20			1			1							2
		DR21							1						1
		DR22						1							1
		DR24	2		1		1				1		1	1	7
		DR25									1		1		2
		DR32	1												1
		DRASSM										1			1
		DRCCU			1							1			2
		DRKIN										1			1
		RHB2									1	1			2
		STIR										1	1		2
	Medicine Total		3	1	4		1	2	3		4	5	3	2	28
	Surgery and Cancer	DR26	1								1	1			3
		DR3							1						1
		DR8							1						1
		DRS11		1							1				2
		DR7							1						1
	Surgery and Cancer Total		1	1					3		2	1			8
	Urgent and Emergency Care	DGAE							1						1
		DGATC											1		1
		DRAE			1										1
	Urgent and Emergency Care Total				1				1				1		3
HOHA Total			4	2	5		1	2	7	1	6	6	5	2	41
COHA	Medicine	DGAE											1		1
		DR20								1					1
		DR24									1				1
		DR25							1						1
		DR32							1						1
		DRKIN								1					1
	Medicine Total								2	2	1		1		6
	Surgery and Cancer	DR26									1				1
		DR9									1			1	2
		DRS12						1							1
		DR19								1					1
		DR7						1							1
	Surgery and Cancer Total							2		1	2			1	6
	Urgent and Emergency Care	DRAE	1				2			1		1			5
		DRASSM									1				1
	Urgent and Emergency Care Total		1				2			1	1	1			6
COHA Total			1				2	2	2	4	4	1	1	1	18
Grand Total			5	2	5		3	4	9	5	10	7	6	3	59

Appendix 3: Gram-negative Bloodstream infection >2 days after admission by ward and division

MESS Organism	Pseudomonas aeruginosa
Year	2024/25

Count of Episode			Mont												
Category	Division	Location	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	Grand Total
HOHA	Clinical Specialities	DRDCC						1							1
	Clinical Specialities Total							1							1
	Surgery and Cancer	DRS12				1									1
		DR19				1					1	1			3
	Surgery and Cancer Total					2					1	1			4
	Medicine	DR21							1						1
		DR32			1										1
		DGA4		1											1
		DR25										1			1
		KEST	1												1
		CCUC2												1	1
	Medicine Total		1	1	1				1			1		1	6
	Urgent and Emergency Care	DRAE					1								1
	Urgent and Emergency Care Total						1								1
HOHA Total			1	1	1	2	1	1	1		1	2		1	12
COHA	Clinical Specialities	DRDCC	1												1
	Clinical Specialities Total		1												1
	Surgery and Cancer	DR19			1	1							1		3
	Surgery and Cancer Total				1	1							1		3
	Children and Families	DRG5												1	1
	Children and Families Total													1	1
	Medicine	DGA4								1					1
		DGC1							1						1
		DRMALL							1						1
	Medicine Total								2	1					3
	Urgent and Emergency Care	DGATC										1			1
	Urgent and Emergency Care Total											1			1
COHA Total			1		1	1			2	1		1	1	1	9
Grand Total			2	1	2	3	1	1	3	1	1	3	1	2	21

Year	2024/25
MESS Organism	Klebsiella sp

Count of Division			Mont												
Category	Division	Location	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09	2024/10	2024/11	2024/12	2025/01	2025/02	2025/03	Grand Total
HOHA	Clinical Specialities	DRDCC		1				1			1		1		4
	Clinical Specialities Total			1				1			1		1		4
	Surgery and Cancer	DR26					1								1
		DR19	1					1	1	1	1				5
	Surgery and Cancer Total		1				1	1	1	1	1				6
	Medicine	DR21								1					1
		DR32									1				1
		CCUC2					1								1
		DR22		1	1										2
	Medicine Total			1	1		1			1	1				5
	Urgent and Emergency Care	DRASSM									1				1
	Urgent and Emergency Care Total										1				1
HOHA Total			1	2	1		2	2	1	2	4		1		16
COHA	Surgery and Cancer	DRS12							1						1
		DR27				1									1
		DR19							1	1					2
	Surgery and Cancer Total					1			2	1					4
	Children and Families	DRCHOU						1							1
		DRG5											1	1	2
	Children and Families Total							1					1	1	3
	Medicine	DR24				1								1	2
		DGA5					1		1						2
	Medicine Total					1	1		1					1	4
	Urgent and Emergency Care	DRAE		1											1
		DRASSM	1							1					2
		DGATC		1								1			2
		DGAE	1												1
	Urgent and Emergency Care Total		2	2						1		1			6
COHA Total			2	2		2	1	1	3	2		1	1	2	17
Grand Total			3	4	1	2	3	3	4	4	4	1	2	2	33

Appendix 4 - Hospital acquired MRSA colonisation cases detected 2024-25.

description	MRSA Colonisation

Count of description		hort_c												
division_name	WardName	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	**Grand Total**
Children and Families	NEONATAL UNIT DRI								1			1		**2**
	SPECIAL CARE BABY UNIT BASS												2	**2**
	Ward G5											1		**1**
	CHILDREN'S WARD		1											**1**
Children and Families Total			1						1			2	2	**6**
Medicine	GRESLEY UNIT				1	1								**2**
	Ward 17						1							**1**
	Ward 22		1											**1**
	Ward C1								1					**1**
	STIRLING WARD						1							**1**
	REHAB 2							1						**1**
	Ward CCU/C2					1								**1**
	KINGFISHER WARD - DO NOT USE FOR IPC									1		2		**3**
	Ward 16 - ACUTE STROKE UNIT					1						1	1	**3**
Medicine Total			1		1	3	2	1	1	1		3	1	**14**
Surgery and Cancer	Ward B5			1										**1**
Surgery and Cancer Total				1										**1**
Grand Total			2	1	1	3	2	1	2	1		5	3	**21**

Glossary of terms

Antimicrobials	Antibiotics
AWaRe	Access, Watch and Reserve Antibiotics category in the WHO essential medicines list
Bacteraemia	The presence of bacteria in the blood
COVID-19	Coronavirus respiratory infection, highly contagious, high mortality.
C. difficile	The organism most frequently identified as the cause of antibiotic- associated diarrhoea
CLABSI	Central Line Associated Bloodstream Infection
CR-BSI	Catheter Related Bloodstream Infection
Colonisation	The presence of a bacteria on or in the body without causing infection
Dashboard	A way of presenting data in a visual format.
ESBL	Extended-Spectrum Beta-Lactamases are enzymes produced by bacteria, making them resistant to broad-spectrum antibiotics.
MRSA	Methicillin resistant Staphylococcus aureus is a bacterium that is resistant to commonly used antibiotics such as Flucloxacillin.
PIR	Post Infection Review is a systematic review of an incident to determine why it happened and lessons to be learnt.

2509 - E2 2024/25 SAFEGUARDING ANNUAL REPORT

Information Item | Karen Jessop, Chief Nurse | 13:00

REFERENCES

Only PDFs are attached

E2 - 2024-2025 Safeguarding Annual Report.pdf

Safeguarding Annual Report 2024 – 2025

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1. Foreword:

This annual report demonstrates that safeguarding remains a priority for the Trust. The report provides assurance that the safeguarding annual work programme has identified and achieved some key safeguarding work streams. The team have evidence the increased safeguarding activity that has been captured during this reporting year. This report also provides the outline of how as a Trust we have continued to evidence multi-agency collaboration.

This reporting year, there has been increased activity across all areas of safeguarding, this has occurred due to an increase in knowledge from our colleagues, evidenced by a stronger training compliance position than the previous year. The increased safeguarding resources has also provided enhanced opportunities to support our colleagues to understand their responsibilities in safeguarding our patients, whilst they are in our care.

The Trust recognises its continued commitment to demonstrate compliance to safeguarding statutory duties and continues to ensure timely completion with statutory requests to undertake Section 11 reporting and complete the annual safeguarding self-assessment when this is requested.

It is evident that there continues to be a clear shared safeguarding vision, underpinned by a detailed safeguarding team work plan and the governance of the Strategic Safeguarding Group. It is also clear that divisional collaboration has remained constant, with the recognition that the increased resources in the safeguarding team that has undoubtedly impacted upon our Trust to enable a proactive and responsive approach to safeguarding.

We look forward to another successful year to come and continuing to support the team to achieve the priorities that have been outlined for the forthcoming year ahead.

Karen Jessop
Chief Nurse

Simon Brown
Deputy Chief Nurse

2. Introduction

Doncaster and Bassetlaw NHS Teaching Hospitals (DBTH) provides acute services for approximately 420,000 people across South Yorkshire, North Nottinghamshire, and the surrounding areas. As a Trust we employ over 6000 colleagues.

As a Safeguarding team covering the DBTH footprint, we are pleased to support all DBTH colleagues every day in identifying and managing safeguarding concerns. This annual report is an opportunity to share with you our safeguarding achievements, improvements, innovations and areas of priorities that we have driven forward over the past 12 months.

This report also provides an overview of the safeguarding activity that has occurred within our Trust, and summarises our areas of risk, good practice and significant developments that have occurred over the last reporting year (1st April 2024 – 31st March 2025).

Safeguarding has remained a Trust priority and this has been evidenced by the significant support and engagement across all Divisions, in the continuation of working together to protect our patients from harm, whilst they access our services.

Safeguarding will always remain unremittingly complex and challenging, but as a Trust we have a clear picture of our areas of safeguarding focus and a clear safeguarding work plan that outlines our commitment to progress, and to address identified and emerging safeguarding themes.

The purpose of this report is also to provide assurance that as a Trust we have robust safeguarding systems in place to effectively respond to safeguarding concerns and uphold our statutory safeguarding responsibilities.

The message that '**safeguarding is everyone's responsibility**' has been at the forefront of all our work and will remain a central focus as we also look forward to the year ahead.

3. Safeguarding Governance

Figure 1: Safeguarding lines of Accountability at DBTH (March 2025 position)

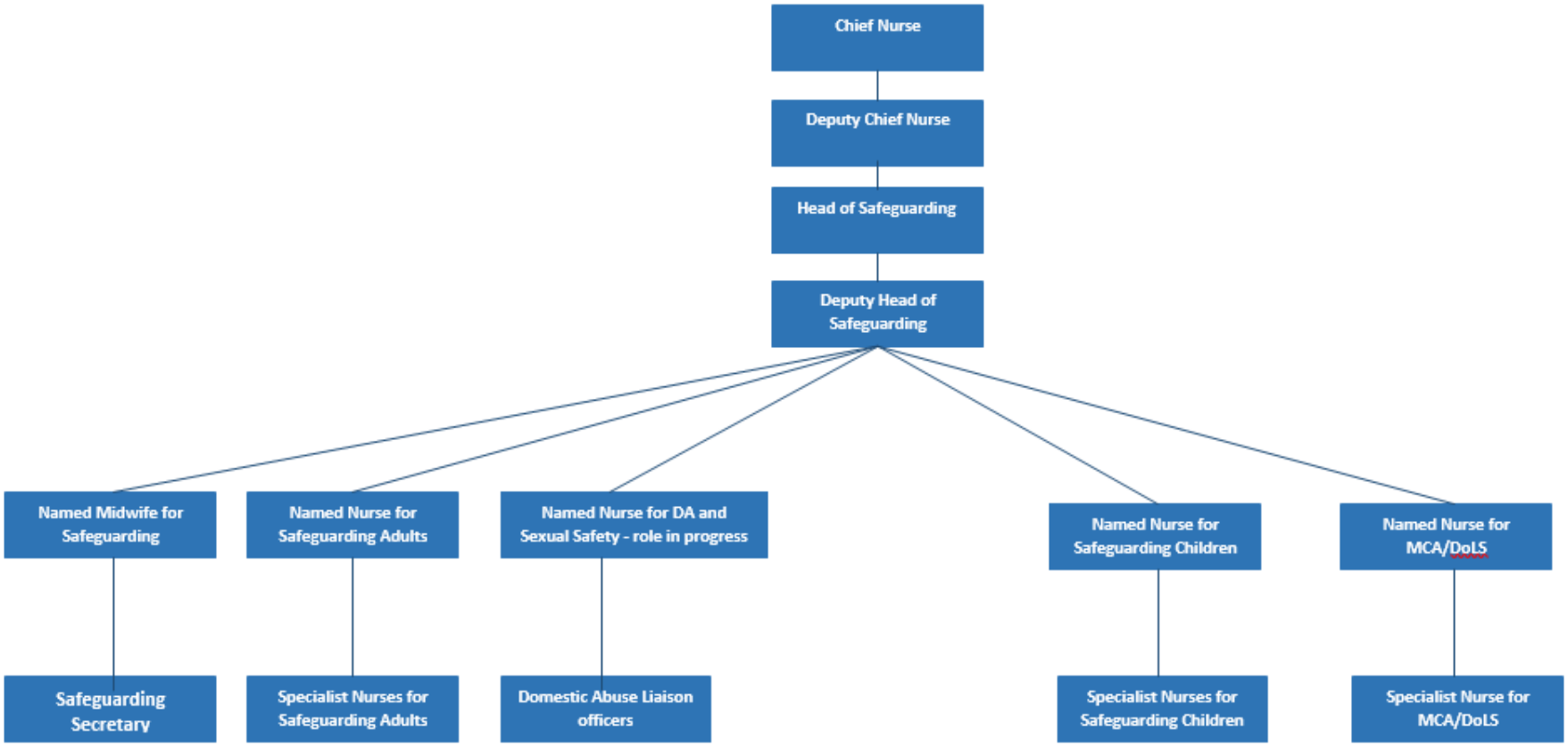


Figure 1.1: Evidences the governance flow and oversight at year end.

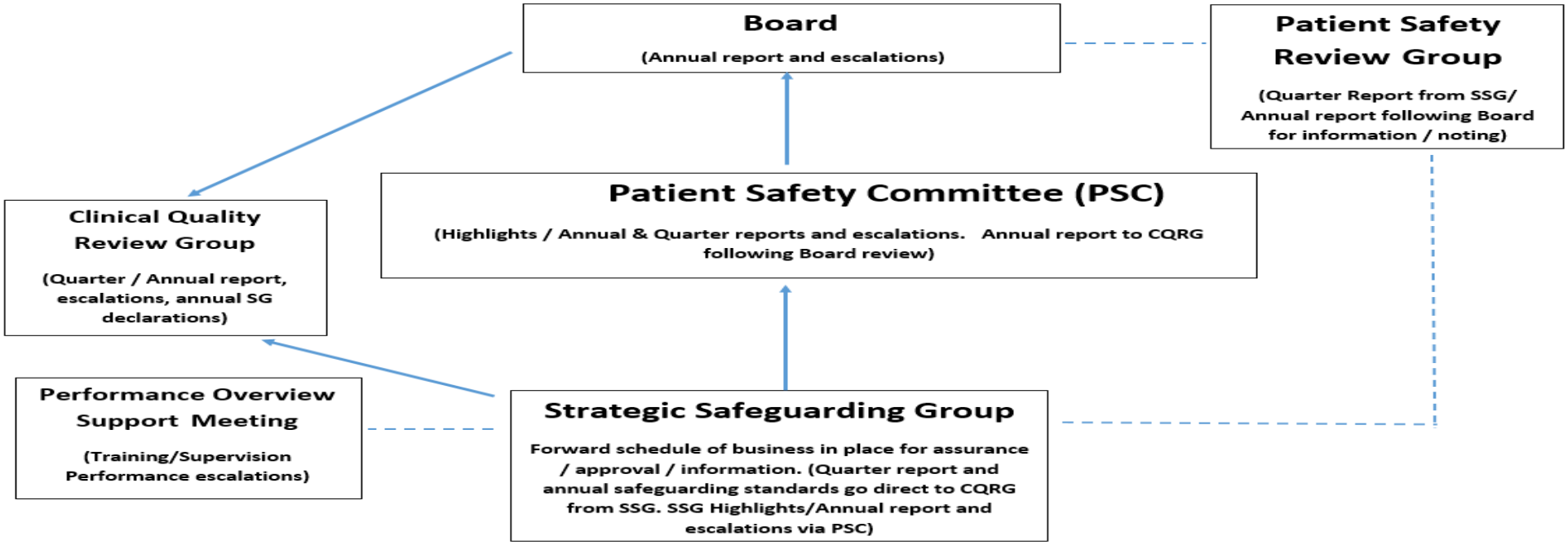


Figure 1 and 1.1 illustrates that there are clear lines of accountability in relation to roles, accountability and strategic safeguarding group / board oversight within DBTH for Safeguarding. The safeguarding team provide specialist advice and support on all safeguarding matters Trust wide, to all colleagues. Of noting, this reporting year has seen the completed streamlining of Trust Governance arrangements of which remains in constant review to ensure arrangements are fit for Trust requirements. The team structure has also evolved as new positions have commenced in post, in line with the previous team structure review and appointments that have been on a staggered implementation to improve safeguarding resources for the Trust. During this year the Strategic Safeguarding Group membership has remained stable and underpinned by the annual forward schedule of business. Divisional representation has also remained consistently high and this has contributed to continued engagement with key safeguarding work streams throughout the Trust. The Strategic Safeguarding Group (SSG), remains the key meeting that oversights and coordinates safeguarding information with Divisional and ICB members in attendance. **Appendix 1** provides an overview of how business was scheduled for discussion at the SSG throughout the reporting year. **Appendix 2** provides a year end summary of the safeguarding work plan. **Appendix 3** provides details of the safeguarding team members.

4. Overview of Safeguarding Activity:

One of the key indicators that we look at is the number of safeguarding referrals that are generated from Trust colleagues to social care, in relation to unborn babies, children and adults.

5. Safeguarding Referrals:

Figure 2: highlights the number of referrals made to social care, where abuse or harm was identified relating to patients accessing DBTH services:

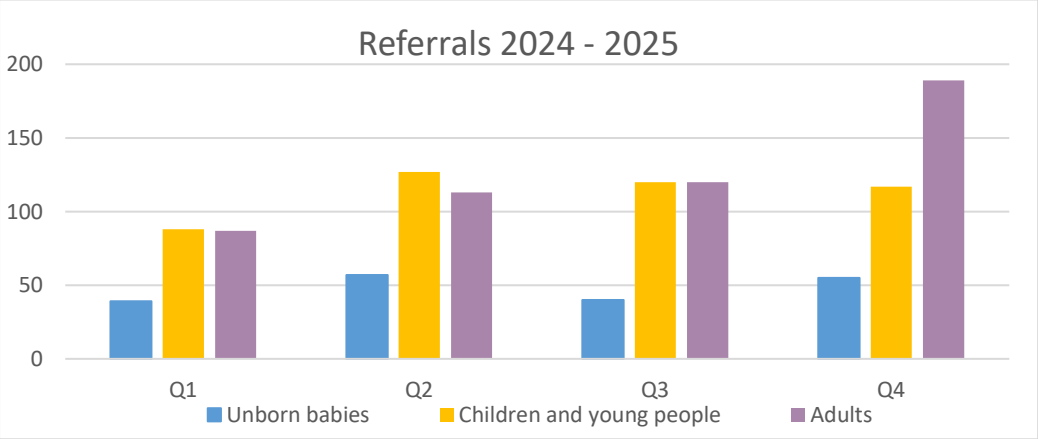


Figure 3: Highlighted comparison referral figures from the previous reporting year.

	Unborn babies	Children and Young people	Adults
Q1	39	88	87
Q2	57	127	113
Q3	40	120	120
Q4	55	117	189
Total 2024 - 2025	191	452	504
Comparison to 2023 - 2024	**122**	**315**	**307**

The above data in **Figure 2 and 3** indicates a significant increase in activity for this reporting year across all areas of safeguarding. In comparison to the previous year's reporting, unborn referrals have increased by 57% (raising from 122 to 191 referrals), children and young people referrals have increased by 44 % (raising from 315 to 452 referrals and adult referrals have raised by 64% (raising from 307 to 504 referrals). In totality the safeguarding referral activity across the Trust has increased by 54% (raising from 744 to 1147 referrals). The continued safeguarding liaison meetings, Divisional engagement and improved training compliance across the Trust continues to contribute to the awareness of safeguarding and has supported colleagues to understand when a safeguarding referral is required.

6. Deprivation of Liberty Safeguards (DOLS):

Figure 4: Deprivation of Liberty Safeguard (DOLS) Applications submitted

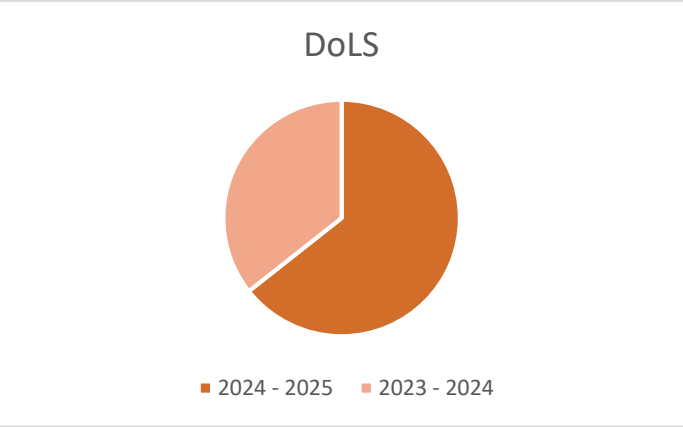


Figure 5: DOLS breakdown by reporting Quarter 2024 - 2025

2024 - 2025	DOLS applications
Q1	132
Q2	146
Q3	160
Q4	151
Total	**589**
Comparison to 2023 - 2024	**326**

The above data in **Figures 4 and 5** provides an opportunity to compare the DOLS activity to the previous reporting year (2023 – 2024). There is a trajectory that evidences continued significant increase, noting 222 applications in 2022 – 2023, 326 applications in the 2023 – 2024 and 589 applications in this reporting year. In summary there has been an increase of 80% for DOLS applications this year. This year has seen an increase in resources with a specific focus on MCA and DOLS, with the appointments of a Band 7 lead and a Band 6 Specialist Nurse for MCA/DoLS.

Figure 6: Number of DOLS standard applications authorised by the Local Authority 2024 - 2025

2024 - 2025	DOLS standard applications authorised by Local Authority
Q1	2
Q2	1
Q3	0
Q4	2
Total	**5**

The above data in **Figure 6** evidences the number of DOLS standard applications that were authorised by the relevant Local Authorities in this reporting year. Work has been undertaken by the MCA / DOLS lead / specialist nurse to improve the notification process from the Local Authority to ensure the Safeguarding team are informed of live updates on authorisations.

7. Mental Capacity Act (2005): Embedding the framework:

During this reporting year, there has been a significant focus on embedding the Mental Capacity Act (MCA - 2005) requirements and the appointment of a Named lead and Specialist Nurse. These key roles have driven forward existing and new work streams, they have been influential in supporting colleagues to understand the processes when caring for patients where there is reason to doubt decision making ability.

Whilst the organisational risk remains open, significant activity has been undertaken including the continued quarterly auditing of documentation to support the identification of where focused support is required. This will assist in continued support and improvement on how we evidence compliance to the Mental Capacity Act.

