



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

Annual Members Meeting Agenda

Tuesday 30 September 2025
Venue: Lecture Theatre, Doncaster Royal Infirmary

INFORMAL SESSION

An opportunity to browse information stands and hear from Trust colleagues about local initiatives and programmes of work. **17:00**

FORMAL SESSION

- 1. Welcome** **17:30**
Suzy Brain England OBE, Chair of the Board and Council of Governors
- 2. To Note:** Minutes of the Annual Members Meeting held on 26 September 2024 were approved as a true and correct record by the Council of Governors' at its meeting on 7 November 2024 **17:35**
- 3. To receive:** Annual Report and Accounts 2024/25
Suzy Brain England OBE, Chair of the Board

Copies available via the Trust website - www.dbth.nhs.uk/about-us/how-we-are-run/annual-report/
- 4. Chair's Reflections on 2024/25** **17:40**
Suzy Brain England OBE, Chair of the Board
- 5. Council of Governors' Report including approval of the Trust's Constitution** **17:50**
Jackie Hammerton, Lead Governors
- 6. Chief Executive's Report** **18:00**
Richard Parker OBE, Chief Executive
- 7. Chief Finance Officer's Report** **18:30**
Sam Wilde, Chief Finance Officer
- 8. Pre-submitted Questions & Answers** **18:40**
- 9. Looking Ahead** **18:45**
Suzy Brain England OBE, Chair of the Board
- 10. Closing Remarks** **18:50**
Suzy Brain England OBE, Chair of the Board

Minutes of Doncaster & Bassetlaw Teaching Hospitals'

Annual Members Meeting

Pre-recorded for broadcast at 6pm on Thursday 26 September 2024

Welcome

The Chair of the Board welcomed viewers to the Trust's virtual Annual Members Meeting. The meeting would summarise the Trust's achievements during the period 1 April 2023 to 31 March 2024.

Minutes of the Annual Members Meeting held on 28 September 2023

The Chair of the Board asked members to note that the minutes of the previous Annual Members Meeting held on 28 September 2023 had been approved as a true record at the Council of Governors meeting on 9 November 2023, a copy of which could be found on the Trust's website <https://www.dbth.nhs.uk/about-us/become-a-member/annual-members-meeting/>.

Reflection on 2023/24 – Suzy Brain England OBE, Chair of the Board and Council of Governors

The Chair of the Board reflected on 2023/24 and shared her appreciation of colleagues' dedication and efforts, which had been pivotal in supporting the Trust's commitment to delivery of outstanding healthcare.

In the last year, the Trust had made significant progress in enhancing services and improving patient outcomes. Facilities at all three hospital sites had been upgraded to meet the evolving needs of patients, including the refurbishment of medical imaging at Bassetlaw Hospital and a charity funded bereavement suite at Doncaster Royal Infirmary. At Montagu Hospital, the Mexborough Elective Orthopaedic Centre of Excellence and Community Diagnostic Centre had set new standards in specialist care and diagnostics, demonstrating the value of collaborative partnership working.

During 2023/24 the Trust had welcomed Deputy Chief Executive, Zara Jones and Chief Information Officer, Dan Howard. Their fresh perspectives would help to shape the Trust's strategic and digital vision for the future. Specialist roles and services were also introduced, including the Early Pregnancy Loss Midwife and the Rapid Diagnostic Service.

The Trust had celebrated the success of its colleagues, with the Estates & Facilities Team securing Team of the Year at the Building Better Healthcare Awards.

The Trust had delivered its 2023/24 financial plan and a record breaking £57.6m of capital investment, which included the Bassetlaw Emergency Village, and the refurbishment of the

Central Delivery Suite at Doncaster Royal Infirmary.

The launch of the DBTH Way was recognised as a significant milestone in shaping the culture of the organisation, the framework emphasised kindness, inclusivity, and collaboration, setting clear expectations of how colleagues should treat each other and patients.

The Trust had launched its health inequalities strategy, led by Dr Kelly MacKenzie and Richard Woodhouse, which was being embedded into Trust activities. Innovation was central to developments, and with the support of the Fred and Ann Green legacy there had been investment in advanced technology, the da Vinci® robot for minimally invasive surgery and a therapy suite for stroke rehabilitation.

Sustainability and net zero ambitions were guiding the Trust's actions and the Trust's Green Plan had achieved significant results, including a transition to renewable electricity and reducing volatile anaesthetic gases.

There had been transformational progress during 2023/24 and the Trust was well placed to deliver exceptional healthcare for all.

The Chair of the Board expressed her thanks to colleagues, governors, members, volunteers, partner organisations and local communities for their support.

Reflection on 2023/24 - Richard Parker OBE, Chief Executive

The Chair of the Board welcomed the Chief Executive, Richard Parker to the virtual Annual Members meeting.

The Chief Executive recognised the challenges faced by the NHS in 2023/24 at a local and national level, with a focus on returning to pre pandemic activity levels and recovery of the waiting lists.

The workforce was a critical factor in this period of recovery, which had been impacted by significant levels of industrial action and the efforts of colleagues in maintaining a safe service throughout this time was acknowledged. The Chief Executive welcomed the pay settlement and encouraged a speedy resolution for the outstanding general practitioner negotiations.

Where there had been a need to source temporary workforce, this had been subject to careful management, significant financial pressures continued to be seen in 2024/25 across the NHS and in the economy.

During 2023/24 the Trust had cared for 131,000 inpatients, 511,000 outpatients, 199,000 visits to the emergency department and delivered 4,572 babies.

In March 2024, the Trust had met the national standard for patients being seen, treated, discharged, or admitted within four hours of arrival in the Emergency Department and were one of the most improved hospitals in the country. The Chief Executive encouraged the public to use the emergency services wisely, making the most appropriate choice for non-emergency or minor illnesses from the range of available healthcare services.

There had been sustained performance in respect of cancer standards, with a reduction in the 62 day backlog and delivery of the faster diagnosis standard. The 62 day referral to treatment

standard remained a challenge but the Trust continued to drive to achieve all standards in a sustainable way.

Efforts to drive down elective waits continued towards no patient waiting more than 52 weeks by the end of the year, which was recognised as a challenging standard locally and nationally.

There had been a greater focus on collaborative working to ensure consistent delivery of standards. System developments in elective, diagnostic and care in the community services were a key focus. The Mexborough Elective Orthopaedic Centre and the South Yorkshire & Bassetlaw Pathology Partnership were recognised as good examples of organisations working together to provide the best possible care to the communities served and with the support of technological advancement. Future opportunities to collaborate on the delivery of children's services were being explored and the Trust was engaged in a programme of work to implement an electronic patient record.

There had been considerable progress made in the year relating to patient experience with improved results on CQC inpatient and outpatient surveys.

In 2023/24 the Trust delivered its financial plan, with an improvement of 11.5% against its planned deficit, an extensive capital plan was delivered and in view of the disappointing news that the Trust was not part of the New Hospital Programme the Trust continued to explore opportunities to enhance its existing services and facilities. The support of local MPs was actively sought and appreciated and the work remained a significant commitment of the Board of Directors.

The Trust had reassessed its key priorities as part of a refresh of its strategy, focused on, patients, people, partnerships, and pounds. The Trust had launched a Nursing, Midwifery and Allied Health Professionals Quality Strategy, implemented the Patient Safety Incident Response Framework, launched the Sexual Safety Charter and updated many of its policies.

From a quality perspective, improvement had been seen in hospital mortality rates, job planning and the introduction of a Health Inequalities Strategy. Disappointingly, following an inspection by the Care Quality Commission in September 2023 the overall rating of the Trust reduced from "Good" to "Requires Improvement". The Trust was committed to improve the areas identified and a robust plan of action was in place to ensure the rating returns to the national standards as quickly as possible following the introduction of the new inspection framework.

During the year senior posts had been recruited to across the organisation, with advances made in the recruitment of nursing colleagues and significant recruitment of midwives. The DBTH Way provided a framework for colleagues to role model behaviours in line with the Trust's We Care values, alongside a focus on Just Culture.

The Staff Survey secured a 67% participation rate, one of the highest in the country, which provided reliable data with which to work. 71% of responses were better than the national average and further actions would be taken to continue to improve colleagues experience. Of the nine national people promises the Trust was above the standard in all categories.

In terms of awards and accreditations, the Trust was delighted to have been named Employer of the Year at the Doncaster Chamber Business Awards, achieved menopause accreditation and many other nominations for local and national awards. The recognition of long service was reintroduced this year and was much appreciated by colleagues, with many colleagues having

service between 20-50+ years.

The significant investment from the Fred and Ann Green legacy to purchase the da Vinci® robot was acknowledged and the Chief Executive placed on record his thanks to Fred and Ann Green and their family for the enormous impact of the legacy for the Trust, its people, patients and community. The Chief Executive signalled the Trust's continuing commitment to provide high quality to patients.

Annual Accounts 2023/24

The Chair of the Board welcomed the Chief Financial Officer to the meeting to provide an overview of the Trust's financial performance.

2023/24's accounts had been audited by Ernst & Young and an unqualified opinion on the financial statements and use of resources had been provided.

The Chief Financial Officer confirmed that the Trust had moved away from the national financial regime in place throughout the pandemic, to earn money for the work completed. In 2023/24 the Trust had earned £568m of income, after paying colleagues and allowing for all in year liabilities the Trust reported a loss of £23.7m, against an agreed deficit plan of £26.8m.

As at 31 March 2024, the cash balance was £36.3m, however, due to a back loaded capital programme there was a total of £24m of capital creditors at year end, which meant the underlying cash position was c. £12m. The Trust continued to pay suppliers promptly to maintain cash flow in the economy.

There was a significant capital spend in year and the Trust experienced increased costs arising from increased utility prices and inflation. The Trust had however reduced its reliance on temporary staffing.

Looking ahead to 2024/25, the NHS would continue to face the challenge to improve waiting times and recover the backlog of elective patients.

The Trust had an agreed deficit plan of £26.7m, with cash support provided by NHS England. There remained a commitment to spend on essential estates maintenance, with an increased spend on medical equipment and IT as compared to 2022/23. An options appraisal for appropriate use of contingency was underway.

The Trust Board was focused on providing the best value for money for colleagues and patients and was working through a plan for a break even position over the medium term.

Question and Answer Session

The Chair of the Board introduced the question and answer session, where executive colleagues provided a response to members questions received prior to the meeting.

"Given the current state of DBTH's finances, how will this affect plans to refurbish DRI, as well as ongoing maintenance costs?"

The Chief Financial Officer confirmed that the Trust was currently working with colleagues at NHS England and the Department of Health & Social Care to review plans for the Doncaster Royal Infirmary site. A business case to refurbish the East Ward Block was being developed, with submission expected in Summer 2025. In the interim a number of schemes were being worked

up to support enabling programmes of work, including potential changes to staff accommodation, car parking and relocation of the Department of Critical Care.

“How is the Trust tackling issues around diversity and representation?”

The Chief People Officer confirmed there was a comprehensive improvement action plan in place to address equality, diversity and inclusion, aligned to the national NHS actions. This work was reported through the Board’s People Committee. Some of the work related to representation and diversity included an established Reciprocal Mentoring Programme and Board Development Delegate Programme to increase diversity in the talent pathway for both internal and external colleagues. Delegates were able to observe the Board and its committees, to understand ways of working and spend time with Board members. A leadership prospectus had been reframed in line with the DBTH Way and a talent management framework, Scope for Growth, had been introduced. Information from national data sets around equality and diversity and staff survey measures had been analysed to understand the impact of the work on our people.

“What type of workforce challenges is the Trust currently experiencing?”

The Chief People Officer confirmed that the Trust had a robust workforce planning process in place, aligned with business planning. There had been some recruitment successes this year, particularly in nursing and midwifery, including newly qualified and internationally educated colleagues. As a result, a reduction in agency and temporary staffing spend had been seen. There remained some areas of national challenge in medical workforce and the Trust continued to work closely with other organisations across the system to establish collaborative opportunities, the Pathology Network was a good example of this. In respect of retention rates, an improvement had been seen linked to the significant work underpinning the People Strategy. The Trust had well established relationships with external education providers where there were lots of opportunities to develop skills through a range of educational pathways and career development across all professions, including a range of apprenticeships.

“The Trust is forecasting a higher deficit than expected – how does the Trust intend to manage this?”

Following an overspend in the first two months of 2024/25, the Chief Financial Officer confirmed that the Finance and Performance Committee of Board had agreed a review to establish the cause. Should no change be initiated, the potential year end deficit was forecast to be c.£52m. Working with colleagues in divisions and directorates actions were identified to bring the finances back in line with the original financial plan.

The Chair of the Board thanked Trust members for their questions and shared her appreciation with executive colleagues for their responses.

Annual Report & Accounts 2023/24

The Chair asked that the Annual Report and Accounts for 2023/24, the annual audit letter and the Trust’s Constitution be received. Copies of which could be found on the Trusts website at www.dbth.nhs.uk

In closing, the Chair of the Board thanked all viewers.

These were exciting times for the Trust, with opportunities for investment and development, however, the financial challenges faced by the NHS were acknowledged and it was imperative that public money was spent wisely with a commitment to deliver the best possible care for our patients.

A handwritten signature in black ink, reading 'Suzy Brain' followed by a stylized flourish.

Suzy Brain England OBE

Chair of the Board

7 November 2024



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



Annual Report and Accounts

Financial year 2024/25

Doncaster and Bassetlaw Teaching Hospitals



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

Annual Report and Accounts 2024/25

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

Contents

Performance Report	1
Chair and Chief Executive's statement	2
Achievements in 2024/25	12
Significant changes and developments since 1 April 2025	35
Performance overview and analysis in 2024/25	36
Investment and infrastructure	42
Sustainability and the Trust's Green Plan	47
Health inequalities	49
Financial performance	52
Going Concern	56
Directors' Report	59
Remuneration Report	66
Governance Report	81
Staff Report	83
Statement of Accounting Officer's responsibilities	136
Annual governance statement	138
Independent auditor's report to the Council of Governors	149
Foreword to the accounts	155

Performance Report

This section of the Annual Report offers an overview of the Trust, outlining its purpose, the key risks to achieving its objectives, and how it has performed over the past year.

A handwritten signature in dark ink, appearing to read 'Rt Parker', with a stylized flourish at the end.

Richard Parker OBE
Chief Executive
30 June 2025

Chair and Chief Executive's statement

Over the past year, Doncaster and Bassetlaw Teaching Hospitals (DBTH) has continued to make significant strides in improving services, strengthening partnerships, and delivering on our vision of exceptional healthcare for all.

Throughout 2024/25, our colleagues have responded to sustained demand with professionalism and compassion. In March alone, we recorded our busiest ever month for urgent and emergency care, seeing over 18,600 patients. This speaks not only to the increasing need for NHS services, but also to the dedication of Team DBTH in rising to that challenge every single day.

This year marked a new chapter in our strategic journey. We launched a refreshed organisational vision: Healthier together – delivering exceptional healthcare for all – and developed a new strategic framework, shaped by the voices of our colleagues, communities, and partners. Built around four clear priorities – Patients, People, Partnerships, and Pounds – our strategy sets the foundation for the years ahead, aligning ambition with action and ensuring we continue to meet the needs of those we serve.

We have made significant progress across all areas of the Trust. Our Montagu Elective Orthopaedic Centre of Excellence (MEOC) celebrated its first anniversary, setting new records for elective surgery in South Yorkshire. Additionally, in February we proudly opened the Bassetlaw Emergency Village, reintroducing 24/7 inpatient paediatric admissions for the first time since 2017 and transforming emergency care for local people.