Below is an overview of Trust initiatives undertaken in relation to MCA during this reporting year:

- Increase in Trust Safeguarding resources to support a focus on MCA and DOLS to support Trust colleagues in their responsibilities and legal duties in relation to MCA
- Redesign of the team DOLS data collection matrix from applications received; this evidences patient demographics, ward areas, date of receipt, date when the application has been forwarded to the relevant local authority, extension activity, and CQC notification, it also flags any ongoing actions for ward colleagues and identifies actions required of the Trust safeguarding team.

- Consistent use of the DOLS flag on nerve centre and the uploading of relevant documents (Mental Capacity Assessment form and DOLS form), this allows ward colleagues to identify those safeguarded with a DoLS easily. Use of the Safeguarding narrative box on nerve centre to record relevant information to assist ward colleagues caring for the patient and at a glance be able to track the patients MCA specialist involvement.
- Embedding the MCA Trust Forum – the inaugural MCA Trust Forum commenced in June 2024 as an output of the MCA quality improvement project. The purpose of the Forum was to provide leadership and operational support and direction for developing processes and systems to embed the Mental Capacity Act requirements safely within DBTH. It was an opportunity to engage with Divisional areas, share good practice and support areas that may require additional bespoke support to enhance understanding. As part of the monthly forums Divisions present their 'highlight report' and have the opportunity to present a case study, share learning or seek support with any questions. The forum reports directly into the Strategic Safeguarding Group via an overarching highlight report to capture the key updates from Forum meetings that have occurred.
- Review and restructure of Safeguarding HIVE resources, this has supported Trust colleagues to have access to relevant forms / policy / 7 minute briefings and key resources to support understanding, it also reiterates Trust contact details for when additional support and guidance is needed.
- Collaboration between key roles within DBTH; the Named Nurse and Nurse Specialist for MCA / DOLS have worked collaboratively with other Named Safeguarding leads, Named Professional for Safety in Caring, nurse specialists in wider Trust areas and Divisional colleagues to provide bespoke training, support with assessments, support colleagues in their care of patients to ensure we are appropriately applying the Mental Capacity Act and evidencing this as part of Trust processes.
- Regular attendance at Complex case meetings.
- The Named Nurse is currently undertaking the Best Interest Assessor course to ensure knowledge based remains enhanced and Trust arrangements remain current and based on current case law and guidance, under the legal framework.
- Commencement of a quality improvement project in the Emergency Department to support MCA being embedded from the initial start of the patient journey.
- Continued quarterly audit reporting and review of the audit framework to support a greater capture of how we evidence compliance with the Mental Capacity Act – in readiness to undertake continued quarterly auditing in 2025 – 2026.
- Update of the MCA eLearning content, to adopt the relevant eLearning for health (elfh) modules.
- Funding successfully acquired to progress additional external training from 'Edge'; this training was in addition to statutory and essential training and was bespoke to the 'acute setting'.
- Distribution of MCA pens with a pull out banner providing an aide memoir for the 5 principles and other key MCA resources, with QR codes linking to the Safeguarding Trust HIVE pages.
- SWOT analysis undertaken by the MCA / DOLS lead to support the identification of the work plan priorities.
- Introduction of MCA questions as part of the weekly 'Tendable' ward based audits, with specific questions around the 5 MCA principles, what steps colleagues should take when a patient's capacity is doubted.
- Inclusion of MCA questions as part of the Trust's Care accreditation.

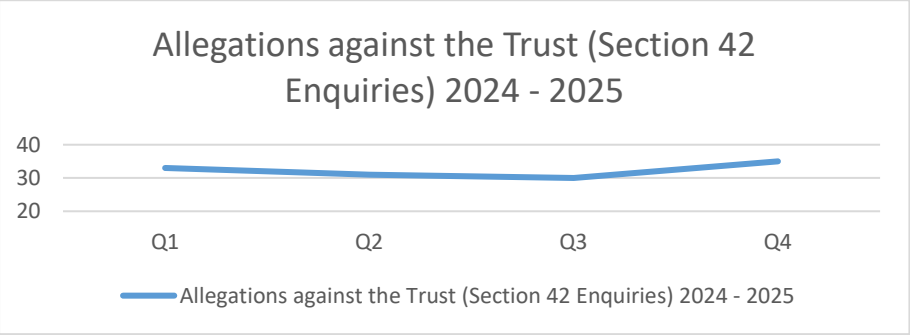
- Trust agreement that embedding MCA requirements will be taken forward as a Trust Quality priority into 2025 – 2026, this will be underpinned by a robust action plan and will include a designated physician to support the work stream.
- Bespoke teaching to clinical and ward areas on MCA and DoLS.
- Attendance from the MCA lead at Grand Round and Divisional Governance meetings to share good practice.

8. Allegations against the Trust:

Allegations against the Trust (Section 42 Enquiries) are submitted centrally by the relevant Local Authorities via the DBTH Safeguarding team. The safeguarding professionals in the team will investigate the circumstances of the concern where possible, or they will direct the concern to the relevant Division for a response. All concerns are reported via the Trust DATIX reporting system on receipt.

Responses are returned to the Local Authority on completion with a clear outline of what actions have been taken by the Trust. Where allegations are upheld, this may also include any learning that has been supported. The number of allegations and top 3 themes are included in the Trust Safeguarding Quarterly report and during this reporting year work has focused on embedding the process of allegation management, to include an internal escalation process to ensure responses are timely and appropriately oversighted when responses are outstanding (**Appendix 4** provides an overview of this process). Feedback has been received from Doncaster Local Authority that response timescales have improved.

Figure 6: provides details of allegations against the Trust that have been received for 2024 - 2025



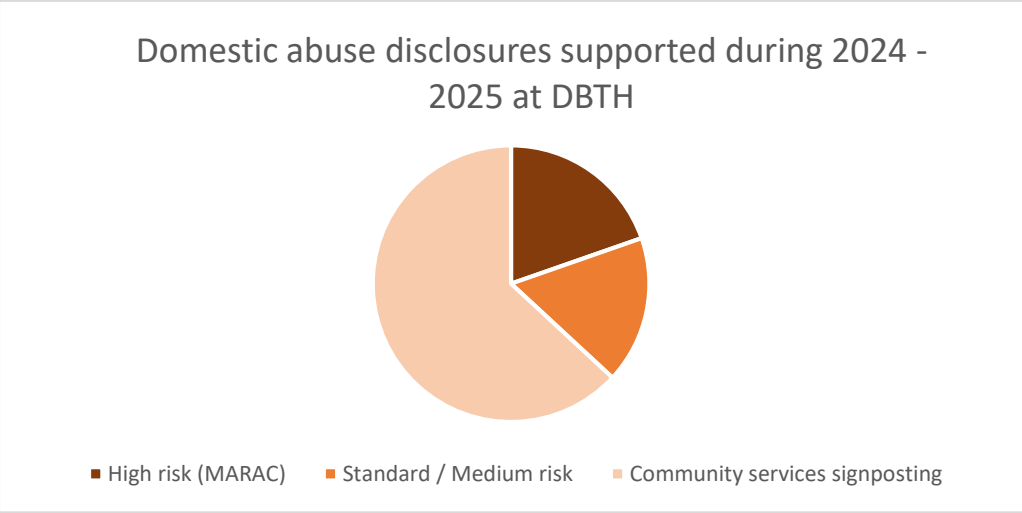
Q1	Q2	Q3	Q4
33	31	30	35

The common themes during this reporting year are related to discharge concerns, neglect and medication concerns. There is wider work in progress by the Discharge team to support Trust improvement on discharge processes, this is anticipated to have a positive impact on this allegation theme going forward. Work is also identified in the coming year to support identification of self-neglect and the progression of a quality improvement project is being developed, this is also anticipated to have a positive impact on this allegation theme.

9. Domestic Abuse:

During this reporting year, our Domestic Abuse Liaison officers have supported 290 people who have disclosed domestic abuse. 57 of these have resulted in a referral to a Multi-Agency Risk Assessment Conference (MARAC) as risk has been deemed high. The purpose of MARACs are to prevent a domestic homicide and disrupt perpetrator behaviours, by providing a risk based response to keeping victims safe. Of the remaining disclosures, 50 cases were referred to the Doncaster Domestic Abuse Hub and the remaining 183 people were signposted to wider services within the community (adult / children's social care, mental health services, substance use services are some examples of community signposting actions that were undertaken.) We also collaborated with Doncaster Domestic Abuse Hub to provide relevant patients with personal alarms prior to discharge, where their circumstances supported this. This resulted in supporting patients who are experiencing domestic abuse, to feel safer on discharge home.

Figure 7: indicates the number of people supported by DBTHs Domestic Abuse (DA) liaison officers (290 in total during 2024-2025)



All crimes that are disclosed by patients are reported to the police, in total we made 101 referrals.

The above data in **Figure 7** shows an 8% increase in comparison to the number of referrals received in 2023 – 2024 (284). Work is progressing in the year ahead to ensure any out of hour's disclosures are captured more robustly and patients are consistently supported to disclose their experiences.

Within the last year the domestic abuse liaison officers have successfully recruited over 100 additional Trust colleagues to be 'domestic abuse champions', taking the running total of DBTH domestic abuse champions to over 560 colleagues. All domestic abuse champions have had

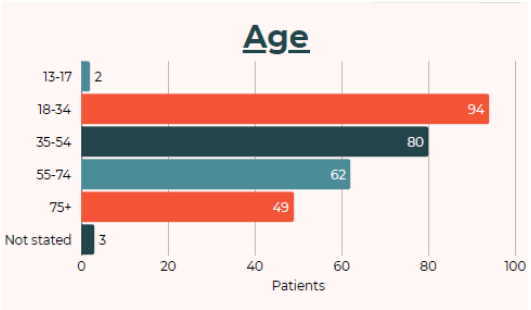
additional training from our DA liaison officers to support them in how to ask the questions sensitively to support domestic abuse disclosure. Importantly, it provides additional training to equip colleagues with the confidence to respond and understand how to enlist support from our specialist DA liaison officers following a disclosure.

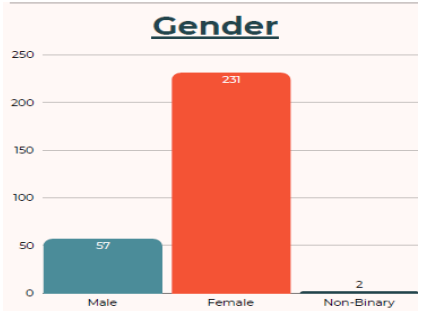
During this reporting year the DA Liaison roles were fully funded by the South Yorkshire Mayoral Combined Authority – for service delivery across the Doncaster footprint only. However going forward to the next reporting year, the domestic abuse liaison officer roles are now substantive positions within the hospital, whilst a proportion of these roles are still supported by the South Yorkshire Mayoral Combined Authority for Doncaster, there will be greater flexibility to progress service development across our Trust's Bassetlaw footprint. The substantive appointment by our Trust evidences the commitment to ensure patients and colleagues experiencing domestic abuse are supported; this sets a fantastic precedent going forward for other hospital trusts to consider employing domestic abuse professionals.

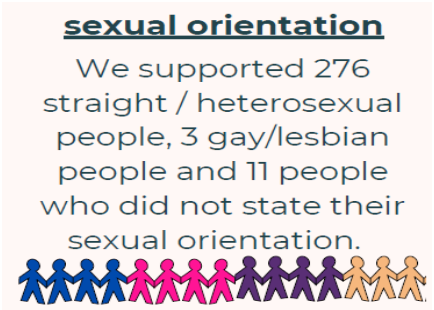
Looking forward to the future the DA officers have set their sights on Bassetlaw hospital provision with a vision to mirror the current service offering that is in place at Doncaster and Mexborough. This will be a challenging undertaking but one that the DA officers are keen to get under way.

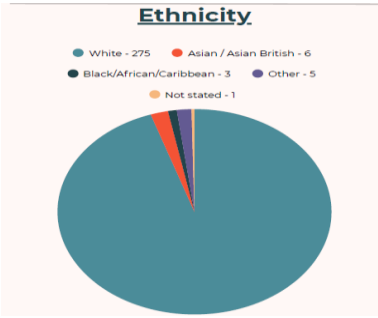
This year there has also been continued focus on ensuring we capture and consider important demographic information to understand the population of people that we are supporting. In recognition that as a Trust our disclosure rate is low from people that identify as having an Asian Ethnicity, our DA Liaison officer attended a local cultural community group to raise awareness on domestic abuse. Some members of the group were unaware of the DA liaison service available at DBTH so it was a useful intervention for members of the group to share across their community network that when people attend our Trust it is a safe space to seek DA support if needed.

Figure 8: indicates the demographic breakdown in terms of age / gender / sexual orientation and ethnicity for the people who have been supported by DBTHs Domestic Abuse (DA) liaison officers during 2024-2025)









The above data in **Figure 8**, evidences alignment with national recognition represented in the Office for National Statistics published in its annual domestic abuse data bulletin, indicating that female disclosures are higher than male disclosures. Predominately at DBTH there is a greater number of disclosures from female, white, heterosexual people. The highest age bracket for disclosures are 18 – 34 years, with 35 – 54 years being the second more prevalent age reporting bracket. In line with national recognition there is an observation about the 'hidden' gender asymmetry in relation to the disparity of male disclosures, however extensive national research recognises important factors that relate to females being more likely to experience domestic abuse, and more likely to be subjected to coercive control and to being seriously physically and mentally harmed or killed.

In addition to supporting disclosures, the domestic abuse liaison officers have successfully driven a number of initiatives and activities across the Trust, including supporting the development of a Trust Non-Fatal Strangulation pathway (in line with the nationally published guideline.)

Figure 9: The pictures below show one of the Safeguarding team stands that was hosted by the DA Liaison officers during the 16 days of action against abuse that commenced on 25th November 2024. **Appendix 5** outlines the detailed timetable of events that was implemented during this period to ensure an increased visibility across the Trust. Examples of some of the 7 minutes briefings that have been published are also depicted below – these remain on the Trust HIVE Safeguarding page as ongoing resources for colleagues to access.

10. Safeguarding Policy updates: During this reporting year the following policies have been reviewed / implemented:

- Safeguarding Children Policy
- Safeguarding Adult Policy
- Safeguarding Supervision Policy
- Sexual Safety Policy (new policy)
- Was not Brought Policy (new policy)
- Managing Allegations: Person in a Position of Trust (PiPoT) (new policy)

In addition to the above, the trust Safeguarding team have developed a number of Standard Operating Procedures (SOP) to underpin team processes. All safeguarding SOPs are approved by the SSG, the following have been approved during this reporting year:

- Safeguarding Liaison Meetings (Adult / Paediatric / Maternity areas)
- Deprivation of Liberty processes

11. Safeguarding Audit activity: During this reporting year safeguarding questions have been included in the weekly divisional tendable audits. the following safeguarding audits have also been completed:

- **Legal process** (reviewing court statement requests): outcome indicated the process is working well
- **MCA** (quarterly audit) to review compliance with Act: outcome indicating further work is needed to evidence robust compliance, plans for improvement underpinned by the Trust Quality Action and Safeguarding work plan.
- **Safeguarding referrals** (adults / childrens / unborn): this audit is being finalised and will be for presentation in June 2025.
- **Domestic Abuse – out of hours**: The outcome indicated an improvement is needed in how out of hours disclosure are supported, to ensure resources are shared with patients and the level of risk is considered robustly to ensure appropriate referral consideration. Work will be progressed in the new reporting year to review how this can be improved. This will be in collaboration with emergency department colleagues and the domestic abuse liaison officers.
- **Child Protection Medicals**: This audit was oversighted via Paediatric medical colleagues in line with adherence to the national standards, the Named Doctor and Designated Doctor for Safeguarding Children are reviewing the recommendations.

In addition to Trust audits the team continue to contribute to Multi-agency audits:

- **Children missing Education** – Doncaster Safeguarding Children Partnership
- **Cross Authority Exploitation** – Nottinghamshire Safeguarding Children Partnership
- **Multi-Agency S47** – Nottinghamshire Safeguarding Children Partnership
- **Domestic Abuse** – Serial Perpetrator – Doncaster Safeguarding Children Partnership
- **Self-Neglect** – Doncaster Safeguarding Adults Board

12. Promotion of the H.O.P.E Boxes:

Charity funded H.O.P.E boxes support families separated from their baby; the roll out of the boxes at DBTH have been aimed at supporting families who are subject to separation orders and this intervention at DBTH has been steered by the Named Midwife for Safeguarding, who has been keen to link with partners in the local authority to share the important messages about use of these boxes.

H.O.P.E boxes, which stands for 'Hold On Pain Eases', are filled with comforting and familiar items, such as baby tags, a milestone book and an SD card filled with pictures of both Mother and baby.

This is a National initiative and research led by Lancaster University found that women who experience separation from their babies at birth, for example as part of social care proceedings, are at an acute risk of mental health crisis, including self-harm and attempted suicide during the postnatal period. It is therefore crucial that as a Trust we are working to support a trauma informed approach at this critical time in a Mother and baby's journey.

The boxes, which were created in collaboration with women who have gone through the separation process, help mothers capture important and long-lasting memories with their babies prior to separation, they also eventually form part of the child's life story for the future. During this reporting year 16 sets of boxes were provided.

Figure 10: The pictures below display some of the contents of the boxes and a representation of our Named Midwife for Safeguarding explaining the use of the box to a 'parent'. This is a promotional picture and the 'parent' in the picture was a member of the team.

13. Pregnancy Liaison Meetings:

Where potential safeguarding concerns emerge during pregnancy, DBTH work closely with our partner agencies to ensure proportionate information is shared and cases are discussed to provide support and ensure families are supported and unborn babies are safeguarded in preparation for birth. As part of this process multi-agency colleagues meet regularly as part of a 'Pregnancy Liaison Meeting - PLM' to proactively plan and support the identification of escalating safeguarding concerns to support risk-based multi –agency decision making. Going forward into next year, work is planned to review the PLM processes to ensure both Bassetlaw PLMs and Doncaster PLMs function within the same multi-agency framework approach.

Figure 11: shows the number of PLMs completed during this reporting year, noting an overall 16% increase from the comparative 2023 – 2024 figures.

2024-2025	Number of patients discussed at PLMs	Comparison with 2023 - 2024
Q1	172	99
Q2	194	188
Q3	181	160
Q4	158	160
Total	**705**	**607**

14. Female Genital Mutilation (FGM)

The practice of FGM includes illegal procedures that intentionally alter or injure female genital organs for non-medical reasons. This practice is irreversible, has no health benefits and can cause serious injury or death (FGM Act, 2003). There is a national requirement to report cases of FGM via NHS Digital, health professionals can also add a FGM-IS tab on a female child's summary care record if they are deemed at risk of FGM – this allows for greater professional awareness to safeguarding female children at risk as they access health services. There is also a mandatory duty for regulated professionals to report known cases of FGM in under 18s to the police via 101.

During this reporting year the work in relation to FGM has continued to be steered by the Named Midwife role for Safeguarding, ensuring that DBTH has the required processes in place to oversight national reporting requirements.

Additionally, this year there has been an extensive review of multi-agency FGM processes which has included collaboration with health organisations across the South Yorkshire footprint, with support from the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB). In line with the rest of South Yorkshire, Doncaster has made the decision to have multi-agency oversight of all FGM cases in pregnancy by implementation of an information sharing process; DBTH are contributing to the reviewed pathway and multi-agency guidance.

Figure 12: The table below indicates the FGM Trust data for this reporting year, going forward the processes for FGM oversight now in place will allow for more robust comparison of reporting data.

2024 - 2025	Number of FGM notifications (for adults)
Q1	19
Q2	14
Q3	19
Q4	14
Total	66

15. Implementation of safeguarding liaison meetings (SLMs) across Maternity:

March 2025 saw the implementation of SLMs across maternity areas in both Doncaster and Bassetlaw. SLMs are short meetings between the Midwife in charge and/or ward manager, and a member of the DBTH safeguarding team. The purpose being to discuss any safeguarding patients and provide a designated opportunity for safeguarding advice and support. Implementation across Maternity areas is in addition to these already being embedded in Adult and Paediatric areas of the Trust.

Across the DBTH footprint for all ages (Maternity, Paediatrics and Adults) there has been a total of 998 SLMs undertaken over the reporting year.

16. Child Protection Information Sharing (CP-IS)

CP-IS is a nationwide system that connects local authorities' child protection information with NHS unscheduled care settings. Depending on the system used the child's record has an 'alert / flag' applied to indicate safeguarding information is available on the National Care Records Service. The rationale for this system is to improve the protection and safeguarding of children (including unborn) who are at safeguarding risk. CP-IS does not replace the requirement to escalate a safeguarding referral, but it does provide information about the safeguarding status of a unborn, child or young person and the details of the 25 most recent unscheduled care presentations along with the contact information for the responsible local authority.

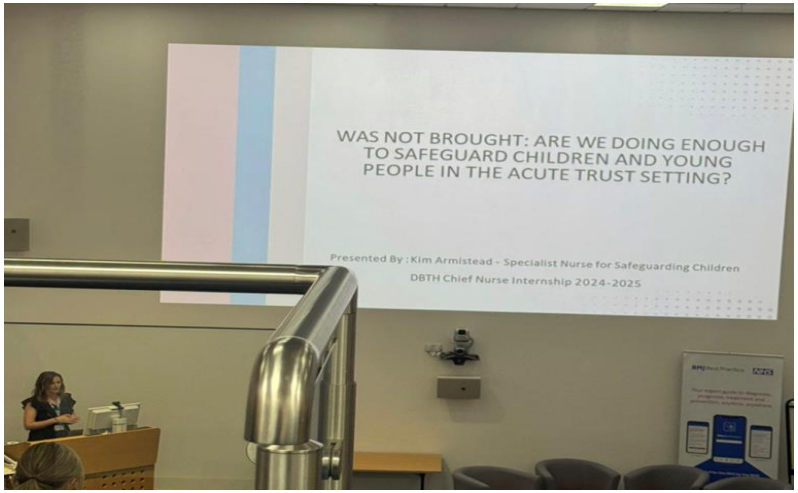
During this year at DBTH a full review of CP-IS processes was undertaken in readiness for the planned national next phased implementation. The review indicated that systems in place at DBTH were not where they needed to be; a Trust risk was identified and a clear action plan was implemented for Maternity, Paediatric and Emergency Departments. Each area now has an identified lead, and standard operating procedures

are being implemented. CP-IS reporting figures are now oversighted at the SSG meeting and the action plan for the overarching CP-IS risk is being supported by the Trust Safeguarding team, in conjunction with identified Divisional CP-IS leads. This will remain work in progress in the coming year until divisional reporting can evidence systems are embedded within the Trust to comply with this national requirement.

17. Chief Nurse Internship Programme and 'Was Not Brought'

Kim Armistead, Specialist Nurse for Safeguarding Children has undertaken the Chief Nurse Internship Programme this year, with a focus of 'Was not Brought' (WNB) for her research project. WNB is a key feature in many child safeguarding practice reviews and this project has provided a valuable deep dive into potential reasons that parents and carers may have difficulties in bringing their children for a DBTH appointment. This research project built on the implementation of the WNB policy and the trust wide dissemination of the WNB voice over briefing that supported the policy implementation. Kim's research focused on the question of 'are we doing enough to safeguarding children and young people who are not brought to their health appointments', and the consideration to identifying any link between WNB and neglect or areas of deprivation. The outcome of the research indicated a noted link between areas of high deprivation and children not being brought, with 57.9% of the children not brought living in the most, second and third most deprived areas. As a trust it was concluded that we are doing enough to safeguard children but Kim will be developing further work to support wider understanding of resources available in the community to support families when needed.

Figure 13: The picture below shows Kim presenting her research project to Trust colleagues and the Trust flowcharts developed at part of the policy review



18. Sexual Safety:

In last year's annual report the Trust's response to NHS England's Sexual Safety Charter was outlined. This year has seen the implementation of the Trust Sexual Safety policy following the ongoing collaboration between the Trust Safeguarding team, People and Organisational Development (P and OD), Patient Safety, Speak up Guardian, Education, Patient Experience, Equality and Diversity and Communications. This collaboration has supported a suite of resources for colleagues which includes a designated 'Sexual Safety' page on the HIVE. The embedding of training for all colleagues has continued, supported by clear reporting processes as outlined in the policy. In the coming year the reporting processes are being developed further to support an anonymous reporting function and a route directly into P and OD to ensure confidential reporting for cases involving colleagues. Since the roll out of the Trust training in September 2025, the compliance at year end was 89.05 % – a clear indication that colleagues are committed to undertake this training as a priority to support their knowledge.

13 cases have been reported via Datix from July 2024 – March 2025, with the expectation that as this embeds across the Trust the reporting figures may increase. There is a strong recognition that cases reported under this threshold may also interlink with process that have been developed to manage allegations against a Person in Position of Trust (PiPoT) and wider Trust Employment conduct frameworks.

19. Managing allegations: PiPoT

This policy was recently approved in February 2025 (published on the 1 April 2025) to support DBTH to have a more robust framework for management of allegations made against an employee, which may indicate they pose a risk to themselves, a child or adult at risk.

The process outlined in this policy is for colleagues / managers to consider when it is alleged that any person linked to DBTH (regardless of current role or place of work) may have:

- Behaved in a way that has, or may have, harmed an adult or child, including omissions to take actions to safeguard.
- Possibly committed a criminal offence against, related to an adult or child (including domestic abuse)
- Behaved (or has alleged to have behaved) in a way that indicates that they are unsuitable to work with children/adults at risk.
- Have been discussed as a perpetrator of abuse in any safeguarding meeting, including Multi Agency Risk Assessment Conference (MARAC) or Multi-Agency Public Protection Arrangements (MAPPA)
- May be subject to abuse themselves and as a consequence, means their ability at that time to support patients with care needs may need to be reviewed and reasonable adjustments made.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children
- Behaved or may have behaved in a way that indicates they may not be suitable to work with adults at risk.

This policy sets out a clear reporting framework / flowchart, templates for supporting the agenda of Trust meetings, recording and capturing information / actions that has been shared and any escalations or referrals that may be required as part of the meetings, this also includes the consideration to the Local Authority Designated Officer (LADO). A LADO referral is undertaken when an allegation has been made about a person in position of trust harming or posing a risk to a child, indicating potential unsuitability if their role involves working with children.

Since the pilot and implementation of this policy, the anecdotal feedback from Divisional / Departmental areas is that this framework has been useful to support concerns and provides a forum for professional discussions when concerns are emerging. As a Trust we are still embedding this policy, and the safeguarding team will be supporting managers in conjunction with P and OD colleagues to understand their reporting and management responsibilities.

20. Slavery Exploitation Risk Assessment Conference (SERAC)

In January 2025, DBTH was invited to contribute to Nottinghamshire's SERAC multi-agency processes. SERAC is for Nottinghamshire based people and supports identification of exploitation, modern slavery and trafficking. The purpose is to establish multi-agency pathways and a joint response to supporting people at risk. This conference takes place monthly and agencies can refer people in for discussion, to date DBTH have referred in 2 cases in February 2025 but have reviewed the case list for each meeting to consider any relevant, proportionate information that may support a person at risk.

21. Good practice (gold standard safeguarding awards)

The 'Gold standard safeguarding award', has continued to be a good opportunity to recognise where colleagues have demonstrated good safeguarding practice for our patients. Throughout this reporting year we have recognised the following colleagues for some great safeguarding practice:

- Sally Lewis – Special Care Baby Unit
- Ward 16
- Dr Jenny Wood
- Samantha Danby – Speech and Language
- Greg Mclaughlin – Paediatric Nurse, Emergency Department
- DRI Emergency Department
- Dr Collins Nweke
- Children's Ward and Children's Observation unit – DRI
- Jeethu James – Acute Medical Unit

In October 2024, the safeguarding team was also shortlisted themselves as part of the DBTH Star Awards, under the category of 'Star of the Year'. Being nominated as a team was fantastic recognition from the Trust for all the work that the team has implemented to support our colleagues, patients and wider Trust arrangements.

Figure 14: The pictures below have captured some of the gold standard award presentations that have been shared on our Safeguarding social media page.

22. Safeguarding cases:

The team provide a detailed quarterly case update as part of the DBTH SSG on all ongoing activity related to child rapid reviews, child safeguarding practice reviews, safeguarding adult reviews, domestic homicides and other thematic safeguarding learning reviews that are initiated across Bassetlaw, (Nottinghamshire Children's Partnership and Adult Board) and Doncaster (Children's Partnership, Adult Board and Domestic Abuse Strategic Board). The activity remains high and the safeguarding team have responded within timescales to all information requests in this reporting year. Whilst there has been no specific learning for DBTH, wider learning identified from reviews has included themes of the following:

- Self-Neglect
- Use of the neglect toolkit
- Professional curiosity
- Record keeping and information sharing
- Exploring strategies to support children and young people on paediatric wards experiencing mental health difficulties
- Understanding a child's lived experience
- Understanding the additional vulnerabilities a child's prematurity and health needs present

Learning that is identified is shared via divisional representatives who attend the SSG. Key themes are also incorporated into the DBTH Safeguarding training and work streams are developed to respond to any specific relevant areas. Examples of DBTH responses include the development of a work streams to look at a self-neglect check list, instilling professional curiosity as the underpinning ethos at safeguarding liaison meetings, progressing resources and 7 minute briefings to recognise and respond to emerging wider learning.

The safeguarding quarterly reports tracks the ongoing number of new and ongoing safeguarding reviews and allegations against the Trust, see quarterly reports for this reporting year in **Appendix 6.**

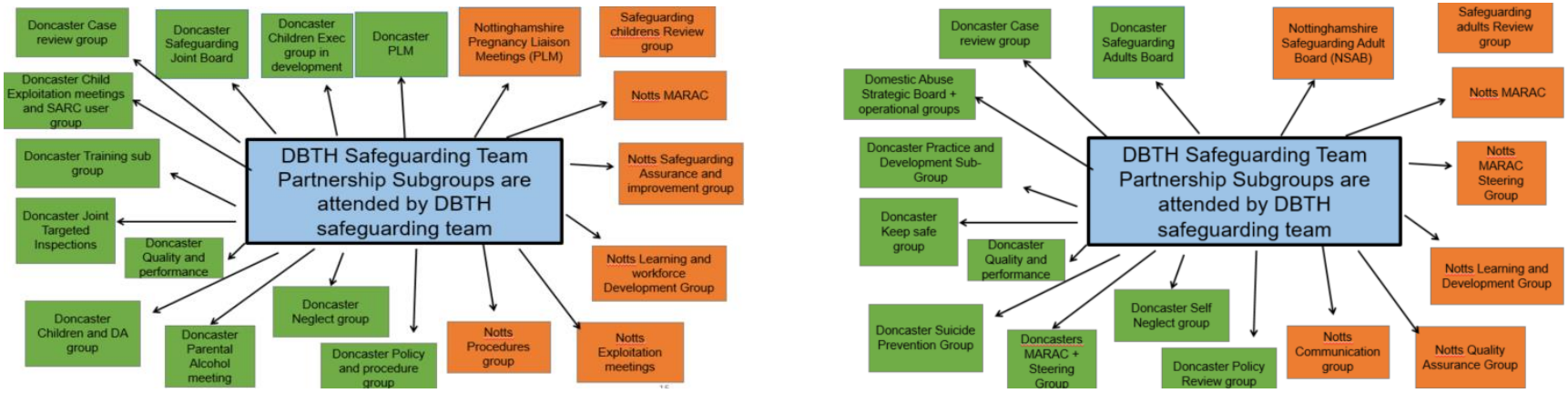
23. How we work with our partners:

During this reporting year the team have continued to maintain representation at partnership safeguarding meetings across both Nottinghamshire and Doncaster (children and adult work streams), to ensure the voice of DBTH is represented and to support the opportunity to continue our active collaboration with local authorities, integrated care board (ICB) members and wider partner agencies. As organisations we work together to share and have joint ownership to improve outcomes for children and adults.

The continued achievement of this is by:

1. Being able to challenge appropriately and hold one another to account
2. Early identification and analysis of emerging safeguarding risks
3. Learning being promoted in a way that as an organisation we can become more reflective and improve services for our patients and families

Figure 13: Provides an overview of key children and adult multi-agency meetings that the safeguarding team actively contribute to *(this is not an exhaustive list)*



24. Risks

The Deputy Chief Nurse and Head of Safeguarding continue to review the safeguarding risks as recorded on the DATIX risk register and at the frequency required for the risk grading. All safeguarding risks are reviewed in addition, each quarter at the strategic safeguarding group (SSG) that is chaired by the Deputy Chief Nurse. The position as of the end of March 2025 identified 4 open risks that related to safeguarding functions, as outlined below:

1. Safeguarding supervision
2. Capacity (resources) in the safeguarding team
3. MCA and DOLS: compliance
4. Compliance with CP-IS

All risks have mitigations and actions in place to address the resolution. The annual safeguarding work plan additionally demonstrates work streams to support risk reduction and mitigation. The SSG meetings provide a further opportunity for wider scrutiny of the Trust risks by its members which includes divisional leads and integrated care board members from Doncaster and Nottinghamshire. A progress report on all outstanding risks is provided as a standing agenda item at each SSG meeting.

25. Training Compliance:

This year there has been a continued focus on increasing the safeguarding training compliance and ensuring all colleagues were correctly aligned to the appropriate level of safeguarding training, a Safeguarding Training Strategy was also developed to outline the framework for the Trust safeguarding training vision (see **Appendix 7**).

As a Trust we are in a strong position that roles are appropriately aligned, compliance has been stable, with some continued focus on Level 3 Children's that is almost at the Trust 90% compliance rate (position being 84.70% at March 2025 year-end), this is an increased position to the last reporting year end of 81%.

In the Trust, we will remain vigilant with safeguarding training as we recognise that a low compliance in safeguarding training, can correlate with colleagues having reduced safeguarding knowledge, which directly impacts on a reduced capacity to recognise and respond to safeguarding concerns.

Training compliance is discussed quarterly at the SSG as a standing agenda item and feature on the Divisional highlight reports, to ensure this remains a Trust safeguarding priority.

Of noting the Level 4 compliance data has been directly related to awaiting compliance updates, the team is working closely with education colleagues to support this to be shared and updated timely. Level 4 compliance on the whole has been achieved with safeguarding colleagues attending the Bond Solon national Level 4 training to support enhanced safeguarding knowledge, however there is a recognition nationally about reduced opportunity for Level 4 and 5 training opportunities. The current position for compliance for level 4 is 100%.

The sexual safety training was implemented in September 2024 with the requirement for all Trust colleagues to complete. Compliance at year end was 89.05%, indicating a swift increased and prioritisation from Trust colleagues.

Going forward to the next reporting year, Mental Capacity Act compliance will be reported on separately, this will give a specific targeted focus to support colleagues to enhance knowledge on MCA and identify any areas where compliance still requires prioritisation.

As part of the MCA Quality action there will be a specific focus on measuring the improvement of training compliance, hence have this function to report compliance in a standalone function is a positive intervention.

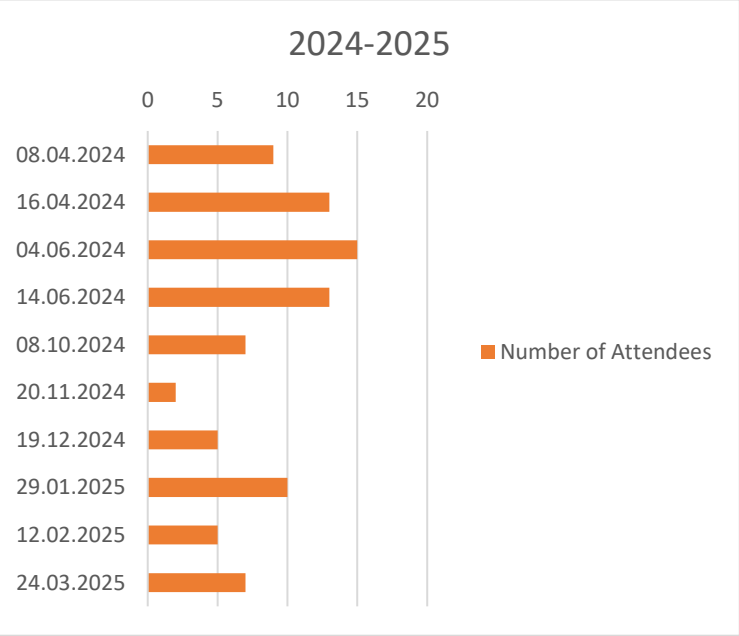
Figure 14: Provides monthly safeguarding training compliance % and highlights the year end position. Training figures have on the whole remained stable and are greatly improved in comparison to the last reporting year.

	Level 1 - Children	Level 2 – Children	Level 3 – Children	Level 4 – Children	Level 1 – Adult	Level 2 - Adult	Prevent	Sexual Safety
April 2024	96.44%	92.12	81.72	100%	96.47%	93.26%	97.20%	
May 2024	96.49	93.28	82.80	100	96.52	94.15	97.27	
June 2024	96.46	93.42	85.28	100	96.49	94.23	97.45	
July 2024	97.03	92.64	83.38	60	97.04	93.18	96.72	
August 2024	97.32	93.37	84.35	100	97.33	93.63	97.08	
September 2024	97.17	93.29	85.54	85.71	97.18	93.39	97.19	67.95
October 2024	97.07	93.25	85.03	100	97.02	93.62	97.41	76.27
November 2024	96.89	91.29	84.27	100	96.84	92.03	97.44	81.00
December 2024	96.54	91.99	85.38	100	96.50	92.35	97.41	83.23
January 2025	95.68	92.09	84.38	100	95.69	92.60	96.60	86.01
February 2025	95.62	93.41	85.55	88.89	95.59	93.95	97.01	88.09
March 2025 (year-end position)	95.17	93.39	84.70	77.78	95.09	93.64	96.74	89.05

Data on training sessions provided:

26. Safeguarding Children Level 3 Training data:

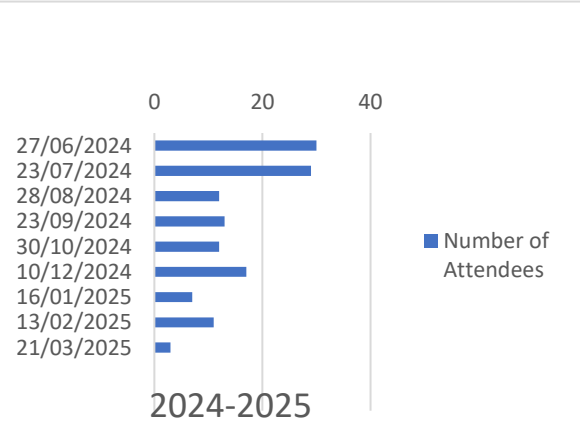
Figure 15: Indicates that during this reporting year there has been 10 offered Children's Level 3 safeguarding full day sessions scheduled, this is 2 more than in the previous year. The availability and room capacity still provides flexibility for more colleagues to attend. In total there have been 86 colleagues trained, a 39% increase from the 62 colleagues trained in the previous reporting year.



Quarter	Date of training	Location of training	Room capacity	Delegates attended
Q1	08.04.2024	**DRI Learning Room 2**	**25**	**9**
Q1	16.04.2024	**DRI Learning Room 3**	**18**	**13**
Q2	04.06.2024	**DRI Learning Room 3**	**18**	**15**
Q2	14.06.2024	**DRI Learning Room 4**	**18**	**13**
Q3	08.10.2024	**BDGH Board Room**	**14**	**7**
Q3	20.11.2024	**DRI Learning Room 2**	**25**	**2**
Q3	19.12.2024	**DRI Learning Room 2**	**25**	**5**
Q4	29.01.2025	**DRI Learning Room 4**	**18**	**10**
Q4	12.02.2025	**BDGH Blyth Room**	**14**	**5**
Q4	24.03.2025	**Lecture Theatre**	**14**	**7**

27. **Safeguarding Adults and Children Level 2 Training Attendance**

Figure 16: Indicates that during this reporting period there has been 9 Level 2 (Joint Adult and Children's safeguarding) training sessions scheduled, facilitating 134 colleagues to be trained during this period. In 2023 -2024 only 114 colleagues were trained, indicating this year there has been a 17.5% increase. As with the Level 3 children's training there is still flexibility in the room capacity for further colleagues to be accommodated at each session.

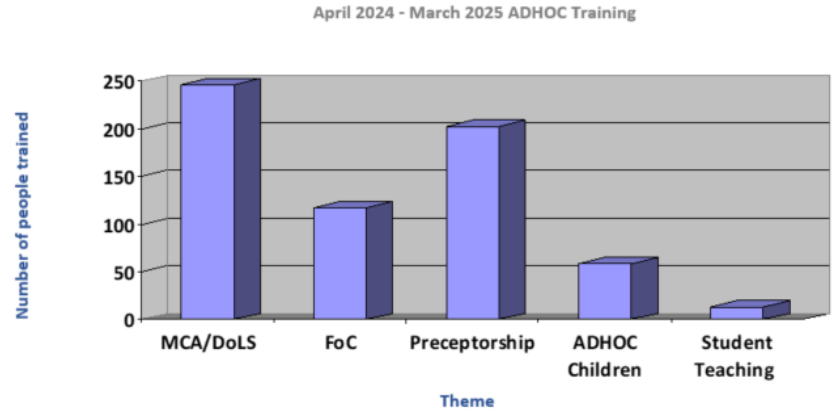


	Date of training	Location of training	Room capacity	Delegates attended
Q2	27/06/2024	DRI Lecture Theatre	140	30
Q2	23/07/2024	DRI Lecture Theatre	140	29
Q2	28/08/2024	DRI Learning Room 2	25	12
Q2	23/09/2024	DRI Lecture Theatre	140	13
Q3	30/10/2024	BDGH Board Room	14	12
Q3	10/12/2024	DRI Learning Room 3 and 4	25	17
Q4	16/01/2025	Lecture Theatre	140	7
Q4	13/02/2025	Lecture Theatre	140	11
Q4	21/03/2025	Lecture Theatre	140	3

28. <u>Bespoke and targeted training support:</u>

In addition to the mandatory safeguarding training sessions (Joint Level 2 children / adult and Level 3 Children), the team have also continued to provide bespoke sessions to support specific identified targeted support.

Figure 17: Indicates an overview of some key additional bespoke training that has also been provided by the Safeguarding team.



The MCA / DoLs sessions were delivered over the year 2024-2025. The total number of people trained on MCA/DoLS between that timeframe was 246. The MCA/DoLS training was delivered to the following areas, overarching content covering MCA / DOLS processes and supporting understanding of the legal framework.

- St Leger Ward 1&3
- FAU DRI
- Ophthalmology OPD
- Ortho trauma
- Ward 16
- CSS sisters
- Ophthalmic governance/ audit meeting

- SAW
- Orthopaedic theatres
- S11
- Gresley Unit
- Montague Hospital Staff
- Lecture Theatre DRI
- AMU at Bassetlaw
- Winter Ward

The FoC (Foundation Of Care) sessions were delivered over the year 2024-2025. The total number of people trained on FoC between that timeframe was 58. The FoC training is three hours long in total and the Safeguarding Team offer this once a month.

ADHOC Children sessions were delivered over the year 2024-2025 to areas to show support and guidance to topics that are requested. Throughout the year, ADHOC Children training was delivered to 58 members of staff and training was completed in:

- adult areas of the Trust
- Orthopaedic Governance Meetings

The Preceptorship Training within 2024-2025 facilitated 3 Preceptorship sessions, 202 newly qualified colleagues attended the training, where a generic safeguarding update was provided.

In addition to the bespoke training information above, the Named Midwives for Safeguarding have contributed a safeguarding input to the Maternity REST days and the Head of Safeguarding and team leads have provided a bespoke safeguarding session to Executive and Non-Executive Board members.

Going forward into the new reporting year the impact of training is being measured as part of the new evaluation processes to demonstrate improvement in knowledge and understanding after the training has been completed.

29. <u>Capturing the voice of our learners:</u>

Below are some of the voices of our learners that have been captured during training evaluation:

30. Looking back on our priorities

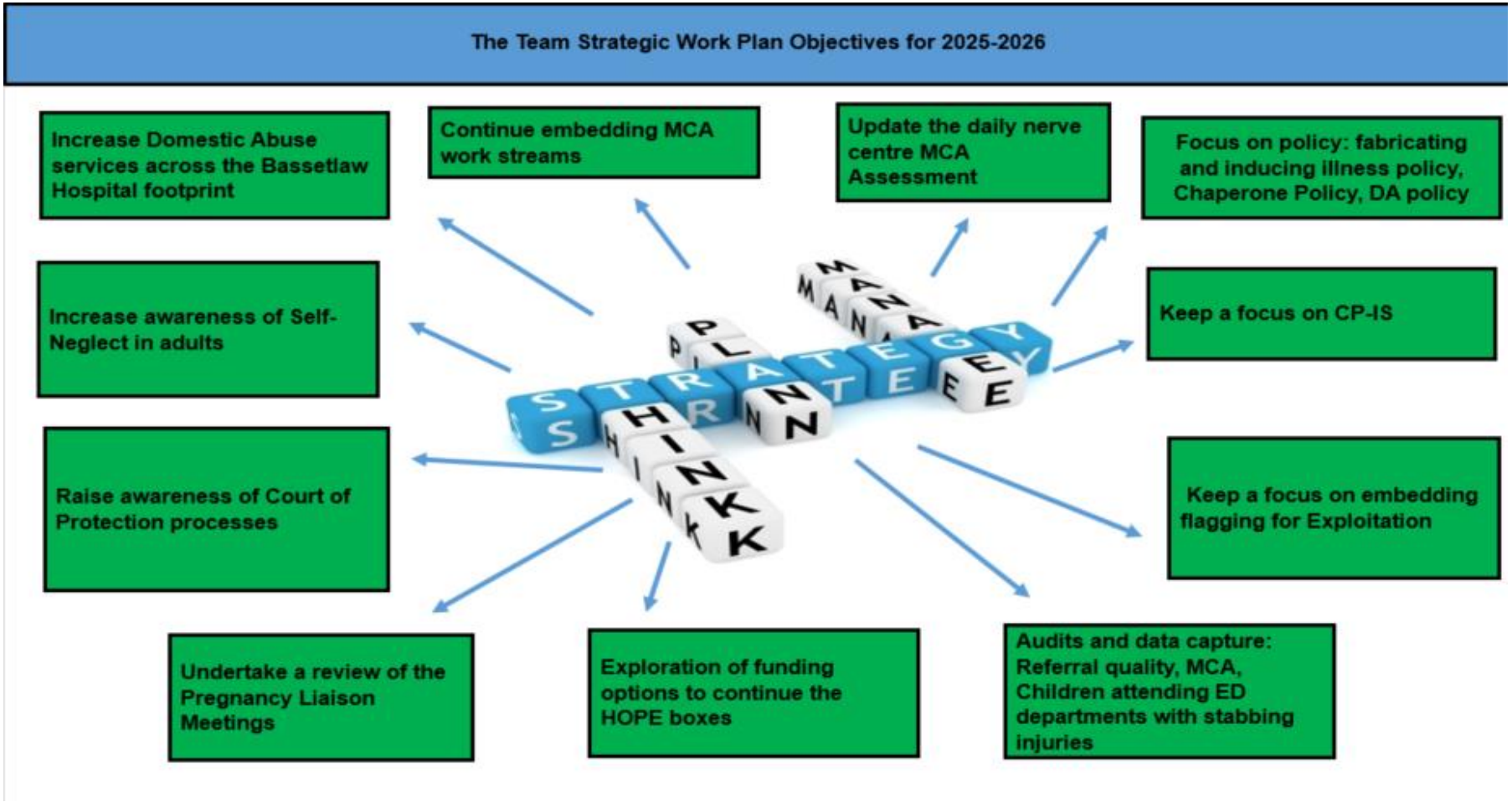
Figure 18: Provides a positive year end position with completion of key priorities that were outlined in the 2023 – 2024 annual report for achievement during 2024 – 2025.