Our capital development programme has continued at pace, with more than £49 million invested this year. At Montagu, the Community Diagnostic Centre was completed, adding vital imaging and endoscopy capacity, while the development of a new robotic stroke rehabilitation suite is now well underway. At Doncaster Royal Infirmary, we began a major programme of redevelopment, including a new Discharge Lounge, a Same Day Emergency Care Unit, and plans for a relocated Department of Critical Care.

Innovation remained central to our progress. We introduced new digital systems such as electronic prescribing (ePMA) and expanded the use of Patient Initiated Follow-Up (PIFU), both of which have been revenue projects. Our robotic surgery programme has now completed over 100 procedures, and newly introduced AI-supported diagnostics are helping to enhance accuracy and speed in care delivery. Our research portfolio continued to grow, with DBTH becoming the first site in Europe to recruit into new clinical trials and achieving national recognition for studies in renal care and stroke genomics.

People remain at the heart of everything we do. Through our second year of delivering the People Strategy, we supported wellbeing, flexible working, development, and leadership – while continuing to embed The DBTH Way as our framework for inclusive and compassionate culture. We launched new mentoring and career development programmes, hosted the 2024 Star Awards, and celebrated long-serving colleagues at a dedicated recognition event.

This year also saw the publication of our first Health Inequalities Strategy, guiding our efforts to provide fairer access to care and address wider health disparities. Supported by new training, outreach programmes, and dedicated leadership, this strategy ensures equity remains at the centre of all we do.

In terms of financial performance, we achieved our financial plan for the eighth year in a row, demonstrating strong financial stewardship despite ongoing challenges across the healthcare sector.

As we look ahead, our focus will be on embedding our new strategy, finalising plans for a new Electronic Patient Record (EPR) system, continuing our capital development programme, and further improving emergency and elective care performance. We will also launch the final version of our new organisational strategy, providing a clear direction for 2025/26 and beyond.

We would like to take this opportunity to thank our colleagues, partners, members, governors, volunteers, and local communities for their ongoing support. The achievements set out in this report would not be possible without their hard work, trust, and commitment.

This Annual Report reflects the work of many, and we are proud to present it as a fair, balanced, and accurate account of our progress in 2024/25. It provides the detail necessary for stakeholders to assess our performance, strategy, and impact, and we commend it to you as a record of a year defined by ambition, progress, and collective purpose.



Suzy Brain England OBE
Chair of the Board
30 June 2025



Richard Parker OBE
Chief Executive
30 June 2025

Who we are and what we do

We are Doncaster and Bassetlaw Teaching Hospitals (DBTH), an acute NHS Foundation Trust serving a population of more than 440,000 people across South Yorkshire, North Nottinghamshire and the surrounding areas.

As one of the busiest providers of emergency care in the region, we deliver a wide range of healthcare services across our sites. We are also a teaching hospital, working in close partnership with the University of Sheffield and Sheffield Hallam University to support clinical education and research.

We work closely with our local Integrated Care Boards (ICS) in South Yorkshire and Nottinghamshire, as well as system partners across the region and locally in Doncaster and Bassetlaw.

Formerly Doncaster and Bassetlaw Hospitals, we were one of the first ten NHS trusts in the country to be awarded Foundation Trust status in 2004. This gave us greater financial and operational autonomy, while maintaining the same high standards and regulatory oversight as a non-Foundation Trust.

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

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

We provide the full range of district general hospital services, a number of community-based services (such as family planning and audiology), and some specialist tertiary services, including vascular surgery.

Our services are delivered across the following sites:

Doncaster Royal Infirmary (DRI): A large acute hospital with more than 450 beds, a 24-hour Emergency Department, and trauma unit status. It offers a wide range of district general and specialist services, with inpatient, day case and outpatient care.

Bassetlaw Hospital (BH), Worksop: A medium-sized hospital with over 170 beds, a 24-hour Emergency Department, and an obstetrics unit. It provides the full range of general hospital

services, including a dedicated breast care unit, with inpatient, day case and outpatient facilities.

Montagu Hospital (MH), Mexborough: A small hospital with more than 50 inpatient beds for patients requiring rehabilitation before discharge. It also houses a nurse-led Urgent Treatment Centre (open from 9am to 9pm), a day surgery unit, renal dialysis, chronic pain services and a wide range of outpatient clinics. The site is home to our Rehabilitation Centre, Clinical Simulation Centre, and the Abdominal Aortic Aneurysm Screening Programme.

More recently, Montagu has also become the base for the Mexborough Elective Orthopaedic Centre of Excellence (MEOC) and the Community Diagnostic Centre (CDC).

Additional locations: We provide outpatient and diagnostic services at Retford Hospital, including medical imaging and clinical therapies. Our Audiology service is based at Sandringham Road Centre, while Mammography and Children's Speech and Language Therapy are delivered from Devonshire House—both located within two miles of Doncaster Royal Infirmary.

Our headquarters are at Doncaster Royal Infirmary:

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

Our strategy, vision, mission, values and objectives

Refreshed vision and priority statements

Throughout 2024/25, we have been developing a new organisational strategy that will shape our direction and priorities for the years to come. This work has marked an important period of reflection and renewal, giving us the opportunity to look closely at the changing needs of our communities, the challenges we face, and the strengths we can build on.

Central to this process has been the involvement of our people. We have engaged widely with colleagues, patients, partners, and representatives from our local communities—drawing upon their experiences, insights and aspirations to help co-create a strategy that is both ambitious and grounded in reality. This approach has ensured that our plans not only align with national and regional priorities, but also reflect the values and expectations of those who use and deliver our services every day.

Our new strategic framework is built around a clear vision: **Healthier Together - Delivering Exceptional Care for All**.

This vision captures our collective ambition to deliver care that is safe, inclusive and person-centred—care that addresses inequalities, improves health outcomes, and supports individuals at every stage of life. It recognises our role as a teaching hospital and our responsibility to develop future generations of health professionals. Additionally, it reflects our commitment to innovation, research, sustainability, and working in partnership with others to make a difference at both a local and system level.

To turn this vision into reality, we have identified four overarching **Strategic Priorities** - core areas of focus that will shape how we plan, invest, and deliver services over the coming years:

- **Patients:** Delivering safe, exceptional, person-centred care that meets individual needs and empowers people to take an active role in their health and wellbeing.
- **People:** Creating a supportive, inclusive, and welcoming environment for colleagues—enabling everyone to thrive and contribute to the success of Team DBTH.
- **Partnerships:** Working collaboratively with others across health, care, education, and the voluntary sector to improve outcomes and deliver joined-up care.
- **Pounds:** Using public resources responsibly, transparently, and sustainably to deliver best value for our patients and communities.

These priorities are supported by four cross-cutting **Strategic Ambitions**, each of which supports our long-term ambition and transformation:

- Tackling Health Inequalities.
- Becoming a leading centre for research and education.
- Becoming a digitally enabled and mature organisation.
- Improving the Trust's estate to provide the best care environment.