Safeguarding Priorities 2023 – 2024: How did we do?

Continue to increase Safeguarding resource capacity and implement the planned recruitment	✓
Process Safeguarding Supervision arrangements	✓
Keep a focus on policy, with plans to finalise WNB, Sexual Safety, Management of Allegations, review the children and adult safeguarding policy.	✓
Progress the flagging of Children at risk of exploitation to increase the opportunities to intervene and safeguard.	✓
Rebrand 'Huddles' as 'Safeguarding Liaison Meetings' and expand to adult and maternity areas of the Trust.	✓
Review the Safeguarding Training content.	✓
Progress audit activity to include MCA, Safeguarding referral quality, domestic abuse, safeguarding on tendable.	✓
Work with relevant areas to explore CP-IS	✓
Embed the use of H.O.P.E boxes	✓

31. Looking forward to our 2025 – 2026 priorities

Figure 19: The safeguarding team have identified a number of key priorities for 2025 -2026 that will strengthen safeguarding arrangements for the Trust. The team work plan provides the ongoing oversight to ensure these priorities remain in focus, under the scrutiny of the Strategic Safeguarding Group. Below are some of the key objectives outlined in the work plan.



32. Conclusion and closing remarks:

As we move forward into 2025 - 2026, development of this annual report has been another opportunity to reflect on the DBTH safeguarding journey. It has allowed for recognition of our achievements and the opportunity to focus our efforts for the year ahead. This report provides assurance to the Trust, its patients and their families, and our partner agencies that safeguarding remains a key priority. During this year, our team has seen a continued growth in resources as part of our team structure review and planned staggered implementation. We have welcomed a Named Nurse for MCA / DOLS, a Named Nurse for Adult safeguarding, a Specialist Nurse for Safeguarding Children and a Specialist Nurse for MCA / DOLS; this increase in resource has been crucial to being able to deliver safeguarding activities and evidencing the impact to safeguarding our patients by having the resource to be responsive to safeguarding requirements.

The increased activity in this report continues to demonstrate the impact of enhanced visibility of the team across all our Trust areas. The governance arrangements and functions of the quarterly Strategic Safeguarding Group has facilitated ongoing Divisional collaboration and continued commitment to prioritise safeguarding. The correlation between a workforce that has enhanced safeguarding knowledge and an increase in safeguarding referrals is also a clear observation that is outlined in this report. Colleagues' ability to recognise, respond and escalate safeguarding concerns has contributed to enhanced Trust safeguarding arrangements and a greater ability to keep our patients safe.

The priorities outlined for this reporting year have all been progressed and further ambitious priorities are outlined for the year ahead, underpinned by the finer detail outlined within the Trust's safeguarding team work plan. I am confident that the safeguarding team will have another productive and proactive year ahead, embedding practice to continuously improve the outcomes for unborn babies, children, young people and adults at risk.

Denise Phillip
Head of Safeguarding

Appendix 1

DBTH SSC Forward Schedule of Business (April 2024 – March 2025)				
For Assurance	**Q1 April – June 2024**	**Q2 July – Sept 2024**	**Q3 Oct – Dec 2024**	**Q4 Jan – March 2025**
SG Quarterly report	✓	✓	✓	✓
Annual Report	✓			
Training Compliance	✓	✓	✓	✓
Safeguarding Self-Assessments	On Completion / when scheduled			
Audit outcomes / action plans	On Completion / when scheduled			
Update on SG workplan	✓			✓
Update on SG risks	✓	✓	✓	✓
Update on SG cases	✓	✓	✓	✓
Good Practice	✓	✓	✓	✓
Outstanding Datix and Divisional responses	✓	✓	✓	✓
Looked after Children's update		✓		✓
SEND update	✓	✓		
MCA / DoLs update	✓	✓	✓	✓
For Approval	**Q1 April – June 2024**	**Q2 July – Sept 2024**	**Q3 Oct – Dec 2024**	**Q4 Jan – March 2025**
Policies	On Completion / when scheduled			
Escalations	✓	✓	✓	✓
ToR	✓			
Group Membership	✓			
Agree Forward schedule of Business	✓			
Audit action plans	On Completion / When scheduled			
For information	**Q1 April – June 2024**	**Q2 July – Sept 2024**	**Q3 Oct – Dec 2024**	**Q4 Jan – March 2025**
SG Briefings	✓	✓	✓	✓
Key SG headlines regional/nation	When available			
Learning from other areas	When available			
Updates from ICB / DBTH Divisions	✓	✓	✓	✓

Meeting dates: **09.02.2024 (10:30 – 12:30), 16.05.2024 (14:30 – 17:00), 05.09.2024 (14:30 – 17:00), 28.11.2024 (14:30 – 17:00), 27.02.2025 (14:30 – 17:00)**

Appendix 2: 2024 – 2025 Work Plan summary

Safeguarding Work Plan: Position update and summary Feb 2025 – Denise Phillip (Head of Safeguarding)
This has been another ambitious work plan for 2024 – 2025, with key priorities and safeguarding work streams identified following the annual review GAP analysis that was undertaken in April 2023. In total there were 22 work streams identified, with some larger team plans from the previous year being carried over. **Current areas completed (numbers reference actions on the work plan:** **Safeguarding Supervision arrangements (Action 1):** Further Supervisor training commissioned and delivered, increasing the number of Trust Safeguarding supervisors to 54, with additional support from 15 trained supervisors in the safeguarding team. The policy is now published and outlines arrangements for role requirements and the framework for supervision to be completed. Reporting compliance mechanism in place for relevant areas via Divisional high light reports and work undertaken to identify relevant colleagues to support future report via ESR and DERICK dashboard. **Safeguarding Policies (Action 2):** Policies due to be approved at Feb 2025 Strategic Safeguarding group include Safeguarding Children / Person in Position of Trust – allegations / Safeguarding Adults Policy. Further policies published this year are Was Not Brought (Children and Adults at risk), Sexual Safety. The Safeguarding team have also contributed comments to a number of wider Trust policies. The Domestic abuse policy date will be extended to allow for process change consideration on reporting mechanism – this will policy will therefore transfer to next year's work plan. **Flagging of children at risk of exploitation (Action 3):** Significant liaisons have been undertaken to shape the next steps to allow for flagging/alerting to commence for Doncaster Children – awaiting a start date agreeing for this in Doncaster. Arrangements for Notts children will continue to 2025 – 2026 work plan, but DBTH have been influential at progression partnership discussions to commence this process across wider health areas of Nottinghamshire. This action will transfer to next year's work plan. **Review of Safeguarding Training (Action 4):** Significant work has been undertaken to review role alignment, update training content, develop a safeguarding strategy on a page, separate reporting for MCA, commence the foundation to report on the additional 4 hours requirement for relevant colleagues at L3 (Children), continue the improvement journey for safeguarding training compliance and update

evaluation processes to enable greater impact to be evidenced in the future. Sexual safety training is now reported also via DERICK dashboard. Training compliance will continue to remain in focus via Divisional highlight reporting and oversighted at the Strategic Safeguarding Group (SSG). Some continued elements from this action will transfer to next year's work plan these will be around the additional 4 hour requirement for L3 children and development of L3 adult safeguarding training.

Female Genital Mutilation, FGM (Action 5): Significant work has been completed to coordinate a Trust position on how risk assessment of pregnant women are managed with a view to utilising a partnership approach to manage risk / information share in line with other South Yorkshire processes. This has been supported by ICB and Local Maternity and Neonatal System (LMNS). A gap analysis on how FGM is reported in the Trust and processes in place to capture data has been completed. Named Midwives oversights all FGM notifications and undertakes monthly reporting to ensure all processes are completed. Some ongoing work will continue into 2025 – 2026 work plan regarding the wider partnership processes and meetings are commencing to start the same partnership conversations with Nottinghamshire. The FGM policy update has been deferred to 2026 (when it is scheduled) this will give time for wider partnership processes to be confirmed so this can be fully referenced in the policy. Reporting flowcharts and risk assessment templates for pregnant women are published on the HIVE.

Child Protection Information Sharing – CP-IS (Action 6): Links have been established for both Doncaster and Notts ICB in preparation for next phase of CP-IS, however baseline work identified that CP-IS was not embedded in the Trust and this was highlighted as a Trust risk (3521). Extensive work has been undertaken to review and develop solutions in unscheduled areas Emergency Department / Paediatric Assessment areas / Maternity unplanned attendance; this is supported by an ongoing action plan which is attached to the risk. Compliance on undertaking CP-IS checks is now part of the reporting on Divisional highlight reports (for SSG) to ensure continued oversight. Whilst elements from this action that has been within DBTH's control have been completed. Further oversight to embed will be a focus on the coming year. This work stream will continue into 2025 – 2026 work plan until improvement in compliance is evidenced and to support the next phase of CP-IS (which is yet to be outlined by NHS England / ICBs).

Sexual Safety work streams (Action 7): Extensive work has been completed to develop a Sexual safety policy, supported by a Trust working task group (including Safeguarding, Equality/Diversity, Freedom to Speak up Guardian, HR Business partner, Patient Safety, Datix lead, Education lead, Comms). Standards of behaviour, reporting systems have been developed and outlined in the Policy. A Trust training package was implemented and has recently been replaced with an elfh package that has just been developed by NHS England – and training requirements have been aligned to all Trust colleagues, which is now reported on DERICK. Trust resources have been developed on a designated HIVE intranet page and a communications launch supported the progression of the work stream, which included a video/infographic to outline sexual safety and how we should respond. Future work will likely include NHS England developing a 'self-assessment' framework but this will be incorporated as core business when required.

Audit Schedule (Action 8): During this work plan audits have been undertaken on Managing crying babies and prevention of abusive head trauma, Domestic abuse in out of hours (ED), Mental Capacity, Legal process for court statements – these have all been presented to SSG. There has been some delay in progressing the Quality of children's and Adult referrals audit due to some changes in support from the Audit team, but this has now resolved and these 2 audit are scheduled for completion in Q4 but will be presented to SSG in June 2025. The initial planning to review tendable audits will not be progressed

currently as Tendable is oversighted via Divisions. Safeguarding questions have been included in the weekly tendable audit questions to support a measure of knowledge / understanding on a small question set (Safeguarding / MCA / 16+17 year olds). A gap analysis on FGM arrangement in the Trust was undertaken instead of an audit. The capacity to consent to unplanned admission audit was replaced by the plans to undertake a quality improvement project, update the daily MCA assessment on nerve centre and schedule work to be progressed in the coming year to look at how MCA are considered in ED. Audit of the quality of supervision was not progressed following recognition the supervision framework requires time to embed prior to consideration for future auditing. The audits that were identified on the final schedule are therefore on track for completion by March / April in time for presentation at the next SSG.

Hope Boxes (Action 9): There has been successful implementation of the HOPE boxes (**H**old **O**n **P**ain **E**ases). This initiative was to offer support to Women and Babies being separated following birth due to local authority intervention, in order to reduce future trauma. The implementation of this initiative has included training and wider partner awareness raising and development of a focus group to drive the work stream. This will remain on the work plan for 2025 – 2026 to support ongoing oversight on future funding and to consider wider feedback / audit to the national project.

Develop Level 3 Safeguarding Adult training (Action 10) – this action was closed down as duplicated and included in Action 4.

Development of a process / template to undertake timely responses to safeguarding adult investigations - allegations against the Trust received – (Action 11): A process flowchart was produced in collaboration with Divisions to outline key questions that will support timely and informative responses to the local authority. This includes a time factored escalation process when responses are required by and agreement on escalation up to Divisional leads where appropriate. A template of key questions has been incorporated within the Datix to support colleagues with appropriate framing of allegation responses. This has resulted in allegation responses being responded to quickly and Divisional leads being aware of any emerging concerns that are not being responded to. Positive feedback has been received from the Local Authority since the implementation of this process.

MCA (Action 12): This action outlined the plans to expand Trust resources (recruitment of a MCA lead and specialist practitioner to support the drive of the MCA work streams), the development of a Trust MCA forum to support divisional engagement and opportunities to learn and share key information, review of the eLearning content of the MCA training and decision in adopt the elfh packages, continuation of bespoke drop in sessions across all sites, continuation of quarterly audits and commissioning of additional external training as an addition to mandatory training – these have contributed to opportunities to support colleagues to learn and increase DBTH resources. While this action is completed the focus on MCA will continue in the 2025 – 2026 work plan, with continued oversight of the Trust risk via SSG.

Annual Safeguarding standard / declaration (Action 13): All requests for statutory returns have been submitted within timescales for both Doncaster and Nottinghamshire. Oversight of these submissions and any ongoing areas that are in progress continues via SSG as part of the forward schedule reporting.

Safeguarding tendable questions (Action 14): Work has been completed to include safeguarding and MCA questions on to the weekly tendable questions. This is a further opportunity for colleagues and divisions to use as a measure of areas that require improvement.

Safeguarding Support for international nurses (Action 15): Work was completed to undertake a survey on safeguarding knowledge of international nurses to identify if any additional support needed. 26 responses were received out of approx. 200 – with mixed outcome responses on confidence of safeguarding knowledge. Knowledge was on the whole identified that colleagues understood how to access support and an awareness that further resources were on the HIVE. International nurse cohorts have been supported via preceptor routes and during safeguarding training, they have also been part of bespoke training sessions that have taken place across all divisional areas. The international educator lead has reiterated how further bespoke support can be accessed if there is a future requirement.

Safeguarding Liaison Meetings – SLM (formally safeguarding huddles) will expand to adult and maternity areas (Action 16): Visibility across the site has continued as part of the SLMs, with successful expansion of these to adult and maternity areas – to ensure we have an 'all age' approach to safeguarding. Processes are all supported by a standard operating procedure that captures the purpose and process of undertaking SLMs, this was approved at the SSG. The rebranding from Safeguarding Huddles to SLMs was supported by communications out via the Buzz and provides continued opportunities to support the safeguarding of patients, share key learning and offer bespoke learning opportunities.

Review of Domestic Abuse Policy (Action 17): Closed - Duplicated action – this was incorporated under the wider action on Safeguarding Policies

Delivery of DASH Risk assessment training (Action 18): Following discussion with Local Authority DA leads negotiation has occurred with them for the Trust SG team to develop a bespoke condensed DASH more appropriate for use in acute hospital areas, this approach is supported. Progressing training on DASH was therefore suspended, whilst this form is developed. Following results in Q4 from the out of hours DA audit – further work is going to be progressed to look how DA referral activity is captured and progressed, with plans to build in DA referrals via DATIX, similar to process that occurs for safeguarding adult referrals. Within this process there will be development of key questions to support colleagues to understand risk levels and wider work will be on the 2025 – 2026 work plan to support Emergency Departments with the identified actions from the out of hours DA audit. Action 18 was therefore progressed due to changes planned and work will be reframed to continue appropriate planning / action development for 2025 – 2026.

Domestic Abuse Audit – Out of hours referrals (Action 19): Closed – duplicate action – this was incorporated under the wider action on Safeguarding audits – Action 8.

Evidence of impact from people who work at DBTH who have referred into DA Liaison officer services (Action 20): A questionnaire feedback form has been developed with a QR code to capture feedback from referrers that work in Trust. Data is still to be reviewed by end of Q4. Verbal feedback from colleagues that have been supported by DA Liaison officers has been positive but survey data will provide

further useful information to consider any different approaches that may be required into the next years' work plan.

Planned rebranding of 'Safeguarding Huddles' to 'Safeguarding liaison meetings' (Action 21): This year has seen wider 'Safety Huddles' rolled out across Trust areas, therefore following liaison with Chief Nurse / Deputy Chief Nurse the decision was made to rebrand the Safeguarding Huddles to ensure Trust colleagues were not confused by the similar names. Rebranding completed in Q2, underpinned by a SOP and planned communications to raise awareness.

Pregnancy Liaison Meetings (PLM) for Doncaster and Bassetlaw to be standardised to support consistent approaches (Action 22): To support a consistent approach to how pregnancy background checking and thereafter progression on to a pregnancy liaison meeting occurs across both areas – it has been recognised that there are some different approaches being used. In Bassetlaw there is a more robust method of multi-agency information sharing to inform the requirement to progress to a PLM but this is more limited multi-agency approach in Doncaster due to the number of cases referred in. This work stream will continue into 2025 – 2026 to allow consultation with partners involved in this process. Meetings are scheduled to support initial discussions with Doncaster partners. DBTH processes to underpin referral for back ground check and progress to PLM will be outlined in a SOP – this is currently in draft format.

Ongoing areas that will transfer to 2025 – 2026 work plan:

Domestic Abuse policy review (Action 2): Review extended to incorporate consideration of a change in reporting.

Flagging of children at risk of exploitation (Action 3): Processes have progressed in readiness for flagging to commence, awaiting confirmation from DBTH digital team for a start date prior to names being sent from Doncaster and work still to progress in Notts to progress how local authority colleagues will share the relevant information with health partners.

Review of Safeguarding Training (Action 4): Development of a Level 3 Safeguarding Adult package will continue to 2025 – 2026 work plan, work is currently underway to identify roles that will require this training.

Child Protection Information Sharing – CP-IS (Action 6): Whilst the DBTH element in this action were completed, this will continue on the 2025 – 2026 work plan as information awaited from NHS England to extend the areas required to undertake CP-IS checks. Further Trust assurance also required on compliance of phase 1 areas – as outlined on CP-IS action plan that is in place.

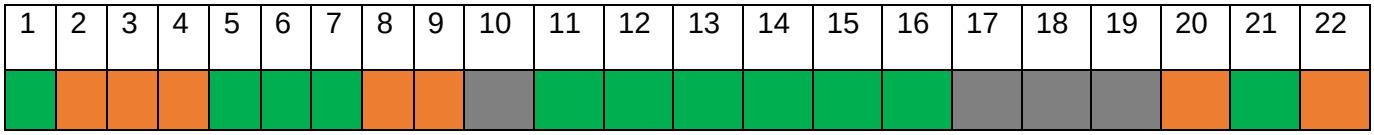
Audits: (Action 8): children and adult referral audit – will be finalised in Quarter 1

Hope Boxes (Action 9): This will continue on the 2025 – 2026 work plan to oversight future funding arrangements and feedback from the national project, when this information is requested.

Evidence of impact from DA Liaison officers (Action 20): Feedback from DBTH staff members that have referred to DA officers is still being collated. This will be carried forward to the next year's work plan

Pregnancy Liaison Meetings (PLM) for Doncaster and Bassetlaw to be standardised to support consistent approaches (Action 22): This will continue on the 2025 – 2026 work plan to support consistency in approaches across Bassetlaw and Doncaster.

Overarching key of Work plan completion – amber areas will transfer to 2024 – 2025:



Key:

Action completed	Action in progress	Action not progressed / no longer required

11 out of 22 completed by end of Q4 - 4 not progressed / no longer required, 7 will continue to 2025 – 2026 work plan = total 22 actions. Noting that some actions had multiple factors involved as detailed in the overarching work plan for 2024 – 2025.

Appendix 3 – DBTH Safeguarding team

Contact us on 01302 642437

dbh-tr.safeguarding@nhs.net

What is our role?

As a Safeguarding team we provide safeguarding support, advice, safeguarding supervision and safeguarding training for colleagues working with adults and children (including maternity services) across Trust areas.

We ensure that safeguarding policies and procedures are in place in order to support safe practice to all patients whilst they are accessing care from service areas.

As a team we work closely with Partner agencies to ensure robust safeguarding arrangements are in place for children and adults in a 'think family' approach. We contribute as a Partner agency to shape and influence, local, regional and national safeguarding arrangements.

We work across South Yorkshire and Nottinghamshire to share practice, develop a shared safeguarding vision and champion a coordinated safeguarding response.

What do we offer?

The team's core hours of work are Monday – Friday (9-5pm). Outside of these hours safeguarding support resources can be found on the HIVE. We support the multi-agency safeguarding partnerships and boards to undertake reviews of serious safeguarding cases, domestic homicides and allegations that may have been made against our Trust; liaising with relevant Trust areas to provide and share information.

We support Trust colleagues with any Safeguarding advice or support that may be required to support care of an adult or child, answering any safeguarding questions that colleagues may have.

We provide Safeguarding training on a range of topics for Trust colleagues and opportunities to access safeguarding supervision.

We disseminate key local and national safeguarding information across Trust areas and signpost to internal and external safeguarding training opportunities.

We are the interface for partners and support safe sharing of safeguarding information when necessary to safeguard an unborn baby, child, young person or adult at risk.

Appendix 4

Escalation Flowchart for 'Allegations against the Trust'

Safeguarding referral received from the Local authority with regards to allegations against the trust.

↓

The Safeguarding team will complete a DATIX and allocate to the Ward manager and Matron to investigate and provide a response. A response is expected within 14 days to meet the local authority thresholds. All governance leads will be added into the DATIX.

↓

There might be a few practical actions that could be taken immediately by the relevant clinical area, to help resolve a Safeguarding allegation.

↓

If the Investigator (Ward Manager / Matron) requires further support or is unable to meet the deadline, please contact the Safeguarding team, within 7 days of the initial DATIX being sent.

↓

If there is no response from the Ward Manager or Matron within 14 days, it will be escalated to the Deputy/Divisional Lead and a response will be expected within 7 days from that escalation date.