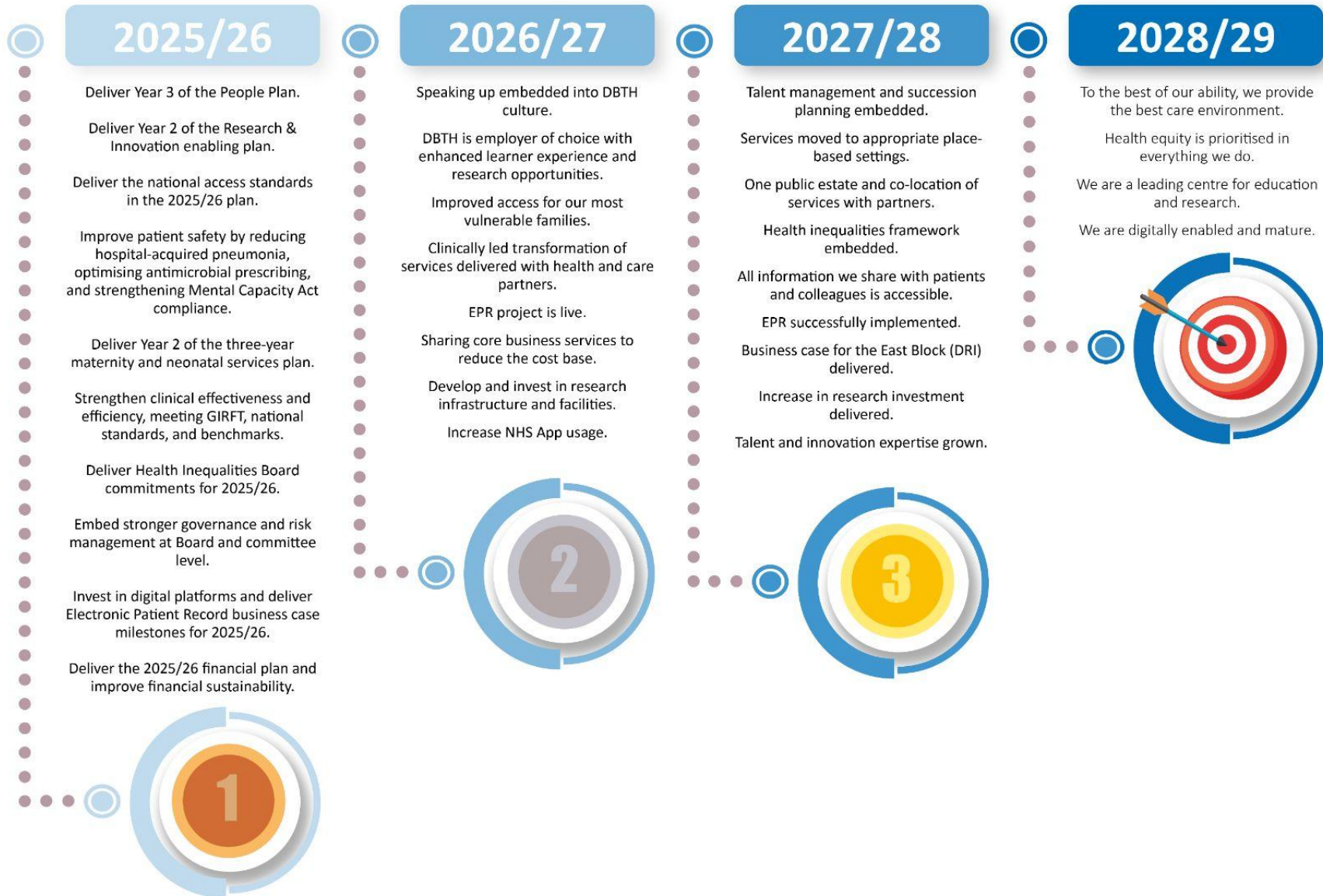
These aims and priorities are underpinned by a series of enabling plans, which translate our vision into practical action.

These include plans for People, Quality, Health Inequalities, Estates and Net Zero, Maternity and others. Together, they provide the detailed framework we need to ensure that our ambitions are achievable and measurable.

To guide delivery over time, we have developed a preliminary strategic timeline, setting out a phased approach that builds momentum year on year.

In the immediate term, we are focusing on key improvement - reducing waiting times, modernising digital systems, and enhancing the working environment for colleagues.

Our timeline can be viewed here:



At the centre of this work is the **DBTH Strategic Wheel**. This visual framework brings together our Strategic Priorities, Strategic Aims and Enabling Strategies into a single, interconnected model.

The wheel helps ensure alignment across all areas of the organisation and reinforces how our efforts support wider priorities, including those of our local Integrated Care Board, the South Yorkshire and Bassetlaw Acute Federation, and national programmes such as the NHS Long Term Plan.

The Strategic Wheel can be viewed here:
<https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/healthier-together-organisational-strategy/>

Our strategy will be finalised and formally launched in 2025/26, following further engagement, refinement and governance review. Once launched, it will become the foundation for our operational planning, decision-making, and performance management—providing clarity of purpose and direction for all parts of the Trust.

We are proud of the work we've done so far, and excited by the opportunities this strategy brings. It reflects who we are, what we value, and where we want to go—always guided by the needs of our patients, the wellbeing of our people, and the health of the communities we serve.

The DBTH Way

The DBTH Way is now well embedded across the Trust, providing a clear and consistent framework that complements our organisational **Vision** – *Healthier together – delivering exceptional care for all* – and our **We Care** values.

Developed with input from colleagues at all levels, this framework sets out our shared expectations of one another and strengthens our collective commitment to delivering high-quality care, while ensuring everyone at DBTH has a positive and rewarding working experience.

Its development was a truly collaborative process, shaped through open engagement sessions, interactive workshops, and vital insights from the annual Staff Survey. It is also closely aligned with our **People Strategy, Just Culture Pledges**, and wider national frameworks, including the NHS Five Year Forward Plan.

The DBTH Way builds on the strong foundation of our We Care values, providing further clarity on what those values look like in practice. It defines how we engage with each other, our patients, our communities, and our partners – fostering a culture rooted in excellence, compassion, and inclusion.

Importantly, the DBTH Way is not a set of rules to memorise, but a guiding principle that captures who we are and how we work. It defines what it means to be part of Team DBTH and creates an environment where every individual feels supported, valued, and empowered to deliver their best.

At its core, the DBTH Way can be summarised by two key statements:

- **We are** Kind, Inclusive, Person-centred, Empowering, Accountable, and Collaborative.
- **We show** Attentive listening, Integrity and Honesty, Courage, and Positivity.

Since its launch, colleagues have embraced the DBTH Way as an integral part of life at the Trust – helping to create a workplace culture that supports both our people and our patients to thrive.

Our Values

At DBTH, our **We Care** Values are at the heart of everything we do. They underpin the **DBTH Way** - setting out how we work together, lead by example, and support each other. Both are more than a set of words; they are the standards we hold ourselves to, creating a culture that is kind, inclusive, empowering, and accountable.



We lead by example and role model the **DBTH Way** and our **We Care Values**

We are



Kind



Inclusive



Person centred



Empowering



Accountable



Collaborative

We show



Attentive listening



Integrity and honesty



Courage and positivity

Achievements in 2024/25

Below is a summary of key achievements, milestones, and significant developments across our hospitals during 2024/25, month by month, and later aligned with our Strategic Priorities.

April 2024

In April, we began the year with a renewed sense of purpose as we refreshed our organisational vision to *Healthier together – delivering exceptional care for all*. This updated vision is now underpinned by four clear strategic priorities: Patients, People, Partnership, and Pounds, providing a firm foundation for our work ahead.

To support this direction, we launched our Operational Plan for 2024/25, outlining key areas of focus for the coming year. These include reducing waiting times, improving the efficiency of our clinics, investing in digital systems, and working more effectively with our partners to enhance patient care.

Alongside this, we introduced our Nursing, Midwifery, and Allied Health Professions Quality Strategy which sets out our commitment to safety and excellence. This included the continued roll-out of the Patient Safety Incident Response Framework (PSIRF) and the introduction of quality dashboards to support data-driven improvements.

Recognising the importance of supporting our colleagues, we continued to invest in wellbeing initiatives. Through wellbeing trolleys, virtual sessions, and the work of our Wellbeing Champions, we helped promote both mental and physical health across the organisation.

We also looked to the future by launching a public engagement campaign, inviting our communities to share their views and help shape our five-year strategy. This input is essential as we build services that reflect the needs and aspirations of those we serve.

Our commitment to education and development was demonstrated with the opening of a refreshed library facility at Doncaster Royal Infirmary – a space designed to support learning, development, and research.

We were proud to celebrate our international colleagues, hosting a graduation event to recognise newly registered nurses and allied health professionals and acknowledge their valuable contribution to Team DBTH.

Innovation remained at the forefront of our work, with the introduction of our new surgical robot – affectionately named Robi Sheldon Alan Surgeonator by the public – to further enhance patient care through state-of-the-art technology.

Research and development also continued to thrive. Our Chief Nurse Research Interns completed their placements, helping to embed evidence-based practice throughout our services.

We were pleased to receive national recognition, being shortlisted for a Student Nursing Times Award in acknowledgment of the strength and quality of our student placement programme.

Finally, we celebrated individual success, with Consultant Podiatric Surgeon Mr Tony Wilkinson elected to the Council of the Royal College of Podiatry – a reflection of his leadership and expertise in the field.

May 2024

In May, we were proud to receive national recognition for our continued focus on safety, earning the Royal Society for Prevention of Accidents' Silver Health and Safety Accreditation. This achievement reflects our commitment to creating a safe and secure environment for both patients and colleagues.

We also looked to the future, welcoming young people from across the region to our *We Care into the Future* event in Bassetlaw. This inspiring day supported NHS careers education and helped spark enthusiasm among the next generation of health professionals.

Advancements in technology continued as we installed a new Siemens Ysio Max X-ray machine at Bassetlaw Hospital, enhancing our diagnostic capabilities. At the same time, we formally introduced AI into our diagnostics service through a partnership with Annalise.ai, supporting quicker and more accurate chest X-ray reporting.

Our Medical Imaging team celebrated several achievements. The department received a 'Good' rating from the Care Quality Commission (CQC), with praise for its leadership and patient focus. We also welcomed three graduates from our in-house programme into permanent roles, strengthening the team further.

Community spirit was on full display as volunteers joined us for a hospital clean-up as part of the Great British Spring Clean, helping to enhance our environment for patients and visitors.

We were pleased to host our first-ever Leadership Conference, bringing colleagues together to explore compassionate, inclusive, and effective leadership at all levels of the organisation.

The month also brought celebration and pride. Grace Rosser represented Great Britain at the European Dragon Boat Racing Championships, showcasing the determination and talent within Team DBTH.

We were shortlisted for eight regional apprenticeship awards, recognising our continued investment in workforce development and opportunities for learning and progression.

Meanwhile, construction at Montagu reached a key milestone with a steel-signing ceremony to mark progress on our new diagnostic facilities. We also officially launched our robotic surgery programme, with a ribbon-cutting event introducing our state-of-the-art robot to patients and colleagues alike.

June 2024

In June, we took a significant step towards tackling health inequality by publishing our first-ever Health Inequalities Strategy. This document set out our commitment to ensuring fairer access to care and better outcomes for all, laying the groundwork for more inclusive services across the Trust.

We also introduced advanced imaging technology to support stroke diagnosis, with CT perfusion now in use to help clinicians make faster, more accurate decisions—ultimately improving care for those experiencing a stroke.

Our commitment to environmental sustainability continued under the Green Plan, with targeted campaigns helping to reduce waste and lower emissions across our sites.

At Montagu, we marked continued progress on our Community Diagnostic Centre with a time capsule event, further strengthening our ties with the local community. The hospital also hosted a wellbeing day, which saw outdoor spaces refreshed and upgraded to support the health and happiness of colleagues and patients alike.

A leadership announcement was made as Jon Sargeant confirmed he would step down from his role as Chief Finance Officer in early 2025.

We also celebrated surgical leadership within the Trust, as Ms Lynda Wyld was appointed to the Council of the Royal College of Surgeons - a prestigious achievement that recognises her contribution to the profession.

To improve support for patients with learning disabilities, we introduced new 'hospital bags' funded by charitable donations. These are designed to offer comfort, reduce anxiety, and aid communication during hospital stays.

The Mexborough Elective Orthopaedic Centre of Excellence reached a major milestone, marking its 100th hip replacement since opening earlier this year - a proud moment and a testament to the team's hard work.

Finally, we continued to share our learning with others. One of our renal nurses presented research findings at a regional event, helping to spread knowledge and strengthen evidence-based practice across the wider NHS.

July 2024

In July, we continued to support healthier living across the Trust and in our communities, hosting a health and wellness fair that offered advice, services, and activities to promote both physical and mental wellbeing.

We strengthened patient safety by introducing a new electronic prescribing and medicines administration (ePMA) system. This digital system helps reduce prescribing errors and improves the efficiency and accuracy of how medications are managed and administered.

Our education outreach continued as we partnered with schools to promote NHS careers, helping young people explore opportunities in healthcare and understand the many roles available within the service.

To improve access to care, we launched a new transport scheme designed to support patients with mobility needs, helping them attend appointments more easily and reducing missed visits.

We were proud to celebrate our apprentices at a graduation event, recognising the achievements of colleagues who completed a wide range of apprenticeship programmes. Later in the month, we hosted a second graduation ceremony to honour those who had completed professional development programmes, highlighting our continued investment in learning and growth.

July also saw us embrace and celebrate the diversity of Team DBTH with a dedicated international event. This brought together colleagues who were recruited from overseas, as well as those who trained outside the UK, recognising the valuable contribution they make to our services and culture.

Our research portfolio grew as the Born and Bred in Doncaster study—our local birth cohort research project—welcomed its 2,500th participant. The study will help shape a better understanding of long-term health trends and inform future care for Doncaster families.

In our neonatal units, we introduced ‘Hold on, pain eases’ or H.O.P.E. boxes - charity-funded care packs that provide comfort items and practical support to families whose babies require specialist care.

We also expanded the use of Patient Initiated Follow-Up (PIFU), a model that gives suitable patients more control over their follow-up appointments, allowing them to request reviews as needed rather than at fixed intervals—helping free up capacity and improve personalised care.

Our reputation for excellence continued to attract attention, and we welcomed national leaders Sir Keir Starmer and Wes Streeting to Bassetlaw Hospital, where they met colleagues and discussed priorities for the NHS ahead of the General Election.

We were proud to host Doncaster’s largest-ever health careers event, with hundreds of students attending to explore future opportunities in healthcare and gain hands-on experience of what a career in the NHS can offer.

Finally, construction at Montagu Community Diagnostic Centre reached a significant milestone with a topping-out ceremony, marking the final phase of development for our new imaging suite.

August 2024

In August, we made further progress in enhancing access to care by increasing the number of telephone and video clinics across the Trust. These remote appointments have helped reduce waiting times and made it easier for patients to receive care at a time and place that suits them.

We also launched a new mentorship scheme to support newly qualified nurses and junior doctors, pairing them with experienced colleagues to help them settle in, build confidence, and develop their clinical skills.

As part of our commitment to sustainability, we overhauled our waste management systems by introducing more recycling points across our sites. This forms part of our wider efforts to reduce our environmental impact and promote greener working practices.

Maternity services saw improvements too, with the introduction of a new care pathway designed to provide greater continuity and better access to specialist support for expectant mothers.

Our robotic surgery programme reached an exciting milestone, with over 20 successful procedures completed using the new system—delivering faster recovery times and better outcomes for patients.

Charitable funding helped us make major improvements to patient spaces in Bassetlaw's Medical Unit, transforming the environment to better support comfort, dignity, and recovery.

Innovation continued through our participation in an AI research study focused on pressure ulcers. The study aims to improve early identification and intervention, helping to reduce harm and enhance patient care.

Our international workforce grew stronger as a new cohort of colleagues recruited from overseas successfully passed their Objective Structured Clinical Examinations (OSCEs), allowing them to begin their roles as registered professionals within the Trust.