↓

When the investigator responds to a DATIX the 'Allegations against the Trust template' should be used. This is located in the documents and templates section in the DATIX. Please attach the completed template to the allocated DATIX.

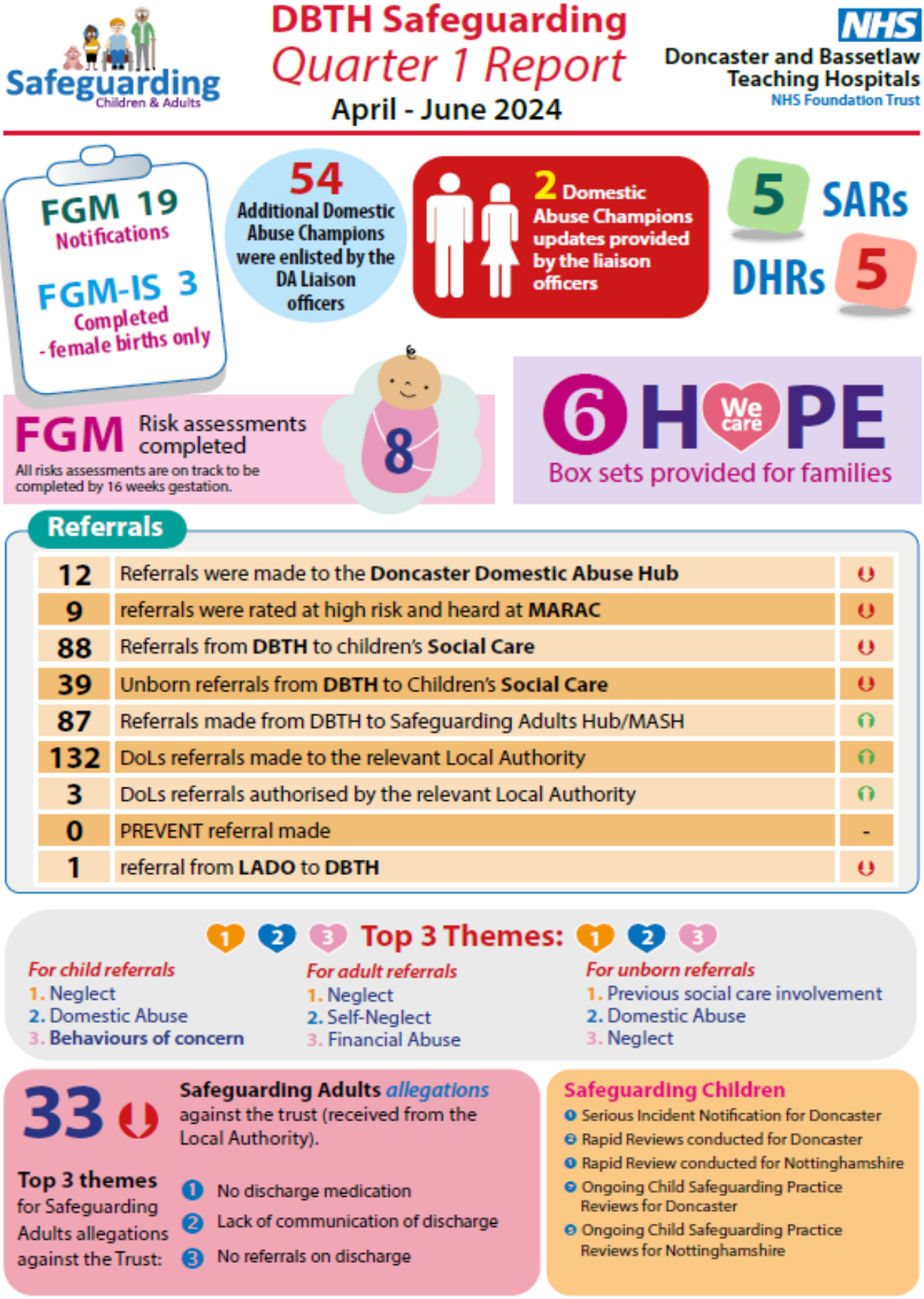
For any support please contact the safeguarding team on 01302 642437

Or email dbh-tr.safeguarding@nhs.net

Appendix 5 – 16 days of action against DA timetable of events

Monday 25th November	**Social Media Post:** Introduction to the 16 Days Campaign
	Walk around: ED, EAU, FAU, MIU
Tuesday 26th November	**Social Media Post:** Understanding the different types of abuse
	Stand outside of canteen: Domestic abuse champions badges, expectations of a DA champion & DA resources
	Walk around Gresley Unit, Children's Outpatients, Ward 32
Wednesday 27th November	**Social Media Post:** Cycle of abuse
	Walk around AMU, Ward 16, Ward 17
	Domestic abuse champions training - 1pm – 3pm
Thursday 28th November	**Social Media Post:** Protection orders for DA
	Walk around Ward 18, Ward 19, Ward 20, Ward 21
Friday 29th November	**Social Media Post:** Online & Digital Abuse
	Walk around CCU, DCC, Ward 24, Ward 25
Monday 2nd December	**Social Media Post:** Local support services for DA victims
	Walk around / Stand Mexborough Montagu Hospital
	Virtual Event – 1pm – 1:30pm : Joined by PC Tattam from South Yorkshire Police Domestic Abuse Team
Tuesday 3rd December	**Social media post:** Ending Harmful Traditional Practices / FGM
	Walk around Orthopaedic Wards
Wednesday 4th December	**Social media post:** Interventions for Children & Child to Parent Abuse
	Walk around Women's & Children's Wards
	Stand in Maternity (1pm-4pm)
Thursday 5th December	**Social media post:** Violence Against Women and Girls: Global Statistics
	Stand outside canteen
	Walk around Ward 26, Ward 27, S10, S11, S12, Jasmine Centre
Friday 6th December	**Social media post:** Perpetrator programmes
	DA Champions Update – 12:30pm – 13:30pm: Domestic abuse & the effects of Christmas
Monday 9th December	**Social media post:** LGBTQ+ Specific DA
	Lunch & Learn – 12pm – 1pm: The Rainbow Network & DA in the LGBTQ+ Community
Tuesday 10th December	**Social media post:** Call to Action: What Can You Do to Help?
	Stand outside canteen

Appendix 6 – Safeguarding Quarterly reports 2024 – 2025



DBTH Safeguarding Training	Trust compliance	Increase or Decrease?
Safeguarding Adults Level 1 (via SET)	96.40%	↑
Safeguarding Adults Level 2	94.14%	↑
Safeguarding Children Level 1 (via SET)	96.37%	↑
Safeguarding Children Level 2	93.27%	↑
Safeguarding Children Level 3	85.30%	↑
Basic PREVENT awareness (via SET)	97.40%	↑

Key Achievements:

- ✔ Following successful recruitment in Quarter 4, the DBTH Safeguarding Team welcomed Kimberley Holbert the new Band 7 Lead Nurse for Safeguarding Adults.
- ✔ A meeting was held with all DBTH Safeguarding Team colleagues to discuss the results of the 2023 Annual Staff Survey results and develop an action plan for the year ahead.
- ✔ Safeguarding questions successfully launched on Tendable.
- ✔ Safeguarding sections added to Nerve Centre located within MDT Handover.
- ✔ Pilot of Level 3 Safeguarding Children completed with multi-team approach for designated sections of the training day.
- ✔ The Domestic Abuse Liaison Officers have a designated desk within the Emergency Department (ED) at DRI to increase visibility and promote professional relationships with colleagues within ED.
- ✔ The MCA pro forma from Nerve Centre has been replicated and is now live on DCC IT system.
- ✔ The DBTH Safeguarding Team have successfully developed actions for the 2024-2025 workplan.
- ✔ Successful recruitment of a new Band 6 full-time Specialist Nurse for Safeguarding Children who will commence in post Quarter 2.
- ✔ Deborah Searson became the Learning Environment Manager for the DBTH Safeguarding Team and have welcomed 5 students for shadowing experience.

148 Safeguarding Liaison Meetings were held across DBTH

Looking forward priorities:

1. Safeguarding Training and Supervision
2. Increasing visibility of the Safeguarding Team
3. Continued focus on the Safeguarding standards and work plan
4. Embed CP-IS across DBTH

Safeguarding Documents: • Neglect • Non-Fatal Strangulation

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DHR - Domestic Homicide Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS – Child protection information sharing

"Safeguarding is *everyone's* business"

Safeguarding Children & Adults

See something, say something

We care

DBTH Safeguarding Quarter 2 Report

July- September 2024

Safeguarding Children & Adults

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

FGM 14 Notifications

FGM-IS 6 Completed - female births only

15 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers

2 Domestic Abuse Champions updates provided by the liaison officers

5 SARs

DHRs 5

FGM

Risk assessments completed

All risks assessments are on track to be completed by 16 weeks gestation.

7

6 HOPE We care

Box sets provided for families

Referrals

13	Referrals were made to the **Doncaster Domestic Abuse Hub**
14	referrals were rated at high risk and heard at **MARAC**
127	Referrals from **DBTH** to children's **Social Care**
57	Unborn referrals from **DBTH** to Children's **Social Care**
113	Referrals made from DBTH to Safeguarding Adults Hub/MASH
146	DoLs referrals made to the relevant Local Authority
0	DoLs referrals authorised by the relevant Local Authority
0	PREVENT referral made
4	referral from **LADO** to **DBTH**
2	**PIPoT** referrals completed

Doncaster:	Bassetlaw:
172 background checks	43 New referrals to PLM
125 total cases discussed at PLM	69 total cases discussed at PLM

31 **Safeguarding Adults** *allegations* against the trust (received from the Local Authority).

Top 3 themes for Safeguarding Adults allegations against the Trust:

1. Discharge Concern – Missing Medication
2. Lack of communication regarding discharge plans
3. Discharge Concern – Package of Care / no care act assessment for care and support needs.

Safeguarding Children

- 0 Serious Incident Notification for Doncaster
- 0 Rapid Reviews conducted for Doncaster
- 0 Rapid Review conducted for Nottinghamshire
- 9 Ongoing Child Safeguarding Practice Reviews for Doncaster
- 9 Ongoing Child Safeguarding Practice Reviews for Nottinghamshire

Top 3 Themes:

For child referrals
1. Neglect
2. Was Not Brought
3. Domestic Abuse

For adult referrals
1. Self-Neglect
2. Neglect
3. Physical abuse

For unborn referrals
1. Previous social care involvement
2. Domestic Abuse
3. Parental Substance Misuse

169 Safeguarding Liaison Meetings were held across DBTH

DBTH Safeguarding Training	Trust compliance	Increase or Decrease?
Safeguarding Adults Level 1 (via SET)	97.03%	
Safeguarding Adults Level 2	93.34%	
Safeguarding Children Level 1 (via SET)	97.03%	
Safeguarding Children Level 2	93.23%	
Safeguarding Children Level 3	85.52%	
Basic PREVENT awareness (via SET)	97.12%	

Key Achievements:

- Gold standard safeguarding awards presented to a speech and language therapist from Ward 16/Rehab and a Paediatric Nurse from Bassetlaw Emergency Department.
- The Was Not Brought Policy was completed and successfully published alongside resources to support colleagues.
- The Safeguarding Supervision Policy has been completed and successfully published alongside resources to support colleagues.
- CP-IS action plan developed and work is underway to link in with key areas in ED / Paediatrics and Maternity.
- We welcomed two new members to our Safeguarding Team – Catherine Naughton is our new Band 7 Named Nurse for MCA / DoLs and Molly Butler our new Band 6 Specialist Nurse for Safeguarding Children.
- FGM maternity guideline approved by the Strategic Safeguarding Group and the FGM risk assessment has been reviewed, developed and published for colleagues to utilise.
- Successful development of a non-fatal strangulation (NFS) pathway has launched and shared with colleagues across the Trust.
- A new pathway for Section 42 allegations against the Trust has been developed and shared with divisional leads at the SSG.
- Creation of a Safeguarding Fundamentals Poster that has been distributed and personalised across all sites at DBTH.
- Successful completion of ICON audit and key findings have been shared with SSG.
- Student placements now active within the SG team.
- The DBTH Safeguarding Team have re-branded huddles to Safeguarding Liaison Meetings
- Development of MCA work streams and acquisition of external MCA Edge training has been offered to colleagues across the Trust.
- Domestic Abuse Liaison Officers have created bespoke teaching sessions for colleagues on S12.
- Clinical Speciality Services have received bespoke training sessions for their Band 7's from the Safeguarding Adults team.
- Significant progress noted in the quick closure of Section 42 allegations against the Trust.

Looking forward priorities:

1. Safeguarding Training and Supervision
2. Increasing visibility of the Safeguarding Team
3. Continued focus on the Safeguarding standards and work plan
4. Embed CP-IS across DBTH
5. Developing policy for managing allegations (PiPoT / LADO)

Safeguarding Documents:

- Making Safeguarding Personal (MSP)
- Professional Curiosity
- Think Family

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DHR - Domestic Homicide Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS – Child protection information sharing
PLM – Pregnancy Liaison Meeting	

DBTH Safeguarding Quarter 3 Report

October - December 2024

Safeguarding Children & Adults

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

19 FGM notifications
0 FGM-IS completed
female births only

24 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers (total now for the Trust is 560)

2 Domestic Abuse Champions updates provided by the liaison officers

5 SAR Requests

Ongoing SARs 7

0 DARDR requests

Ongoing DARDR 5

FGM Referrals

Risk assessments completed

All risks assessments are on track to be completed by 16 weeks gestation.

5

4 HOPE We care

Box sets provided for families

12	Referrals were made to the **Doncaster Domestic Abuse Hub**
25	referrals were rated at high risk and heard at **MARAC**
120	Referrals from **DBTH** to children's **Social Care**
40	Unborn referrals from **DBTH** to Children's **Social Care**
120	Referrals made from DBTH to Safeguarding Adults Hub/MASH
160	DoLS applications made to the relevant Local Authority
0	DoLS applications authorised by the relevant Local Authority
0	PREVENT referral made
1	referral from **LADO** to **DBTH**
0	**PiPoT** referrals completed

Doncaster:	Bassetlaw:
137 background checks	47 New referrals to PLM
113 total cases discussed at PLM	68 total cases discussed at PLM

30 **Safeguarding Adults** *allegations* against the trust (received from the Local Authority).

Top 3 themes for Safeguarding Adults allegations against the Trust:

1. Neglect
2. Discharge concerns
3. Hospital acquired pressure damage

Safeguarding Children

0 Serious Incident Notification for Doncaster
0 Rapid Reviews conducted for Doncaster
1 Rapid Review conducted for Nottinghamshire
2 Ongoing Child Safeguarding Practice Reviews for Doncaster
3 Ongoing Child Safeguarding Practice Reviews for Nottinghamshire

Top 3 Themes:

For child referrals
1. Was Not Brought
2. Domestic Abuse
3. Neglect

For adult referrals
1. Self-Neglect
2. Physical abuse
3. Neglect

For unborn referrals
1. Previous social care involvement
2. Domestic Abuse
3. Neglect

395 Safeguarding Liaison Meetings were held across DBTH

DBTH Safeguarding Training	Trust compliance	Increase or Decrease?
Safeguarding Adults Level 1 (via SET)	96.46%	↓
Safeguarding Adults Level 2	92.34%	↓
Safeguarding Children Level 1 (via SET)	96.50%	↓
Safeguarding Children Level 2	91.99%	↓
Safeguarding Children Level 3	85.48%	↓
Basic PREVENT awareness (via SET)	97.37%	↑

Key Achievements:

- Domestic Abuse Liaison Officer's attended a Domestic and Sexual Abuse Practitioners Event for Professionals at the Legacy Centre where we shared worked completed relating to domestic and sexual abuse within DBTH with other professionals in the partnership.
- Named Nurse for MCA and DoLS attended the ophthalmic governance meeting to deliver MCA training power point and hosted a Q+A session.
- Lead Nurse for Safeguarding Adults and Named Nurse for MCA and DoLS delivered a bespoke training session based on Safeguarding Adults and MCA to Orthopaedic Theatre colleagues.
- Sexual Safety e-learning for health package approved and added to ESR for colleagues to complete.
- Successful appointment of a Band 6 Specialist Nurse for MCA and DoLS, Memory Chidziva who will commence in post January 2025.
- The Specialist Nurse for Safeguarding Adults have continued to conduct ward rounds at MMH.
- The DBTH Safeguarding Team conducted another very successful Safeguarding Awareness Week in November. The team hosted stands across DBTH and delivered Lunch and Learns on MS teams about a variety of key Safeguarding topics.
- The Domestic Abuse Liaison Officers hosted stands, lunch and learns, walk arounds and daily social media posts during the 16 days of activism against Gender-Based Violence campaign.
- Specialist Nurse for Safeguarding Adults collaborated and delivered on the Nottinghamshire partnership event.
- We welcomed a new Safeguarding Secretary to the team, Jorja Williams.
- Creation of a proposal for 12 months of support to ED from the Safeguarding Adults Team.
- Creation of a proposal for embedding and documenting MCA in ED.
- Specialist Nurse for Safeguarding Children was successful in her Chief Nurse Internship application. Kim Armistead will be conducting research on the Was Not Brought policy and connection to neglect and areas of high deprivation.
- Self-Neglect multi-agency Audit conducted for Doncaster in which DBTH engaged and future work planned to identify and support self-neglect.
- DBTH linked with universities to share sexual safety resources developed and implemented at DBTH.
- The DBTH Safeguarding Team delivered training to Foundation Year Doctors (Year 1 & 2).
- Successful involvement in the Children in Adult areas study day.

Looking forward priorities:

- Safeguarding Training and Supervision
- Increasing visibility of the Safeguarding Team
- Continued focus on the Safeguarding standards and work plan
- Embed CP-IS across DBTH
- Developing policy for managing allegations (PiPoT / LADO)

Safeguarding Documents:

- Controlling and Coercive Behaviour
- Hoarding (Self-Neglect)
- Child Exploitation

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

Abbreviation List	
FGM - Female Genital Mutilation	FGM-IS - Female Genital Mutilation - Information Sharing
SAR - Safeguarding Adult Review	MARAC - Multi-agency Risk Assessment Conference
DARDR - Domestic Abuse Related Death Review	LADO - Local Authority Designated Officer
DoLs - Deprivation of Liberty Safeguards	CP-IS - Child protection information sharing
PLM - Pregnancy Liaison Meeting	

DBTH Safeguarding Quarter 4 Report

January - March 2025

Safeguarding Children & Adults

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

14 FGM notifications
0 FGM-IS completed female births only

10 Additional Domestic Abuse Champions were enlisted by the DA Liaison officers (total now for the Trust is 570)

1 Domestic Abuse Champions updates provided by the liaison officers

5 SAR Requests
Ongoing SARs **8**
1 DARDR requests
Ongoing DARDR **5**

FGM Referrals

Risk assessments completed
All risks assessments are on track to be completed by 16 weeks gestation.

6

HOPE

We care

Box sets provided for families

11	Referrals were made to the **Doncaster Domestic Abuse Hub**	↓
16	referrals were rated at high risk and heard at **MARAC**	↓
117	Referrals from **DBTH** to children's **Social Care**	↓
55	Unborn referrals from **DBTH** to Children's **Social Care**	↑
189	Referrals made from DBTH to Safeguarding Adults Hub/MASH	↑
151	DoLS applications made to the relevant Local Authority	↓
1	DoLS applications authorised by the relevant Local Authority	↑
0	PREVENT referral made	-
4	PREVENT Information Sharing Requests	-
2	referral from **LADO** to **DBTH**	↑
3	**PiPoT** referrals completed	↑

Doncaster:	Bassetlaw:
154 background checks ↑	111 New referrals to PLM ↑
97 total cases discussed at PLM ↓	61 total cases discussed at PLM ↓

35 ↑ **Safeguarding Adults** *allegations* against the trust (received from the Local Authority).

Top 3 themes for Safeguarding Adults allegations against the Trust:

1. Communication on discharge
2. Equipment Concerns
3. Medications concerns

Safeguarding Children

0 Serious Incident Notification for Doncaster
0 Rapid Reviews conducted for Doncaster
1 Rapid Review conducted for Nottinghamshire
2 Ongoing Child Safeguarding Practice Reviews for Doncaster
3 Ongoing Child Safeguarding Practice Reviews for Nottinghamshire

Top 3 Themes:

For child referrals	*For adult referrals*	*For unborn referrals*
1. Neglect	1. Self-neglect	1. Previous social care involvement
2. Child Mental Health	2. Domestic Abuse	2. Domestic Abuse
3. Parent substance misuse	3. Neglect	3. Neglect

286 Safeguarding Liaison Meetings were held across DBTH

DBTH Safeguarding Training	Trust compliance	Increase or Decrease?
Safeguarding Adults Level 1 (via SET)	95.05%	↓
Safeguarding Adults Level 2	93.62%	↑
Safeguarding Children Level 1 (via SET)	95.13%	↓
Safeguarding Children Level 2	93.40%	↑
Safeguarding Children Level 3	84.68%	↓
Basic PREVENT awareness (via SET)	94.74%	↓

Key Achievements:

- ✔ Commencement of ADHOC Adult Supervision
- ✔ Delivery of Supervision/ Case Studies in ED
- ✔ Release of Updated Mental Capacity Assessment form (MCA1)
- ✔ Number of Bespoke Safeguarding Training Sessions across Trust areas
- ✔ Further cohort of Safeguarding supervisors trained
- ✔ Review and publication of Children's and Adult's safeguarding polices
- ✔ Development and publication of Managing Allegations (PiPoT/LADO) policy
- ✔ Safeguarding Referral audits commenced
- ✔ Feedback commenced from Doncaster local authority on the outcomes of children attending for Child Protection medicals.

Looking forward priorities:

1. Safeguarding Training and Supervision compliance
2. Embedding PiPoT/LADO processes
3. Continuing visibility of the Safeguarding Team
4. Embedding CP-IS across DBTH
5. Engagement of Medical colleagues in use and documentation of MCA principles

Safeguarding Documents:

Safeguarding 7 Minute Briefing – The Hive (dbth.nhs.uk)

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Appendix 7

DBTH Safeguarding Training Strategy 2025-2027

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Our Vision:

All DBTH colleagues should be trained and competent to be alert to potential indicators of abuse and neglect, know how to act on those concerns and fulfil their roles and responsibilities for safeguarding children and adults at risk. Different staff groups require different levels of competence depending on role and level of contact with children, young people and families including adults at risk.

Underpinning Drivers:

This strategy is aligned with the following legislation and guidance:
Children Act 2004 Children Act 1989
Working Together to Safeguarding Children 2023 Working together to safeguard children 2023: statutory guidance
The Care Act 2014 Care Act 2014
Intercollegiate Document 2019 Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing
RCN Adult Safeguarding: roles and competencies of health care staff 2024 Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing
RCN Looked After Children: roles and competencies of health care staff 2020 Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing
Mental Capacity Act 2005 Mental Capacity Act 2005

What we will do:

- We will ensure all our staff groups are aligned to the correct level of safeguarding training according to job role.
- We will ensure that role specific, relevant and up to date training with suitable expiry periods is available for all colleagues.
- We will ensure colleagues are given protected time to undertake training.
- We will clearly communicate role specific training requirements; how and where this can be accessed within DBTH.
- We will clearly communicate opportunities for enhanced learning within DBTH and external to the Trust.
- We will develop bespoke packages of learning in response to themes from referral data, audit and significant cases.
- We will undertake regular robust monitoring and reporting on training compliance and completion

How will we do

By providing Safeguarding Training and share links to additional learning opportunities.