Finally, we were encouraged to see improvements in our Adult Inpatient Survey, which showed progress across several key areas of patient experience—a reflection of our ongoing efforts to listen, learn, and improve.

September 2024

In September, we were proud to be named finalists in the Doncaster Business Awards, with recognition for both our Apprenticeship and Charity teams. These nominations reflected our ongoing commitment to development, opportunity, and community support across the Trust.

For colleagues, we upgraded our rostering systems with the introduction of a new digital scheduling tool. This improved how shifts are managed and supported greater flexibility and clarity for teams.

To enhance communication and experience for patients, we strengthened our patient liaison service by increasing staffing and improving contact routes, making it easier for individuals and families to get the information and support they need.

We also began piloting a digital booking system, aiming to improve the speed, accuracy, and convenience of appointment scheduling—helping patients access the care they need more efficiently.

September also brought international pride as porter and photographer Graham Beardsley travelled to Paris with Team GB, capturing powerful moments at the Paralympic Games and showcasing the talent and passion within our wider DBTH family.

We continued to invest in clinical care with over £50,000 allocated to strengthen our response to sepsis. This funding supported new equipment, educational initiatives, and awareness-raising across our hospitals.

Our commitment to compassionate care was formalised through the launch of our Visitors' Charter—a guide to ensure respectful, supportive visiting experiences for patients, families, and staff alike.

At Montagu, progress on the Community Diagnostic Centre continued, with local MP Ed Miliband visiting the site and placing a time capsule to mark this important development for the area.

We also celebrated success in midwifery recruitment, welcoming a record number of new starters to the team. This boost in workforce supports safer, more personalised care for women and families across our communities.

October 2024

In October, we marked World Patient Safety Day with a campaign that highlighted the important role everyone plays in keeping patients safe. From frontline care to support services, we reinforced that safety is a shared responsibility across the entire Trust.

To support better communication around appointments, we introduced NHS App reminders. These notifications help patients manage their bookings more easily and reduce the number of missed or forgotten appointments.

Our hospital sites were lit pink for Organ Donation Week, raising awareness of the lifesaving impact of organ donation and encouraging more people to consider registering their decision.

We strengthened support for cancer patients through a new partnership with Macmillan Cancer Support. The collaboration will help improve care pathways and the overall experience for individuals undergoing cancer treatment.

To further reduce waiting times and improve access, a second CT scanner was introduced at Bassetlaw Hospital, increasing capacity and helping ensure patients receive timely, high-quality imaging.

We celebrated national recognition for compassionate care, as Healthcare Assistant Elizabeth Marshall received a Chief Nursing Officer Award—a well-deserved honour reflecting her exceptional dedication to patients.

The theatre reception at Bassetlaw was refurbished to create a calmer, more welcoming environment for patients arriving for procedures—an improvement shaped by colleague and patient feedback.

We confirmed the permanent appointment of Sam Wilde as Chief Finance Officer.

Recognition also came in the form of a Nursing Times Workforce Award shortlisting, acknowledging our efforts to support internationally recruited nurses through tailored induction, training, and pastoral care.

Our hospital gardens were re-accredited Green Flag status, celebrating them as safe, welcoming, and well-maintained spaces that support the wellbeing of patients, visitors, and staff alike.

Finally, we launched a new women's health service at Doncaster Royal Infirmary with the opening of the Gynaecology Assessment and Support Clinic, offering faster access to care and specialist advice for women in need of urgent support.

November 2024

In November, we came together to celebrate our Star Awards 2024, with hundreds of colleagues gathering at Doncaster Dome to recognise the incredible individuals and teams making a difference across the Trust. It was an evening of pride, gratitude, and shared success.

We were also pleased to be re-accredited as Veteran Aware, reaffirming our commitment to delivering personalised, understanding care for veterans and Armed Forces families as part of the national Veterans Covenant Healthcare Alliance.

Our rostering software was further refined following colleague feedback, supporting improved workforce planning and helping teams manage their shifts more effectively.

As part of our efforts to tackle health inequalities, we launched a diabetic eye screening outreach programme aimed at increasing uptake among underserved groups—bringing this vital service into the heart of local communities.

We also strengthened our commitment to women's health research by awarding honorary contracts to key academic partners, supporting greater collaboration and future research activity.

Professional achievements were celebrated, with Sarah Ritzmann receiving a Fellowship from the British Society of Echocardiography—recognition of her significant contribution to the field and continued excellence in patient care.

At Bassetlaw, we expanded paediatric care services, introducing overnight and extended hours to better support local children and their families with timely, high-quality care.

Montagu's endoscopy service marked one year of local care delivery, celebrating a successful first year of operation and the improved access it has brought to patients across the area.

We were honoured to receive a community award from University Campus Doncaster, recognising our ongoing contribution to education and engagement across the borough.

Supporting the next generation of clinicians, we hosted a regional careers day for Foundation Year 2 doctors, helping junior doctors explore their next steps and connect with development opportunities.

In a major milestone for research, we held our first-ever Research and Innovation Conference. The event brought together staff, academics, and partners to focus on maternal and child health, sharing insight and inspiring future work.

Finally, colleagues completed our Board Development Programme, supporting leadership growth across the organisation and strengthening the pipeline of future leaders at DBTH.

December 2024

In December, we brought the calendar year to a close by celebrating the incredible dedication of our long-serving colleagues. At a special afternoon tea event, we honoured those who had reached milestones of 10 to 50 years of NHS service—recognising their commitment, compassion, and contribution to patient care.

Our work was recognised once again at the Doncaster Business Awards, where both our Apprenticeship and Charity teams were shortlisted. These nominations reflected the Trust's focus on developing people and supporting our wider community through education and engagement.

We were grateful to receive a generous £5,000 donation to support children's health education, helping to fund early years learning around healthy lifestyles and giving young people the knowledge to make informed choices about their wellbeing.

In clinical research, we led the way across Europe, becoming the first site to recruit into a new prostate cancer trial—placing DBTH at the forefront of international research efforts.

A new cohort of nurse research interns began their placements, continuing our commitment to developing evidence-based practice and supporting colleagues to pursue clinical research careers.

Innovation in stroke care progressed with the launch of a national pilot in genetic testing. The trial, focused on genomics and personalised treatment, aims to improve outcomes for those affected by stroke.

At Montagu Hospital, we introduced a new ultrasound system to support therapy services, improving diagnostic accuracy and treatment planning. In addition, construction began on a new stroke rehabilitation gym, designed to aid recovery and improve quality of life for patients following a stroke.

Finally, we created new employment pathways with the opening of a dedicated healthcare training room. This new space will help local people develop the skills and confidence to take their first steps into a career with the NHS.

January 2025

In January, we took an important step forward in joined-up care with the launch of the Doncaster and Bassetlaw Shared Care Record. This new system allows colleagues to access regional patient information, supporting safer, more co-ordinated care across health and care services.

We also expanded our diagnostic capacity with the opening of a new Imaging Suite at Montagu Hospital. The facility introduced additional CT, MRI, and ultrasound services for the local area, helping to improve access and reduce waiting times.

Virtual Wards continued to grow, enabling more patients to receive safe, supported care at home through remote monitoring and clinical oversight- freeing up hospital beds while maintaining high standards of treatment. Across the financial year, the service cared for more than 2,000 patients across 12 specialities.

At Doncaster Royal Infirmary, we began a new phase of redevelopment, with works starting to improve our Discharge Lounge and Department of Critical Care. These changes are designed to enhance both patient experience and accessibility.

Our focus on education and workforce development was strengthened through a new partnership with Doncaster College, aimed at creating more opportunities for local people to develop careers in health and care.

We paused to remember and pay tribute to Peter Brindley, a valued friend of the Trust who helped to steward the Fred and Ann Green Legacy as executor of the former's will. His dedication and kindness were warmly remembered across DBTH.

At Montagu Hospital, patients recovering from stroke began to benefit from a new music therapy initiative—part of a holistic approach to rehabilitation that supports both emotional and physical recovery.

We also celebrated one year of the Montagu Elective Orthopaedic Centre of Excellence (MEOC), marking 12 months of delivering high-quality, planned orthopaedic care in a purpose-built environment.

February 2025

In February, after a period of service transition we proudly opened the Bassetlaw Emergency Village - a major development bringing emergency, children's, and assessment services together under one roof. Designed to support safe, modern, and integrated care, the new facility represents a significant investment in the future of urgent and emergency services for local people.

We also continued our work in research and innovation by joining a national pilot exploring the role of genetics in stroke care. This study aims to assess how genomics could improve diagnosis and lead to more personalised treatment for stroke patients.

At Montagu Hospital, final preparations were completed for the new Imaging Suite. With team training and equipment commissioning now finalised, the facility is ready to deliver increased diagnostic capacity for the community.

We also went live with the Yorkshire and Humber Care Record, enabling clinicians across the region to securely access shared patient information. This development marks a major step forward in joined-up care, helping to improve safety, reduce duplication, and support more informed decision-making.

Our Skin Integrity Team received national recognition for their work in wound care, having been shortlisted for three awards—an achievement that reflects their commitment to excellence and innovation in preventing and managing pressure ulcers.

Finally, we opened a new £14,000 sensory room, designed to support children with additional needs. This calming and engaging space provides comfort and reassurance for young patients, helping to improve their experience while in our care.

March 2025

In March, we took time to reflect and remember as we marked five years since the start of the COVID-19 pandemic. We paused to honour those we lost and to thank our colleagues for their extraordinary efforts, resilience, and compassion during one of the most challenging periods in NHS history.

We also celebrated a milestone in our ongoing transformation, recognising that since 2020, more than £100 million has been invested in our hospital estate. This record investment is helping us to modernise services, improve environments, and plan for the future.

Our charitable spirit was on full display as we hosted our first-ever charity abseil. Thirty-five brave fundraisers descended 160 feet down, raising over £11,800 for the DBTH Charity and supporting projects that enhance patient care and experience.

A new record was set at the Montagu Elective Orthopaedic Centre of Excellence (MEOC), where five joint replacements were successfully completed in a single day—a first for the region, highlighting the centre's efficiency and exceptional care.

We were also proud to support the NHS on the global stage, as Advanced Nurse Practitioner Eleanor Bull competed in Ironman and ice swimming events for Team GB.

Our stroke genetics pilot advanced further, with 130 participants enrolled and 20 individuals already identified for potentially life-changing treatment. This innovative work is helping to shape the future of personalised care for stroke patients.

Finally, we announced our intention to launch an Electronic Patient Record (EPR) in early 2026, with full implementation completed by late 2027—marking a major step towards safer, more efficient, and joined-up care.

From milestones to strategy

As you can see from the previous section, the past year has seen continued progress across our services—from local innovations and national recognition to collaborative projects and major developments across our sites. These achievements reflect the hard work of colleagues across Team DBTH and our shared commitment to delivering outstanding care.

In the following section, we align further successes to our four strategic priorities - **Patients, People, Partnership and Pounds** - highlighting how they support our long-term ambitions and the DBTH Way.

Strategic Priorities:

Patients - “We deliver safe, exceptional, person-centred care.”

The 2024/25 year has seen significant progress and achievement at Doncaster and Bassetlaw Teaching Hospitals, reflecting our commitment to providing outstanding patient care and improving health outcomes for our communities. Through targeted investment, innovation, and strong clinical leadership, we continued to enhance safety, quality, and experience across our services.

Operational achievements

Emergency care improvements: In March 2025, we achieved 72% against the four-hour standard for Emergency Department performance (76%), a slight decline from the previous 12-month period, which saw 76% both achieved and standard. However, during this time, we saw 11,159 more patients, reflecting the increased demand on services. Continued improvements in urgent and emergency care were supported by the increased use of our discharge lounge, expansion of the Virtual Ward model, and more efficient ambulance handovers. A major milestone was the completion and opening of the Bassetlaw Emergency Village, which not only improved patient flow and experience by consolidating emergency, paediatric, and assessment services under one roof but also brought back overnight inpatient observation for paediatric patients —a first since 2017.

Cancer care advancements: We made continued progress in improving cancer pathways, reducing delays, and meeting the Faster Diagnosis Standard. A new partnership with Macmillan Cancer Support was launched to enhance wraparound care for patients following diagnosis.

Diagnostic and elective care: We expanded our diagnostic capacity with new imaging facilities at Montagu and Bassetlaw hospitals, and saw strong progress in reducing long waits for elective care. The Montagu Elective Orthopaedic Centre of Excellence marked its first full year of operation, with positive outcomes and improved access.

Outpatient service improvements: We achieved a significant reduction in outpatient Did Not Attend (DNA) rates, dropping to just above 7% from a Trust high of 10% a few years ago. This was achieved through the implementation of the NHS App, further collaboration with Dr Doctor, and improved communication to help patients cancel and rearrange appointments more effectively.

Winter period management: Throughout the winter, we maintained safe services with minimal elective cancellations and increased resilience through Virtual Ward, helping patients receive high-quality care at home.

Nursing and Midwifery

Embedding strategic priorities: Following the launch of our Nursing, Midwifery, and Allied Health Professionals (NMAHP) Strategy in late 2023/24, this year marked our first full year embedding its principles into everyday practice. We prioritised improving patient experience, strengthening professional leadership, and nurturing our workforce. Highlights included the launch of our first Visitors' Charter, clearly communicating compassionate and respectful standards for visiting loved ones, reinforcing our commitment to person-centred care.

Safe staffing and responsive care: Throughout 2024/25, we made substantial progress embedding evidence-based safe staffing models across clinical areas, especially during challenging periods, particularly in winter.

Work commenced on safe staffing reporting for Allied Health Professional (AHP) services, with initial focus on Therapies including Dietetics, Occupational Therapy, Orthotics, Physiotherapy, Speech & Language Therapy, and Diagnostic Radiography.

Our Enhanced Therapeutic Observations of Care project, a Trust-wide quality improvement initiative, has launched to improve support for our most vulnerable patients. This initiative will equip colleagues with skills and confidence to deliver compassionate, high-quality care, reinforcing our safety-first culture.

Safeguarding and compassionate practice: We enhanced safeguarding capabilities through team expansion and the introduction of dedicated Domestic Abuse Advisors. These new roles significantly strengthened our capacity to provide trauma-informed, personalised care to vulnerable patients, ensuring their safety and dignity.

Transformative patient safety practices: The successful implementation of the Patient Safety Incident Response Framework (PSIRF) marked a transformative step in our patient safety culture, moving from reactive measures towards a proactive, learning-focused approach. Additionally, the introduction of Patient Safety Partners embedded patient voices directly into our patient safety initiatives, ensuring meaningful involvement in safety improvements.

Maternity excellence: Our maternity services delivered exceptional outcomes this year, meeting all criteria of the Maternity Incentive Scheme (CNST Year 5) we also achieved one of our most successful Registered Midwife recruitment drives to date, demonstrating our commitment to safe and compassionate maternity care.

Professional growth and recognition: Our first cohort of Chief Nurse Fellows successfully completed their programme, developing future nursing and midwifery leaders.

Care Excellence Accreditation: The Trust-wide rollout of our Care Excellence Accreditation Framework began last year, promoting consistent, high-quality standards across inpatient wards. Our focus for 2025/26 is our 'Meal Times Matter' initiative, enhancing patient meal experiences through targeted improvements.

Patient empowerment with Call4Concern: Approval and initial preparations for our patient-led safety escalation initiative, Call4Concern, were completed. Aligned with Martha's Rule, this initiative empowers patients and families to escalate urgent clinical concerns, reinforcing our commitment to responsive, accountable, and patient-centred care.