- As part of Foundations of Care
- Level 1 Adults & Children
- Level 2 Adults & Children
- Level 3 Adults & Children
- Prevent
- External Level 4 Training
- MCA and DoLS aligned to Level 2/3 Requirement
- Bespoke MCA Training for Specific Roles
- Domestic Abuse Champions Training
- Safeguarding Supervision Training
- 7 Minute Briefings
- Mandatory essential to role updates
- HIVE Resources including DBTH training framework
- Safeguarding Liaison Meetings
- Multi-agency training via Buy Doncaster and Nottinghamshire Safeguarding Childrens Partnership, DSAB and NSAB
- E Learning for health modules adopted where appropriate

2509 - E3 2024/25 PATIENT EXPERIENCE ANNUAL REPORT

Information Item | Karen Jessop, Chief Nurse | 13:00

REFERENCES

Only PDFs are attached

E3 - 2024-25 Patient Experience Annual Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patient Experience Annual Report 2024/2025

Simon Brown

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1 INTRODUCTION

The 2024/2025 annual report provides an overview of our patient feedback, based on data captured by the Friends and Family Test (FFT), National Surveys, as well as themes from PALS enquiries, complaints, website communications and engagement events.

2 ACTIVITY

3 PATIENT EXPERIENCE

During 2024/25 we continued to provide a variety of ways for our patients to provide feedback on our services. This included friends and family test, PALS contacts, engagement events and national and local surveys.

Patient Opinion

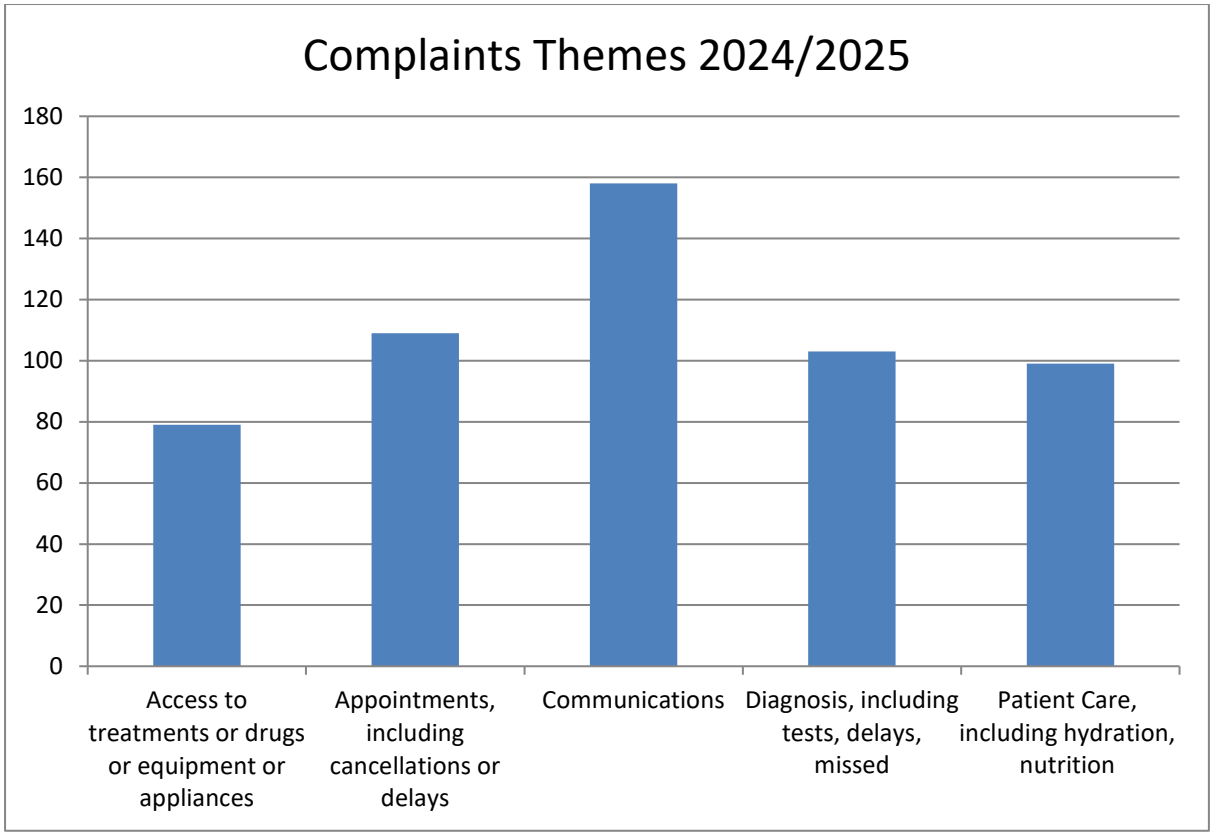
We continued to actively seek the view of our patients throughout 2024/25. There were 126 patient feedback submissions to Patient Opinion in 2024/2025.

Each of the opinions received is responded to and feedback provided to the relevant service/area for action/information as required.

Complaints

In the period 2024/2025, 682 complaints were reported to the Trust this is a 10% increase on the number (620) reported during 2023/2024. Whilst this is an increase, it demonstrates accessibility of our complaint function and patients being able to raise concerns.

When analysing the complaints opened during 2024/25 there were several themes identified. The graph below illustrates the five main themes throughout the year. It should be noted that during 2024/25 we looked at ways in which we could improve theming our reporting of complaints to align to national reporting principles as such, we are unable to provide any robust comparison data om previous years, comparative data will be provided for 2025/26.



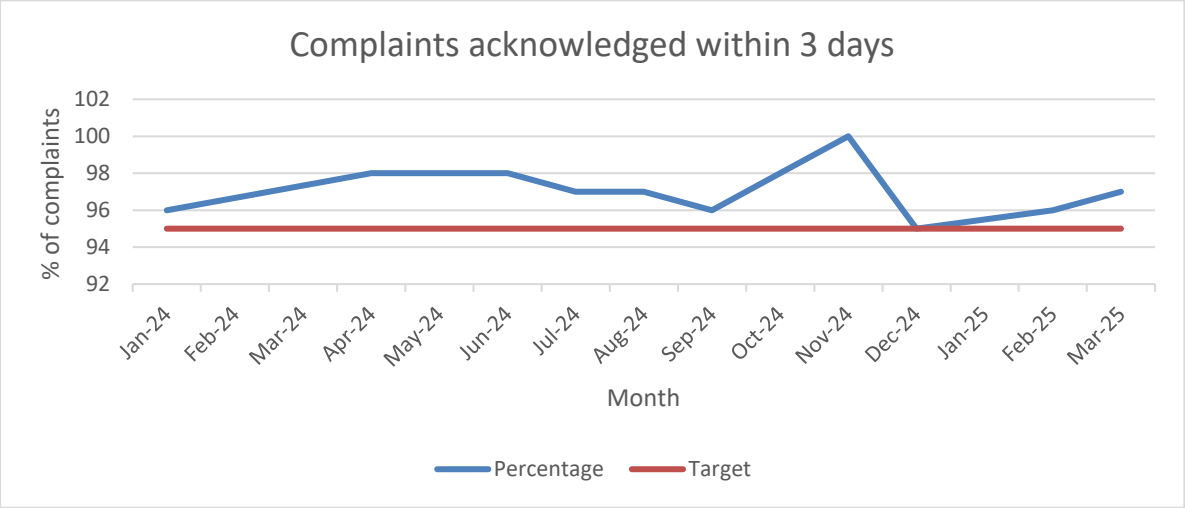
During 2024/25 an external audit was undertaken to review the complaints handling process. The audit was an opportunity to identify areas of improvement which would enable changes in processes to be developed.

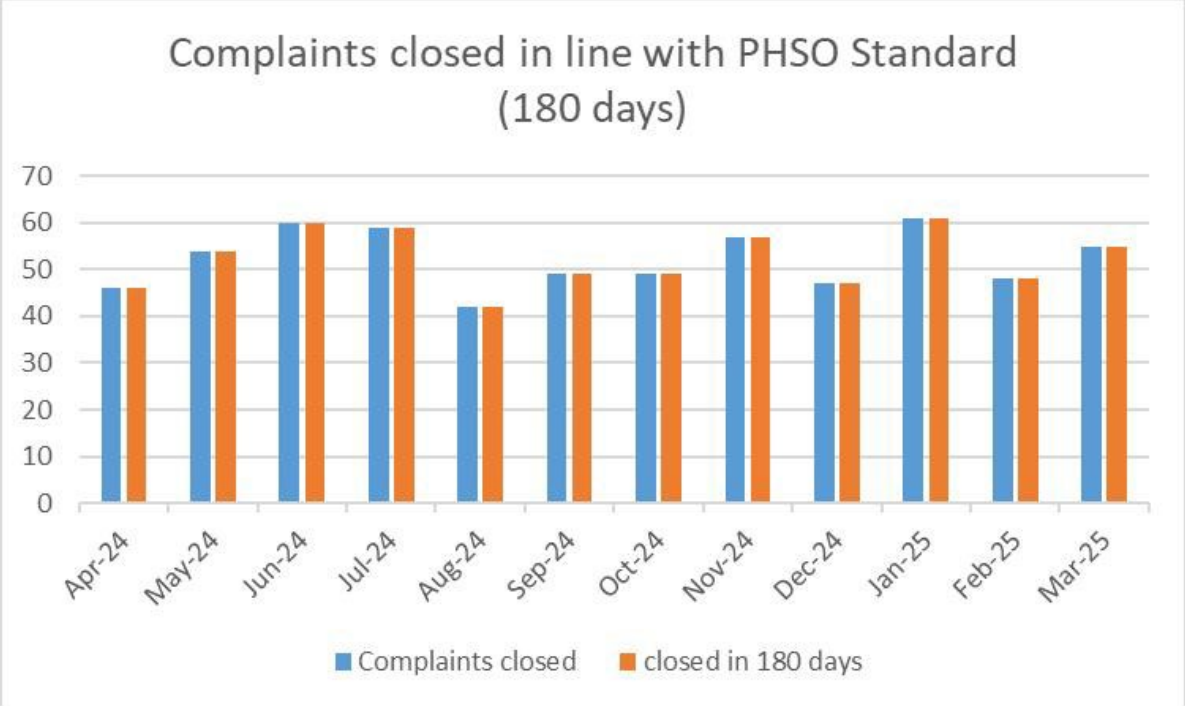
It is hoped that by implementing changes in processes we can achieve swifter resolution of concerns/complaints for complainants. Furthermore the improvements made in reporting will strengthen assurance and enable prompt escalation to the Chief Nurse and in turn the Board.

We use the following key performance indicators to help us to continually monitor the effectiveness of our complaints handling process:

- Acknowledgement within 3 days (Target 95%)
- Complaints closed in line with PHSO standard (Target 180 days)

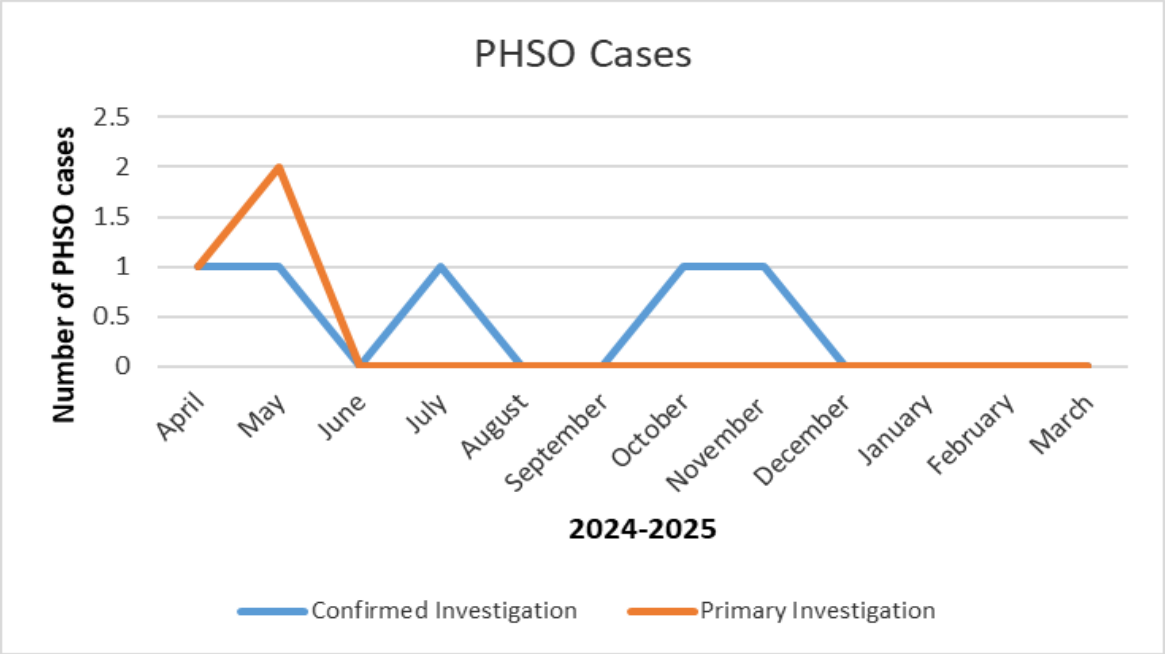
Our performance against those measures are outlined below:

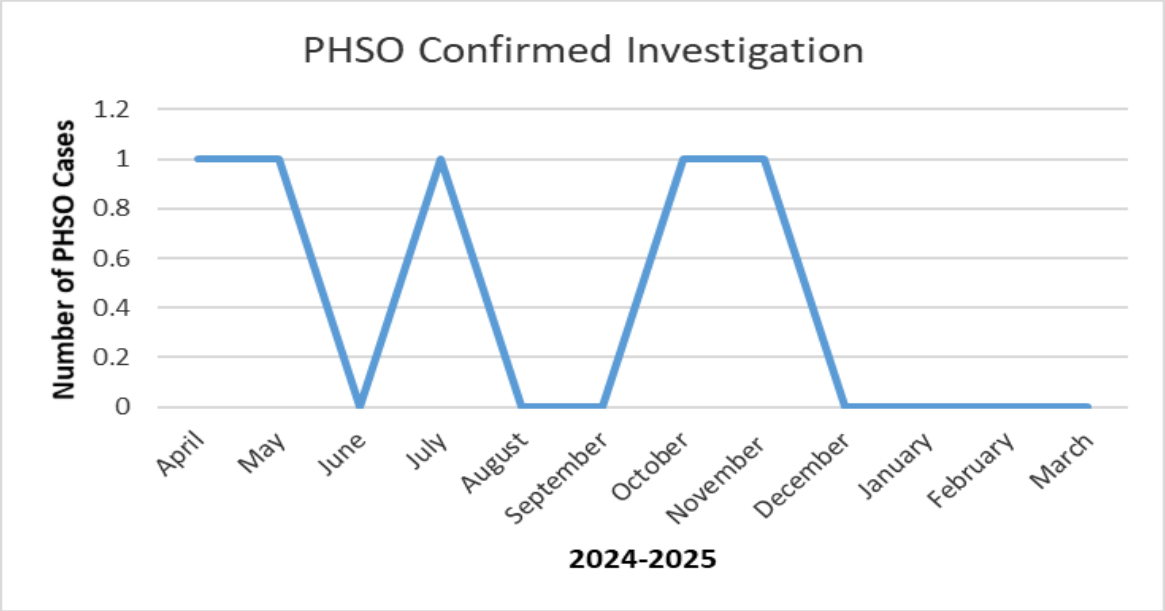




Parliamentary and Health Service Ombudsman (PHSO)

The number of PHSO contacts reduced from the previous year, with an average of two requests for information made per month.





Learning from PHSO Complaints

During 2024/25 only one complaint was upheld by the PHSO, however, five complaints were partially upheld.

The learning identified from the upheld and partially upheld was as follows:

PHSO	SUMMARY	LEARNING FROM COMPLAINT
Partially Upheld	Complaint regarding an overdose of sedative drug	Education session on safe dosage of sedative medication for all the ED doctors. Discussion also held at clinical governance meeting. PHSO recommend financially remedy.
Upheld	Delay in diagnosis	Implementing Artificial Intelligence (AI) pilot to triage all non-contrast CT head scans and Chest X-rays. This will be audited to ensure the process is robust and effective with a plan to continue this pending a successful bid, All Imaging, which is presented at a Specialist MDT, will be peer reviewed as part of the case discussion and agreed outcome within the team. All screening mammograms and CT colonoscopies performed in DBTH will be double reported as a minimum standard.
Partially Upheld	Use of antibiotics, falls management and making a safeguarding referral	Quality improvement project implemented focusing on falls prevention in line with NICE guidance in a care of elderly setting. Reintroduction of falls champions. Implementation of 'Excellence in care day' focusing on patient experience working alongside strategic plan and fundamentals of care and patient safety. Separation of the previously combined falls and confusion risk assessment to give a clearer focus on falls prevention by allowing a comprehensive multifactorial risk assessment in line with NICE guidance. Increased staffing structure for safeguarding adult's team to provide wider visibility of the team in Trust areas. Review of safeguarding governance. Sustained implementation of safeguarding huddles daily. Improvement in safeguarding training compliance.
Partially Upheld	Waiting time for elective surgery	No recommendations for the Trust.
Partially Upheld	Fluid management, usage of PRAFO boot and provision physiotherapy and communication	NMAHP quality strategy successful implementation of all strategic themes including fundamentals of care work stream in division Implementation of nurse in charge roles and responsibilities. Nerve centre oversight utilised to ensure compliance with accurate fluid balance records. Reintroduction of

		traffic-light jugs to ensure adequate daily hydration. Sustained implementation of board round with medical engagement to aid communication with medical team - enable early identification and escalation of concerns with hydration.
Partially Upheld	Management of a patient with a fractured collarbone	The Trust consider financial remedy.

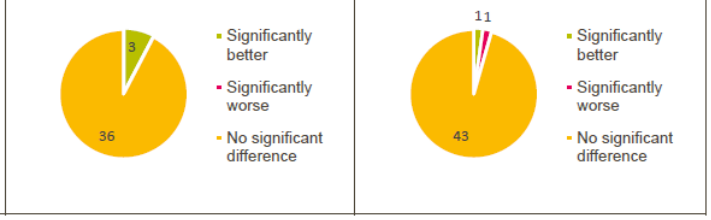
National Surveys

Participation in all of the nationally required CQC surveys has been completed. Results of which are outlined below. Following each survey, a dedicated action planning sessions with key stakeholders is undertaken. Action plans are in place for all surveys and monitored by the patient experience and involvement group. Caring Group maintain oversight of action plans.

Inpatient Survey 2023

1250	1148	41%	43%	40%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (467)	Average response rate for similar organisations	Your previous response rate

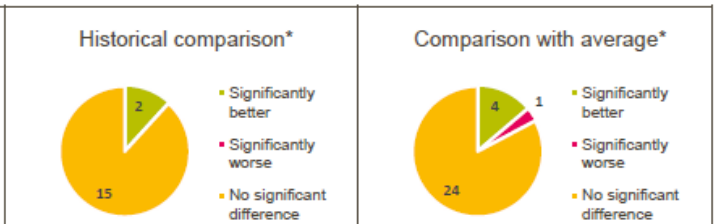
82%	Q49. Rated overall experience as 7/10 or more
98%	Q48. Treated with respect and dignity overall
98%	Q18. Had confidence and trust in the doctors



Urgent & Emergency Care 2024 Results

950	904	30%	30%	25%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (275)	Average response rate for similar organisations	Your previous response rate

71%	Q43. Overall A&E experience
94%	Q42. Treated with respect and dignity
93%	Q21. Had confidence and trust in the doctors and nurses



Children and Young People's Patient Experience Survey 2024 Results

1250	1238	17%	22%	NA
Invited to complete the survey	Eligible at the end of survey	Completed the survey (211)	Average response rate for similar organisations	Your previous response rate

95%	P44. Parent felt child was looked after in hospital
94%	P46. Parent or carer was treated with dignity and respect by the staff
81%	P48. Parent's overall rating of their child's experience in hospital (being 7/10 or more)

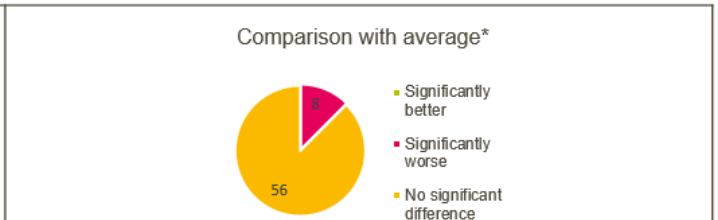


*Chart shows the number of questions that are better, worse, or show no significant difference

Maternity 2024 Survey Results

335	333	41%	40%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (135)	Average response rate for similar organisations	Your previous response rate

		Historical comparison*	Comparison with average*
96%	C17. Treated with respect and dignity (during labour and birth)		
93%	C18. Had confidence and trust in staff (during labour and birth)		
89%	C16. Involved enough in decisions about their care (during labour and birth)		

Friends and Family Test

The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to provide feedback on their experience. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Listening to the views of patients and staff helps identify what is working well, what can be improved and how. The FFT is made up of a single mandatory default question followed by at least one open free-text question, so that people can tell us what they want us to know in their own words.

The number of responses received for the Friends and Family Test survey can be used as a sense of how effectively we have implemented the Friends and Family Test survey as well as allowing us to review if are consistent with other settings in the proportion of responses received.

The Trust changed the management of the survey from an in-house process to an external company "Iwantgreatcare" in January 2024.

Nationally, NHS England do not publish response rates for the Friends and Family Test Survey as a patient can feedback as many times as they want. They do however suggest national data can be reviewed to consider if the Trust is aligned with other providers nationally.

There are several mechanisms, which allow the patients to provide this feedback, the options available includes text messages, paper forms and QR codes. Iwantgreatcare also allows patients to complete the survey in other languages providing an inclusive way for feedback.

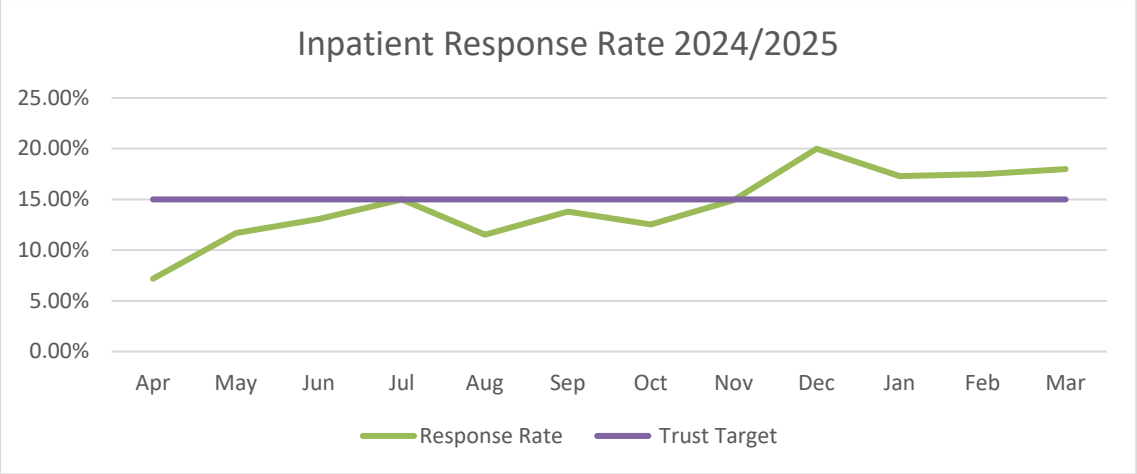
The contract with Iwantgreatcare was extended for a further twelve months from January 2025.

Inpatients

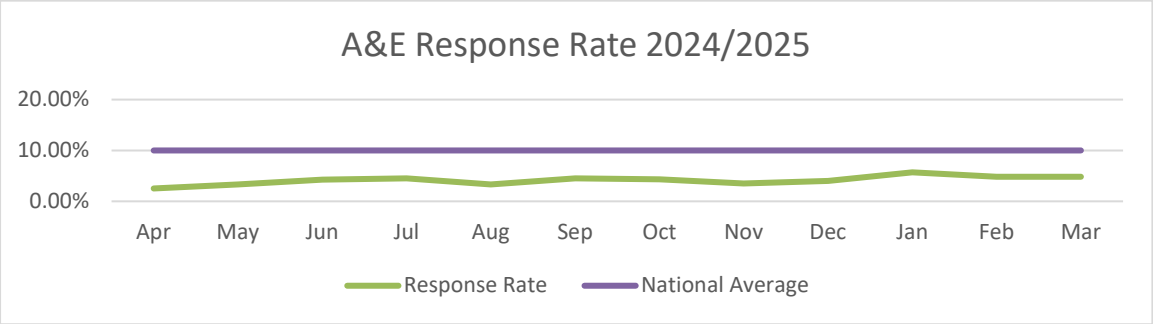
In 2024/25, as part of the Trusts Nursing and Allied Health Professionals Strategy Plan, an internal key performance indicator for inpatient responses rates was implemented.

A target inpatient response rate of 15% was set for with a view of increasing this to 20% for 2025/26.

In December 2024, the inpatient response rate increased to 20% exceeding the internal target of 15%, which was similar to other Trusts nationally. Although the response rate decreased in March 2025 to 18%, the internal Trust target remained achieved.



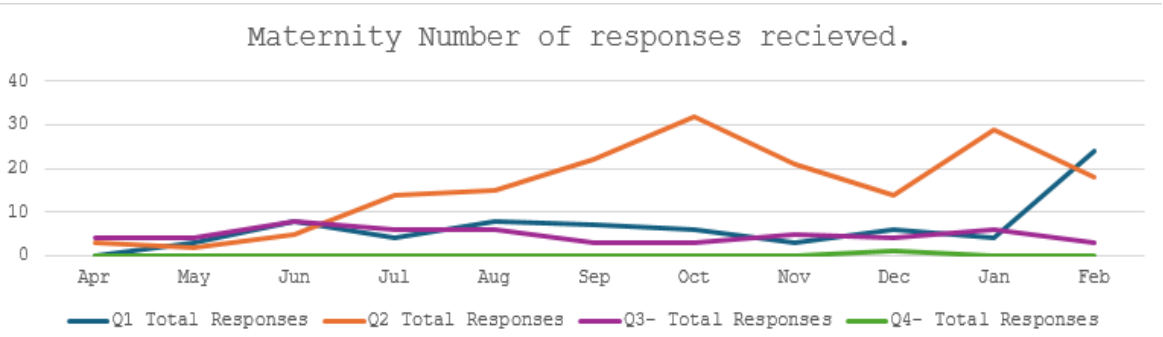
Emergency Department



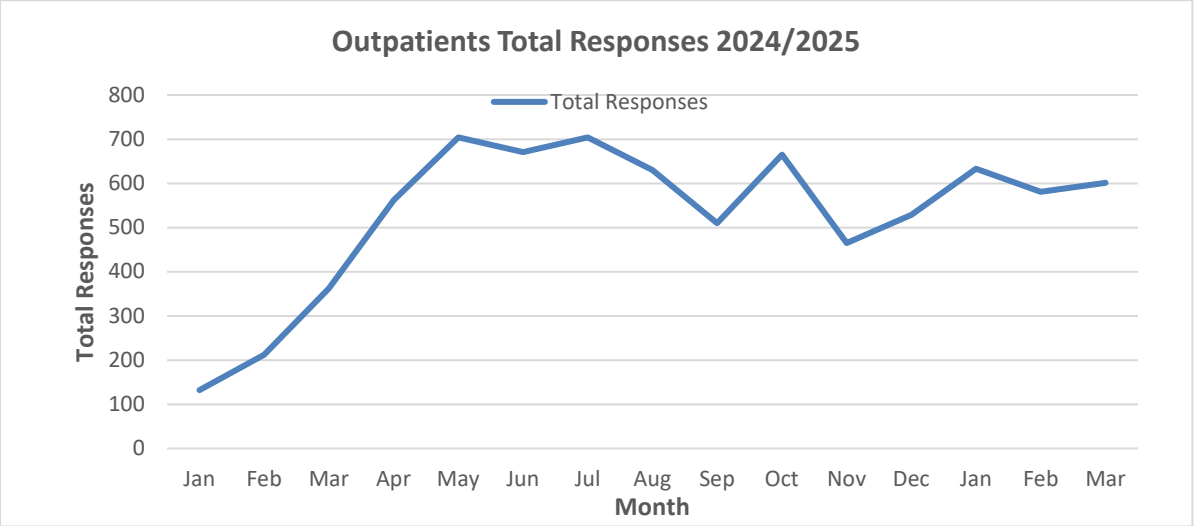
Maternity

Maternity national data is slightly different in the way the data is provided. Unlike the Inpatient and Emergency Department data collection, the Maternity data collection only provides data on the total responses of received and does not provide an opportunity to capture eligible patients.

As a result we are unable to report an actual response rate, or provide any national comparison data.



Outpatients



4 PATIENT ENGAGEMENT

The Trust has participated in twelve engagement events throughout 2024/25.

PUBLIC/ COMMUNITY ENGAGEMENT PIECE OF WORK	GROUPS ENGAGED WITH FOR THEIR VIEWS	INSIGHTS GAINED	ACTIONS TAKEN
Care Accreditation Patient Involvement	People Focused Group	The People Focused Group have participated in the Trusts Care Accreditation visits across the Trust.	Feedback to ward areas on caring aspect of accreditation.
Reasonable Adjustments	The Hesley Group	Feedback from residents included: • Residents did not like waiting. • Most residents did not like noises. • Staff at the Hesley Group feedback that more adjustments can be made by the Trust when patients come for appointments.	Feedback inputted into work Trust undertaking on reasonable adjustments.
	Parkinson's UK	There were about 80 members attended. Key points in the feedback were patients were not receiving timely medication. There was also feedback regarding audiology waiting times.	Parkinson's Pledge meetings already running in the Trust. Member of Parkinson's UK invited to join the meeting to provide patient view.
PLACE Visits	People Focused Group, Partially Sighted Society, Retford Oaks Academy, Hall Cross Academy, Healthwatch	Patient led visits on Trust estates and facilities.	Action plan to be developed based on the report. Initial priority areas selected for work to improve disability and dementia domains.

Learning Disabilities	CHAD	Attended CHAD event at the People Focused Group and the feedback was overall positive. Two of the members stated they attended physiotherapy appointments and the staff were nice. One wished we had hand rails in the corridors. Another member visited A&E three times. Two experiences were good. One experience was not as good as they felt staff were treating them as if they should not be there even though they had Ventricular Tachycardia. They said the staff on CCU were lovely when they went there.	Feedback from the CHAD event is being shared with the action planning for capital spending regarding hand rails in corridors.
BSL Users	Deaf Community Centre	The Trust had a focus group with the deaf community and the deaf community centre. Themes were the use of appropriate language. It was suggested there should be some BSL training for audiologists and the service team or employing a BSL user in the team. There were discussions regarding the availability of interpreters with support for looking at digital solutions as there was limited number of interpreters available. The focus group suggested staff need to think about their speech to allow for lip reading and the need to be text messaging options.	Requested Procurement team review the provision of video relay messaging and see if we can now add Signlive to our contract. Audiology action plan on-going in the Trust.
Parkinson's UK support group.	Patients living with Parkinson's disease.	Attended a Parkinson's UK support group meeting and fed back with actions following the last engagement meeting. One of their members stated the Frailty Unit were fantastic with her husband with Parkinson's decease. She said they had their phone alarms set and he got all his medication on time. She said it did not seem to work for the patch that he had but the medication came on time. Another member suggested putting alarms on the Nerve Centre devices. This has	The Trust has a Parkinson's pledge meeting and have invited members of Parkinson's UK to attend the meeting to provide a patient view in the meeting. Following the initial visit to Parkinson's UK support group feedback was positive and reported staff using alarms to provide timely medication.

		been fed back to the Divisional nurse who will feed back to the Frailty unit and advised putting the alarms on the Nerve centre devices had been explored previously but not progressed as the devices would not get communication from Well sky. Another member fed back on variances in patient management with other Trusts giving an example for a procedure at DRI they had to be nil by mouth but at another Trust they were allowed to drink water. There were also some feedback regarding the time patients were having to wait for audiology appointments.	
Prison	HMP Lindholme Prison, Doncaster Prison, HMP Moorlands.	Prisoner experiences at the Trust were good however; the Prison Health care service had lost contacts with the trust and were not able to communicate when they were not able to bring prisoners to the Trust. This results in some prisoners being discharged as did not attend.	Meeting arranged between Prison Health Service and Patient access team. Patient access team to develop SOP for prisoners along the lines of 'was not brought' so they are not discharged when they have not been able to attend.
Visitors Charter	Health watch	Feedback on wording on visitor's charter.	
Trust Maps	Citizens Panel	Citizen's Panel reviewed Trust maps and provided feedback that they were too big and complex and suggested maps cover certain sections of the trust for ease of understanding.	Draft maps amended as per Citizen's Panel feedback.
SEND feedback	Doncaster carers voices	Met six mothers with children with Special Education Needs and Disabilities. The majority of the feedback was about the Autism In particular difficulties with the education completing some of the parts of the assessment. The group were happy with the information that they were given that the trust were	Work to be undertaken with divisions that see children with special education needs and disabilities to develop social stories for children coming to the areas.

		now going to be doing a joint Autism assessment and ADHD pathway assessment. They gave feedback on the form and pathway. Feedback was that children found having bloods taken traumatic and at times this affected their future visits to the trust. One mum gave feedback that when their child had bloods taken it was done very well and there was someone distracting the child. Another mother gave feedback on visiting ENT and the language used by the consultant which was not helpful. This has been fed back to the team. On feeding back it was identified the child did not have a special flag highlighted they had been diagnosed with special education needs. The staff member was to ring the mother and confirm this before adding the flag. There was feedback that social stories may help those children who do not want to come to the hospital showing them the journey they would experience prior to coming to the Trust and Special Education Assessments.	

5 VOLUNTEERS

Volunteers are integral in enhancing the quality of care to patients at Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT).

There are a wide range of roles undertaken by our dedicated volunteers; escorting patients around the hospital, ward volunteers, clinic volunteers, library volunteers and A&E Volunteers.

On average, there are 169 volunteers, which has remained consistent with 2024/2025. We are in the process of completing checks for 25 more volunteers.

Work is ongoing in the development of a Trust database to manage volunteers and record hours as well as demographic data. This will support a more strategic recruitment as we will it will focus our recruitment of volunteers in those groups that are underrepresented.

In 2023/24 the Trust developed some priorities for achievement during 2024/25, achievement against these measured is outlined below:

The next 12 months and beyond
Work will continue to deliver the objectives outlined in the Nursing Midwifery and Allied Health Professionals Quality strategy.

Year 2 objectives in relation to patient experience are as follows:

- Introduce and embed the role of Family Liaison officers within the trust and ensure mechanism for assuring the effectiveness of the role in line with PSIRF principles.
- Create and embed a process of “digital stories” for celebrating success stories when we have engaged with patients families to change/learn/improve services.
- Demonstrating learning from complaints – create a process for patient/digital stories as a mechanism for sharing information.

2509 - E4 BOARD WORK PLAN

Information Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

REFERENCES

Only PDFs are attached

E4 - Board Work Plan.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE	07/05/2024	02/07/2024	03/09/2024	05/11/2024	07/01/2025	04/03/2025	06/05/2025	01/07/2025	02/09/2025	04/11/2025
OPENING ITEMS													
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting										
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting										
Chair's Report (including partnership updates and impact on DBTH)	Chair of the Board	Every Meeting	Every Meeting										
Chief Executive's Report (including partnership updates and impact on DBTH)	Chief Executive	Every Meeting	Every Meeting										
BOARD LEARNING & REFLECTION													
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	H&WB		Wendy's Story	Frailty Services			Staff Survey			**TBC** - HI Case
PATIENTS													
Audiology Service Update	Deputy Chief Executive	Every Meeting	Sep-25										
Maternity & Neonatal Update	Director of Midwifery	As per schedule	Nov-25										
Learning from Deaths	Executive Medical Director	Quarterly	Sep-25		**verbal**								
Patient Experience Annual Report	Chief Nurse	Annual	Sep-25										
Winter Plan	Chief Operating Officer	Annual	Sep-25										
Quality Accounts	Chief Nurse	Annual	Jul-26										
Safeguarding Annual Report	Chief Nurse	Annual	Sep-25										
Clinical Audit Plan	Executive Medical Director	Annual	Sep-25										
Infection Prevention & Control Annual Report	Chief Nurse	Annual	Sep-25										
PEOPLE													
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Nov-25										
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-26										
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-26										
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Nov-25										
Staff Survey Results	Chief People Officer	Annual	May-26										
Maternity Workforce	Director of Midwifery	Bi-annual	Jan-26										
Research & Innovation Case Study	Chief People Officer	Annual	Jul-26										
PARTNERSHIP													
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	As required	Nov-25										
Wider Partnership updates	DCEO	As required											
POUNDS													
Financial Position	Chief Financial Officer	Every Meeting	Every Meeting										
Financial Plan	Chief Financial Officer	Annual	May-26										
Going Concern	Chief Financial Officer	Annual	May-26										
Delegation for the Approval of Annual Accounts and Annual report	Chief Financial Officer	Annual	May-26										
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-26										
Annual Business Plan	Chief Financial Officer	Annual	Jul-26										
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-26										
ASSURANCE & GOVERNANCE													
Integrated Quality & Performance Report	COO/CN/EMD/CPO	Every Meeting	Every Meeting										
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Sep-25										
Board Risk Appetite	Deputy Chief Executive	Annual	May-26										
Review of Strategic Risks	Deputy Chief Executive	Annual	May-26										
2025/2026 Strategic Priorities Success Measures	Deputy Chief Executive	Annual	May-26										
Delivery Update 2025/26 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Nov-25										
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-25										
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-25										
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	Sep-25		**verbal**								
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Sep-25										
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Sep-25										
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Sep-25										
~~Chair's Assurance Log - Charitable Funds Committee~~	CFC Chair	Post Committee											
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-26										
~~Annual Report - Chartable Funds Committee~~	Chair of CFC	Annual											
Board Work Plan (approval)	AD of Strategy, Partnerships &	Annual	Mar-26										
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annually	Nov-25										
Trust Seal	AD of Strategy, Partnerships &	Annually	Nov-25										
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships &	Annual	May-26										
Board Effectiveness	AD of Strategy, Partnerships &	Annual											
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships &	Annual	May-26										
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships &	Annual	May-26										
Terms of Reference - People Committee	AD of Strategy, Partnerships &	Annual	May-26										
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships &	Annual	May-26										
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Deputy Chief Executive	As Req'd	Sep-25									Green Plan/HI	
ENABLING STRATEGIES													
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027										
People Strategy 2023/27	Chief People Officer		2027										
Research & Innovation Strategy 2023/28	Chief People Officer		2028										
Speaking Up Strategy 2024/28	Chief People Officer		2028										
Tackling Health Inequalities 2023/28	Director of Recovery, Innovation & Transformation		2028										
TRUST POLICIES													
CORP/FIN 1 - A Standing Orders - Board of Directors	AD of Governance	Annual	May-26										
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	May-26										
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	May-26										
CORP/FIN 1 - D Fraud, Bribery and Corruption Policy and Response Plan	Chief Financial Officer	2 Yearly	Mar-26										
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships &	3 yearly	Sep-25										
CORP/COMM 11 - Management of Reviews, Visits, Inspections and Accreditations Policy	AD of Strategy, Partnerships &	2 yearly	Dec-25										
CORP/COMM 25 - Establishment and Administration of Committees Policy	AD of Strategy, Partnerships &	3 yearly	Feb-26										
CORP/FIN 4 - Standards of Business Conduct and Employees Declarations of Interest Policy	AD of Strategy, Partnerships &	3 yearly	Jun-26										
CORP/RISK 30 - Risk Identification, Assessment, and Management Policy	AD of Strategy, Partnerships &	3 yearly	Oct-26										
CORP/COMM 1 - Approved Procedural Documents (APDs) Development and Management Policy	AD of Strategy, Partnerships &	3 yearly	Mar-27										
INFORMATION													
Work Plan	AD of Strategy, Partnerships &	Every Meeting	Every Meeting										
Appointment of External Auditors	Chief Financial Officer	As Req'd											
Appointment of Internal Auditors	Chief Financial Officer	As Req'd											
CLOSING ITEM													
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting										
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting										
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting										
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting										
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd										

LEGEND KEY - (ensure reason entered in comments column or cell as appropriate)

Presented as planned
Planned for future meeting(s)
Rescheduled for valid reason(s) - as stated
Not considered as planned
Items added to the work plan post agreement - ensure reason entered in comments column

Process for administration of actions logs/work plans:
A review of the work plan administration process has been undertaken. Each Year a Board work plan MUST be assigned a separate worksheet (plan) for each Year. Once agreed, ***no changes to workplan must be added without correct audit trail tracking and comments****. If an item has been identified for addition to a workplan then this* ***must*** *be added to the appropriate board/board committee meeting action log so full audit trail is available. Full annotation of whether a report has been to committee or not MUST be logged on to the workplan with appropriate comments as to why and when it will be presented and appropriate colour coding used identified in the legend (see above legend key). An additional column has been added to each work plan at the end headed "comments" to log any required supplementary information for audit/tracking purposes.*

2509 - F CLOSING ITEMS

13:00

2509 - F1 MINUTES OF THE MEETING HELD ON 1 JULY 2025

Decision Item | Suzy Brain England OBE, Chair of the Board | 13:00

5 minutes

REFERENCES

Only PDFs are attached

F1 - Board of Directors Minutes - 1 July 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in public on Tuesday 1 July 2025 at 9:30am in the Boardroom, Bassetlaw Hospital

Present:
Mark Bailey - Non-executive Director
Suzy Brain England OBE - Chair of the Board
Hazel Brand - Non-executive Director
Jo Gander - Non-executive Director
Karen Jessop - Chief Nurse
Dr Emyr Jones - Non-executive Director
Zara Jones - Deputy Chief Executive
Zoe Lintin - Chief People Officer
Dr Nick Mallaband - Acting Executive Medical Director
Lucy Nickson - Non-executive Director
Richard Parker OBE - Chief Executive
Kath Smart – Non-executive Director
Denise Smith - Chief Operating Officer
Sam Wilde - Chief Finance Officer

In attendance:
Rebecca Allen - Associate Director of Strategy, Partnerships & Governance
Professor Sam Debbage - Director of Education & Research (agenda item A5)
Dr Jane Fearnside - Head of Research (agenda item A5)
Angela O'Mara - Deputy Company Secretary (minutes)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Hannah Beardmore - Staff Side
Christopher Berry - The Value Circle
Toni Brunt - Doncaster & Bassetlaw Teaching Hospitals
Ian Hall - The Value Circle
Gina Holmes - Staff Side

Apologies:

ACTION

P25/07/A1 **Welcome, apologies for absence and declarations of interest**

The Chair welcomed everyone to the Board of Directors meeting, including observers. There were no apologies for absence and no conflicts of interests were declared.

P25/07/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 1 and 3 - Trust Strategy and 2025/26 Success Measures - would be considered for approval today, at agenda item D2.

Action 5 – Risk Rating Strategic Risk Two - further to a discussion at June 2025's People Committee it was confirmed that the target risk rating of 12 would be retained. The Board Assurance Framework would be reviewed and the content approved at agenda item F2. Action to be closed.

P25/07/A3 **Chair's Report (Enclosure A3)**

The Board received and noted the Chair's report, which provided an overview of activities, visits, and key events in the Trust calendar since the last Board of Directors meeting.

Non-executive Director, Emyr Jones confirmed three Consultant Paediatricians had been appointed, rather than the two referenced in the report.

The Board:

- ***noted the Chair's Report***

P25/07/A4 **Chief Executive's Report (Enclosure A4)**

The Chief Executive's report provided an overview of items of interest at a local, system and national level connected to the work of the Trust and aligned to its strategic priorities.

The Chief Executive highlighted the Trust's journey and commitment towards being an anti-racist organisation, to ensure the organisation was a fair and equitable place to work and receive care.

The impact of the significant reorganisation of the local Integrated Care Board was recognised, with revised structures expected to be announced imminently. The Trust was committed to supporting its partners during these challenging times.

The Paediatric Dental Surgery Hub, developed by South Yorkshire & Bassetlaw Acute Federation had been established at DRI to improve access and reduce waiting times. The Trust was working collaboratively with specialist consultants in paediatric dentistry from a neighbouring trust.

In response to a question from Non-executive Director, Kath Smart regarding ongoing negotiations with the Local Authority to support the provision of Health on the High Street. The Chief Executive confirmed that discussions were ongoing with regards to the head lease, a confidential meeting of the Board would take place in due course as discussions progressed. The direction of travel aligned with the Secretary of State's strategic priority to move care, where appropriate, from the hospital into the community, alongside the Trust's strategic ambition to provide the best care environment.

Non-executive Director, Mark Bailey enquired what community based opportunities existed, the Chief Executive confirmed Nottinghamshire Healthcare and Rotherham, Doncaster & South Humber NHS Foundation Trusts delivered services across Bassetlaw and Doncaster respectively. The virtual ward capacity across Doncaster and Bassetlaw differed significantly, with the potential to increase utilisation in the latter. Efficiency

and effectiveness opportunities could arise from the vertical integration and harmonisation of services, guidance on which may be seen in the 10 Year Health Plan.

Non-executive Director, Hazel Brand reflected on the plans for Derby & Derbyshire, Nottingham & Nottinghamshire and Lincolnshire Integrated Care Boards to form a cluster. Whilst the Mayor of Greater Lincolnshire had shared concerns, it was expected the decision would be taken by the Secretary of State for Health & Social Care. South Yorkshire was expected to be the smallest Integrated Care System, which may make the delivery of the back office savings more challenging.

The Board:

- ***noted the Chief Executive's Report***

P25/07/A5 **Research & Innovation Update (Enclosure A5)**

The Chair of the Board welcomed the Director of Education & Research and the Head of Research to the meeting to provide an update on research and innovation activity as part of the Trust's ambition to become a leading centre for education and research.

There was a focus on raising the profile of research, including growth in activity, public engagement and attracting clinical academics. A dedicated clinical research space was being created at Doncaster Royal Infirmary and there was a real emphasis on all colleagues having a part to play in research, including participation, engagement and leading research activities, with the Chief Nurse and Chief People Officer taking on Principal Investigator roles.

The Trust had an established track record in rheumatology commercial research, with Consultant Rheumatologist, Dr Yee acting as Chief Investigator. The research activity placed the Trust at the forefront of clinical practice with local and out of area patients referred for treatment, not widely available within the NHS.

The importance of developing an innovative culture was noted and an Innovation Expedition workshop, commissioned with the University of Lincoln, had focused on two specific projects. One related to improving patient information sheets for post haemorrhoidectomy, and the other for auto injectable vitamin B12 pens. In addition, support would be provided to the newly developed DBTH improvement (DBTH-i) hub. The support of the Board in being an advocate of research was requested.

In response to a question from Non-executive Director, Jo Gander regarding broader commercial opportunities, the Head of Research advised of the potential to support renal patients pre-surgery with a new weight loss drug to promote better outcomes.

The Chief Executive enquired of opportunities to work in partnership with neighbouring trusts, it was confirmed that discussions were currently in train with the South Yorkshire & Bassetlaw Acute Federation regarding patient pathways.

Non-executive Director, Lucy Nickson welcomed the dedicated clinical research space, in terms of activity and occupancy of the Unit, this would begin with rheumatology patients and expand over time, including the potential to extend to out of hours and inpatient activity.

In response to a question from Non-executive Director, Kath Smart, in order to be inclusive, whilst recognising the size of the team, an equitable approach was taken across the divisions. There was a good level of interest developing in response to trials.

Non-executive Director, Emyr Jones recognised the importance of research as part of the Trust's ambition to be a University Teaching Hospital and enquired if there were sufficient opportunities to support the Trust's involvement. The Director of Education & Research recognised some research activity, such as the Born and Bred in Doncaster programme, related to specific demographical challenges. It was also apparent from a benchmarking exercise that not all organisations were able to support medical device research.

The Chief Executive reflected on previous interest in bed based research and enquired of the current thinking, as this had been an opportunity linked to securing a place on the New Hospital Programme, which had not progressed. Should space become available on site, there was the potential to take advantage of this, as opportunities and associated income were limited across the system. The implementation of an electronic patient record would also support due to digital enhancements.

The Chair shared her appreciation and encouraged the recognition and celebration of research and innovation.

The Board:

- ***noted the Research & Innovation Update***

P25/07/B1 **Audiology Service Update (Enclosure B1)**

The Deputy Chief Executive provided an update on the audiology service recovery and improvement programme.

Since the last update, the paediatric recall programme had identified a case of severe harm. The Deputy Chief Executive and Chief Executive offered their sincere apologies and confirmed the Trust had undertaken Duty of Candour discussions with the family. Learning would be shared and applied across the service, pathway and wider organisation.

Non-executive Director, Kath Smart welcomed the ongoing feedback from community groups to inform the improvement journey. Improvements in activity levels were noted and it was suggested that performance against agreed trajectories, including clinical priorities, be included in future Board reports. **ZJ**

In response to a question from Non-executive Director, Hazel Brand, the Deputy Chief Executive confirmed that adult waiting lists were five times greater than paediatric lists. Progress was being made in determining anticipated wait times, however, the Acting Executive Medical Director acknowledged this was dependent upon ongoing competency training. The Chief Executive confirmed that he felt that the current service model was unsustainable in South Yorkshire and as part of the Acute Federation fragile service review would require a change in delivery.

In respect of the 29 children who had not attended their recall appointment, the Deputy Chief Executive assured the Chief Finance Officer that the *Trust's Was not Brought polic*y had been followed. The need for a referral to other professionals was considered as part of this. Should the child re-engage with the service in the future, a harm review would be undertaken, with the consent of the family.

For those children where harm reviews were yet to be completed, Non-executive Director, Lucy Nickson questioned the potential for further harm to occur. The Deputy Chief Executive confirmed that the children were being seen and receiving interventions, the wait related only to the review itself.

In response to a question from Non-executive Director Mark Bailey, relating to the potential for similar issues to be seen elsewhere in the organisation, the Deputy Chief Executive confirmed that learning from this programme of work would identify themes that could be relevant in other areas, which may not be identified as part of routine reporting. The triangulation of evidence, including patient and people metrics, would serve as an early warning system. The Chief Nurse confirmed that divisional nurses and general managers were considering those smaller service areas which may be affected.

The Chief Executive acknowledged the importance of responding to early internal and external alerts and to ensure robust governance arrangements were in place. An independent review of children's hearing services had been commissioned by the Secretary of State for Health & Social Care in response to the approach arising from the NHS Lothian paediatric audiology review in 2021.

The Board:

- ***noted the Audiology Service Update***

P25/07/B2 **Maternity & Neonatal Update (Enclosure B2)**

The Chair welcomed the Director of Midwifery to the meeting to present the Maternity and Neonatal update. The report provided an overview of the progress made against the Single Delivery Plan, maternity self-assessment tool and the requirements of the Clinical Negligence Scheme for Trusts (CNST). This included the review and learning from patient safety events, perinatal mortality reviews and patient safety investigations.

Since the last report there had been no Maternity & Newborn Safety Investigations (MNSI) referrals.

The perinatal quadrumvirate leadership team had met with the Board Safety Champion and non-executive Maternity Champion on 22 May 2025 and continued to work closely to develop and sustain cultural improvements in maternity services.

The Board received and noted the Q4 Perinatal Mortality Report and Avoiding Term Admissions into Neonatal Units report and the Q3 Saving Babies Lives Care Bundle (v3).

The Director of Midwifery advised the Board that confirmation had now been received that all ten CNST compliance standards had been achieved for Year 6 CNST.

The Board's attention was drawn to neonatal nursing and medical staffing compliance with the British Association of Perinatal Medicine (BAPM) national standards. As standards had not been met, progress was reported against the nursing action plan and an updated medical staffing action plan to reflect the requirements of Year 7 CNST was provided.

The Chief Executive referenced the Secretary of State for Health & Social Care's recent announcement that a national maternity review would take place, ten hospitals were expected to be part of the review, the detail of which was not yet known. A focus on services who demonstrated what good looked like would be welcomed by the Chief Nurse. In view of the ongoing scrutiny on maternity services, the Chief People Officer recognised the support required by leaders and the resultant impact on colleagues.

Over time the complexity of patients had increased, this was not recognised in Birthrate Plus® or in tariff income. Should this change, there would need to be a review of the 2025/26 financial plan, with changes reflected in future contracts.

The Board:

- ***noted and took significant assurance from the Maternity & Neonatal Update***
- ***reviewed and approved the Q4 Perinatal Mortality Report***
- ***reviewed and approved the Q3 Saving Babies Lives Care Bundle v3***
- ***reviewed and approved the neonatal & nursing medical workforce progress updates against last year's plan***
- ***reviewed and approved the Q4 ATAIN report***
- ***noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal medical workforce have not been met and approved the neonatal medical workforce action plan progress update against last year's plan***
- ***noted that the relevant British Association of Perinatal Medicine (BAPM) national standards for the neonatal nursing workforce have not been met and approved the progress update against last year's plan***
- ***noted the number of Maternity and Newborn Safety Investigation (MNSI) / Early Notification Scheme (ENS) cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place***
- ***noted the bi-monthly Board Safety Champion meetings with the perinatal leadership team and any support required of the Trust board has been identified and is being implemented***
- ***noted progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the board safety champion meetings, and the maternity and neonatal safety quality committee and any identified support being considered and implemented***

P25/07/B3 **<u>Bi-annual Midwifery Workforce Report (Enclosure B2)</u>**

The Board received and noted the bi-annual midwifery workforce report. The 2022 Birthrate Plus® assessment used to calculate workforce requirements was currently being reassessed and was expected to be finalised by late Summer 2025.

The Chief Nurse confirmed that clarification had been sought on how the nationally recommended specialist midwife roles would be captured. The Chief Executive also

noted that across the Local Maternity & Neonatal System, the Trust was the only organisation who operated across two sites which impacted upon the requirements for specialist midwives.

In response to a question from Non-executive Director, Mark Bailey regarding the recruitment of newly qualified midwives, the Chief Nurse confirmed that anticipated attrition had been taken into consideration, the current Birthrate Plus® assessment had been used, however, professional judgement could be exercised in respect of known complexities.

The support offered by specialist midwives during periods of absence was recognised by Non-executive Director, Kath Smart. In terms of the number of reported red flag events in March 2025, the Director of Midwifery confirmed this was a cyclical pattern due to a peak in births, with any delays in activity only supported when safe to do so.

The Board:

- ***noted and took significant assurance from the Bi-annual Midwifery Workforce Report***

P25/07/C1 **<u>Guardian of Safe Working Quarterly Report (Enclosure C1)</u>**

The Chair of the Board welcomed the Guardian of Safe Working to the meeting to provide an overview of exception reporting for the period February to April 2025.

Exception reporting was now completed on Healthrota and the data categories and collection within this report reflected this change. A total of 71 exception reports had been received during this period, the majority of which related to additional hours worked and reflected the workload of resident doctors. In respect of fines levied, the Guardian of Safe Working confirmed that all related to the non-resident on call rota for urology. In response to a question from Non-executive Director, Kath Smart, work was underway to address the current rest period following an on call duty and revised rota arrangements. It was acknowledged that further work was required on this in the coming months.

The revisions to the exception reporting framework agreement were due for implementation by 12 September 2025. The Chief People Officer acknowledged the significant operational differences, including the impact on Medical HR colleagues.

In response to a question from the Chief Nurse with regards to the triangulation of data and thematic analysis, it was proposed that this be revisited once the reforms were in place, as an increased level of reporting and granularity of detail was anticipated.

Reflecting on the size of the organisation, Non-executive Director, Emyr Jones noted the current low level of exceptions, the Guardian of Safe working recognised this but confirmed this was in line with local and national reporting levels.

In response to a question from the Chief Executive with regards to the poor attendance at May's Resident Doctors Forum, the Guardian of Safe Working confirmed attendance had been an historical issue. A range of actions had been taken to support improved

attendance, including his involvement in the induction programme. Non-executive Director, Kath Smart reinforced the importance of meaningful engagements with the resident doctors.

The Board:

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

P25/07/C2 **Workforce Race & Disability Equality Standards (Enclosure C2)**

The Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data had been reviewed by the Executive Team and the Board's People Committee ahead of the national submission deadline of 31 May 2025.

The Board received and noted the summary report, recognising the positive changes as compared to last year's submission and the areas of focus for ongoing improvement.

In response to a question from Non-executive Director, Kath Smart regarding the number of Black and Minority Ethnic candidates shortlisted and subsequently appointed, the Chief People Officer confirmed that the Trust remained committed to ensuring no disparity, through an inclusive recruitment process.

The Deputy Chief Executive enquired of the span of the cultural competence training referenced in the report, the Chief People Officer confirmed this was currently underway across the nursing workforce. Active Bystander training was being considered to improve accessibility.

The Board:

- ***noted the Workforce Race & Disability Equality Standards***

P25/07/D1 **Doncaster & Bassetlaw Healthcare Services Update (Enclosure D1)**

The Chief Finance Officer brought the Board's attention to the key highlights of the report, noting Doncaster & Bassetlaw Healthcare Services Limited had exceeded its income budget for the fifth consecutive year, enabling a total dividend payment of £450k to the Trust since its incorporation. The potential for future opportunities, aligned with the Trust's strategic priorities would continue to be explored.

The Deputy Chief Executive suggested it would be helpful to establish a broader set of metrics against which the success of Doncaster & Bassetlaw Healthcare Services Limited could be reported. The Chief Finance Officer agreed to progress this. **SW**

The Board:

- ***noted and took full assurance from the Doncaster & Bassetlaw Healthcare Services Update***

P25/07/D2 **Trust Strategy and 2025/26 Strategic Priorities Success Measures (Enclosure D2)**

Developed with the support of colleagues, patients, partners and the wider public, the Trust's Strategy was received by the Board for approval.

The strategy articulated the Trust's vision, mission and strategic priorities and ambitions. Whilst the 10 Year Health Plan had not yet been published, the government had previously communicated its three strategic shifts and the strategy had been developed with these in mind. The need for a flexible, future proofed approach was recognised and although dated 2025-29, it was expected that an annual review would be required.

In order to demonstrate progress, the Board was asked to consider the proposed success measures and framework, to be reported on a bi-annual basis, supported by externally validated data.

Non-executive Director, Kath Smart welcomed the measured approach to the development of the strategy and the engagement and ownership as part of the Board Development sessions.

In response to a question from the Chief People Officer in respect of previously published focused strategies, such as the People Strategy, it was confirmed these would be enabling plans to support delivery of the overall strategy.

In response to a question from Non-executive Director, Lucy Nickson regarding the mechanism to report where success measures were off track, it was confirmed that this would be explicit within the narrative and supporting data. The Board Assurance Framework would also capture the risk to delivery of the strategic objectives.

Confirmation on which tier the Trust had been categorised in was awaited. The Chief Executive confirmed that due to the Trust's financial performance tier three would be the best case scenario and it was hoped that the national validation reflected this. The Trust's internal Performance Review Meetings would oversee the required delivery, or improvements and mitigating actions. The Chief Operating Officer confirmed there was an emerging narrative around productivity, with a monthly national report expected.

The Board:

- ***approved the Trust strategy, success measures and progress reporting***

P25/07/E1 **Financial & Activity Report – Month 2 (Enclosure E1)**

The Chief Finance Officer reported an on plan month two and year to date deficit of £0.3m and £1.8m respectively.

In month, the Trust had delivered £2.5m of savings, £3.3m of savings year to date, which was in line with the plan submitted to NHSE, although with a greater proportion of recurrent savings. Unidentified savings for 2025/26 had now been eliminated.

The total year to date capital expenditure of £1.2m was £8.9m below plan.

The cash balance was £20.9m, due to a lower level of capital expenditure than planned.

The Chief Operating Officer confirmed that elective activity during May and in the year to date had exceeded all four points of delivery (outpatient new, outpatient follow up, daycase and elective, excluding Mexborough Elective Orthopaedic Centre). There was a focus on reducing additional, premium rate sessions by delivering the required activity as core sessions.

Non-executive Director, Mark Bailey thanked his executive colleagues for their rigour and focus on simplifying reporting through the Board's Finance & Performance Committee. The risks in the financial and operational plans were noted.

The Chief Executive highlighted the reference in the papers to the earlier than anticipated non-recurrent technical adjustment and stressed the need for delivery of savings throughout the year, as the plan was not back loaded.

There would be a focus on finance, alongside quality, with colleague briefings raising awareness and encouraging engagement and ownership to ensure the best use of resources to improve services in a sustainable way. Progress was noted on the reduction of nursing agency spend, with opportunities to be further explored on medical workforce spend. This would be linked to a workforce plan to reduce the reliance on bank and agency usage.

The potential for industrial action to impact on spend was noted, although it was hoped that negotiations would reach a satisfactory conclusion in view of the challenged system.

Non-executive Director, Mark Bailey acknowledged the need to unlock space to provide additional capacity for the delivery of urgent and emergency care on the Doncaster site. The Chief Operating Officer recognised the limitations of the current estate at Doncaster Royal Infirmary and confirmed the ambition to move services into the community would support this. The Chief Executive reinforced the need to maximise virtual ward utilisation for both step up and step down provision and ensure alternatives to conveyance to the Emergency Department were provided.

The Chair welcomed the new format of reporting.

The Board:

- ***noted the Month 2 financial and activity report***

P25/07/E2 **<u>Estates Return Information Collection 2024/25 (Enclosure E2)</u>**

The Board received the 2024/25 Estates Return Information Collection for approval ahead of the submission date of 1 July 2025.

The Chief Finance Officer brought the Board's attention to the 2.3% increase in backlog maintenance, a reduction in energy costs, arising from a change to a variable tariff, and a reduction in waste management costs.

In response to a question from the Chief Nurse in respect of sustainable solutions, the Chief Finance Officer confirmed that the Trust had secured funding to support the installation of solar panels and were progressing the installation of electric vehicle charging points, through a third party.

For the benefit of those observing the meeting and reflecting on the reference to an increased level of investment in 2024/25, alongside a higher backlog maintenance, Non-executive Director, Kath Smart clarified that elements of the capital investment had been for ring fenced improvements.

In respect of the reference on appendix one to the lack of an estates development strategy, the Chief Finance Officer confirmed that whilst there was a master development plan for Doncaster, this did not extend to all sites. The Chief Executive suggested that without a clearly defined clinical strategy it would be difficult to develop an estates development strategy, although an estates enabling plan was in place. The master development plan was dependent upon funding for the East Ward Block, and subject to confirmation further plans could be aligned to clinical requirements.

The Board:

- ***approved the Estates Return Information Collection 2024/25***

P25/07/F1 **Integrated Quality & Performance Report (Enclosure F1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for April 2025 and remaining access, quality, and workforce standards for May 2025. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The Deputy Chief Executive confirmed that the national Performance Assessment Framework for 2025/26 had not yet been finalised, once published the IQPR would be reviewed in line with this.

The executive directors provided an overview of their respective key performance indicators.

Non-executive Director, Emyr Jones noted the 12 month rolling Summary Hospital-level Mortality Indicator (SHMI) remained above the local target of 100, standing at 114.3. The Quality Committee continued to scrutinise learning from deaths and the Acting Executive Medical Director confirmed all aspects, including clinical coding, which impacted upon the Trust's performance was subject to review.

Non-executive Director, Kath Smart recognised the ongoing work in respect of medical job plans and the recent internal audit report which showed a significant improvement. A moderate assurance opinion had been provided, which compared favourably with other organisations' audits completed by 360 Assurance.

The Board:

- ***noted and took significant assurance from the Integrated Quality & Performance Report***

P25/07/F2 **Board Assurance Framework including Trust Risk Register (Enclosure F2)**

The updated Board Assurance Framework (BAF) was received for assurance and approval following scrutiny by the Board's assurance committees and for strategic risk six (partnerships) by the Board at its development session in June 2025.

The Deputy Chief Executive confirmed that four of the seven strategic risks had a risk score of 16 or above, this would be subject to an ongoing assessment. The number of overarching operational risks had reduced and confirm and challenge discussions at the Risk Management Group were maturing. Since the introduction of the risk management eLearning module in March 2025, 55% of those assigned the training had completed it.

Non-executive Director, Kath Smart reflected on private discussions with the auditors ahead of the year-end Audit & Risk Committee, where the limited opinion risk management follow-up audit and moderate opinion Board Assurance Framework audit had contributed to the moderate Head of Internal Audit Opinion. Whilst improvements had been made in the latter part of 2024/25 the opinion reflected performance across the year and there was a need to maintain the current approach going forwards.

Further to discussions at the previous Board meeting, the Chief People Officer confirmed the target rating of 12 had been considered by the People Committee and would be retained.

The Board:

- ***took significant assurance from the Board Assurance Framework, approved the content & noted the Trust Risk Register***

P25/07/F3 **2024/25 Annual Report & Accounts, including Annual Governance Statement (Enclosure F3)**

The Board received the 2024/25 Annual Report and Accounts for noting. With delegated authority from the Board of Directors, the Audit & Risk Committee had approved the Annual Report and Accounts, subject to minor non-material changes arising from completion of the external auditors work. The Chief Finance Officer confirmed that the accounts had been submitted to NHSE in accordance with the national deadline.

Non-executive Director, Kath Smart confirmed a below the threshold misstatement and misclassification had been reported as unadjusted audit differences.

The Board:

- ***noted the 2024/25 Annual Report & Accounts, including Annual Governance Statement***

P25/07/F4 **Chair's Assurance Log – Finance & Performance Committee (Enclosure F4)**

The Board received the Finance & Performance Committee Chair's assurance logs from May and June 2025 committee meetings. The logs recognised the level of risk in the breakeven 2025/26 financial plan, provided an overview of assurance taken, areas

of ongoing work and decisions made by the Committee.

The Board:

- ***noted and took significant assurance from the Chair's Assurance Log***

P25/07/F5 **Chair's Assurance Log – Quality Committee (Enclosure F5)**

The Board received the Quality Committee Chair's assurance log which summarised the assurance taken, areas of ongoing work and decisions made by the Committee.

The Board:

- ***noted and took significant assurance from the Chair's Assurance Log***

P25/07/F6 **Chair's Assurance Log – People Committee (Enclosure F6)**

The Board received the People Committee Chair's assurance log which provided an overview of the assurance taken and decisions made by the Committee in respect of the target risk score for strategic risk two.

The Board:

- ***noted and took significant assurance from the Chair's Assurance Log***

P25/07/F7 **Chair's Assurance Log – Audit & Risk Committee (Enclosure F7)**

The Board received the Audit & Risk Committee Chair's assurance log, which summarised the moderate assurance internal audit reports received, provided an overview of assurance taken and decisions, which included approval of the 2024/25 Annual Report and Accounts, including the Annual Governance Statement, subject to any minor, non-material alterations arising from the completion of the external auditors work.

P25/07/F8 **Audit & Risk Committee Annual Report (Enclosure F7)**

The 2024/25 Audit & Risk Committee Annual report provided assurance that the committee had operated in accordance with its Terms of Reference, summarising its roles and responsibilities. All of the Board's assurance committees had undertaken an effectiveness review, which had been considered by the Audit & Risk Committee, with a satisfactory conclusion.

The Board:

- ***noted and took significant assurance from the Audit & Risk Committee Annual Report***

C25/07/G1 **Board of Directors Work Plan (Enclosure G1)**

The Board:

- ***noted the Board of Directors Work Plan***

C25/07/H1 **Minutes of the meeting held on 6 May (Enclosure H1)**

The Board:

- ***approved the minutes of the meetings held on 6 May 2025***

C25/07/H2 **Pre-submitted Governor Questions regarding the business of the meeting (verbal)**

No governor questions were received.

C25/07/H3 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

C25/07/H4 **Date and Time of next meeting (verbal):**

Date: 2 September 2025
Time: TBC
Venue: MS Teams

C25/07/H5 **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.***

C25/07/I **Close of meeting (Verbal)**

The meeting closed at 13:04

2509 - F2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:05

10 minutes

2509 - F3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 13:15

10 minutes

2509 - F4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 12:45

Date: Tuesday 4 November 2025
Time: 10:30
Venue: Montagu Hospital

2509- F5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 13:25

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.