Celebrating professional excellence: Looking forward, we are proud to host the International Nurses Day (IND) Conference at DBTH on 12 May 2025. With prominent speakers including Professor Michael West and Duncan Burton, Chief Nursing Officer for England, the conference will inspire colleagues, celebrate our professions, and reinforce our commitment to professional excellence and compassionate care.

Quality and Safety

Maintaining safety during disruption: Throughout periods of operational pressures, we prioritised patient safety by successfully implementing flexible, responsive staffing models. These adaptive strategies ensured that critical services remained safely staffed, care was prioritised based on clinical need, and colleagues received clear guidance and support.

Strengthening clinical governance: We enhanced our clinical governance processes by embedding structured job planning and increasing medical appraisal compliance. These improvements fostered greater transparency, accountability, and professional development, contributing to a robust governance culture focused on safety and continuous improvement.

Reducing health inequalities: Our inaugural Health Inequalities Strategy was launched and began influencing key areas such as resource allocation, quality improvement prioritisation, and equity in access. Equity audits, targeted team engagement, and dedicated training were integral to this initiative, embedding health equity into our organisational culture.

Enhancing patient experience: Patient experience was significantly improved through new sensory rooms, specially adapted care environments, and expanded digital tools for managing appointments and communication. These innovations supported patients with additional needs, reducing anxiety and enhancing satisfaction.

Pressure ulcer prevention: We achieved a 64% reduction in Category 2 and above hospital-acquired pressure ulcers, reflecting a multi-year effort to embed prevention into clinical practice. Interventions such as HeelPro offloading devices, enhanced mattress provisions, and StatLock catheter securement significantly reduced skin damage. A comprehensive education programme further boosted clinical knowledge and confidence.

Clinical effectiveness: Divisional Quality Dashboards and structured Effectiveness Highlight Reports significantly improved local governance, enabling teams to quickly identify and respond to performance trends.

Audit and assurance: We maintained full participation in national clinical audits and confidential enquiries, embedding their findings into local quality improvement initiatives. This ongoing commitment has reinforced our dedication to evidence-based, continuously improving care.

People - “We are supportive, positive, and welcoming.”

2024/25 marks the second year of our five-year People Strategy, and we’re proud of the significant progress we’ve made to improve the experiences of our colleagues and continue our journey to becoming an employer of choice.

Our DBTH People Strategy, published in June 2023, sets out how we will develop as an organisation by embedding an inclusive culture and improving the working lives of our people. The strategy is shaped around four key pillars: **‘Looking after our people’**, **‘Belonging in #TeamDBTH’**, **‘Growing for the future’**, and **‘New ways of working and delivering care’**, with defined measures of success across leadership, inclusion, wellbeing, speaking up, recognition and development.

This year’s achievements reflect our commitment to these priorities:

Looking after our people

Health and Wellbeing: We reviewed our wellbeing diagnostic framework, completed a health and wellbeing survey (with support from the Evidence Centre), and aligned findings with existing priorities. We also refreshed our Statutory & Essential Training (SET) resources and launched a wider training framework to support ongoing development.

Occupational Health investment: With approval from the Corporate Investment Group, we strengthened our support offer through investment in additional Occupational Health services, including new mental health nursing roles.

Flexible working: Quality improvement sessions helped us shape new approaches, and we launched a new Flexible Working Policy and toolkit. A steering group is now developing wider action plans around this work.

Staff survey: We achieved a 62% response rate in the 2024 NHS Staff Survey. Results were largely maintained from the previous year, with notable improvements in some areas and clear opportunities to improve in others. These insights, along with learner surveys and exit feedback (now gathered through a new electronic process), are helping us shape further action.

Appraisal Season: Over 90% of eligible colleagues completed an appraisal, with refreshed paperwork and messaging to support high-quality conversations and meaningful development planning.

Research in the workplace: We took part in two major workforce research projects — the IGLOO study, looking at how long-term sickness is managed, and the Magnet study, exploring wellbeing and retention. DBTH was among the top organisations in Europe for enrolling participants into both studies.

Belonging in #TeamDBTH

The DBTH Way: Developed in partnership with colleagues, the DBTH Way sets out how we work together. This year we focused on further embedding it across our organisation through communications, workshops, and integration into recruitment, appraisals, and colleague recognition.

Leadership development: Our 12-month Leadership Prospectus sets out development opportunities for colleagues at all levels. This includes action learning sets, a new coaching network and continued use of the Team Engagement and Development (TED) tool to support team culture.

Equality, Diversity and Inclusion (EDI): We completed another successful cohort of the Board Development Delegate Programme and have recruited for the next. We also continued the Reciprocal Mentoring Programme to support inclusive leadership.

Recognition: Long Service Awards returned in 2024 with a celebratory event recognising colleagues who had reached significant NHS milestones. The 2024 Star Awards also saw record nominations and attendance.

Speaking Up: A new strategy was developed following wide engagement. New implementation tools and training sessions are now helping embed a culture of openness and psychological safety.

Growing for the future

Workforce planning: A new workforce planning tool supported this year's business planning process and our learning needs analysis, helping us better anticipate future gaps and development needs.

Inclusive recruitment: We developed an action plan and continued sharing ideas with other NHS organisations to improve the inclusivity and accessibility of our recruitment.

Preceptorship and early careers: We maintained Gold Standard accreditation for our preceptorship offer, supporting large cohorts of newly registered colleagues as they start their careers.

Widening participation: We increased our work experience placements (including T-levels), maximised our use of the apprenticeship levy, and launched the Health Career Champions programme. Our 'We Care into the Future' events in Doncaster and Bassetlaw were the largest to date.

Pre-registration education: Placement numbers for students and trainees increased by 30% from the previous year, with growth across multiple professional groups.

Succession planning: We introduced the Scope for Growth framework to support career conversations and a new approach to succession planning for leadership roles.

New ways of working and delivering care

Automation and efficiency: Robotic Process Automation (RPA) tools such as the New Starter Bot were introduced to improve accuracy and free up time for teams.

Education quality: A new Education Quality Framework was launched aligned to our Trust and national standards. We also expanded our Role-Specific Training (ReST) offer to help teams develop relevant skills.

Safe staffing: Implementation of SafeCare within our e-rostering system improved our ability to match staffing levels with patient acuity.

Temporary workforce management: We completed a series of audits and projects to improve oversight of agency usage and sickness absence, strengthening planning and governance.

Education and Research

In 2024/25, colleagues at the Trust continued to deliver high-quality education and research, driving innovation and supporting professional development. Key highlights include:

Education Quality Framework: Fully embedded, ensuring education aligns with our People Strategy and national frameworks.

Multidisciplinary training: Comprehensive provision covering Statutory and Essential Training (SET), Role Specific Training (ReST), professional development, and clinical placements.

Maximising funding opportunities: Effective use of the apprenticeship levy, with apprentices comprising 3.5% of our workforce, contributing to strong retention rates.

Anchor partnerships: Strengthened collaboration with local schools and colleges through initiatives like 'We Care Into the Future', engaging over 1,700 students.

Strategic alliances: Formalised partnership with Doncaster College through the Healthcare Education Strategic Alliance, contributing to Doncaster's Education and Skills Strategy 2030.

Clinical placements: Provided over 1,000 placements annually across multiple disciplines including medicine, nursing, midwifery, allied health professions, healthcare science, and pharmacy.

External recognition: Continued positive feedback from external assessments such as NHSE Senior Leaders Engagement (SLE) and the University of Sheffield's Medical School annual review.

Research and Innovation Strategy: Successful delivery of year one of our five-year strategy, aligned closely with our People, Clinical Quality, and Health Inequalities strategies.

Born and Bred in Doncaster (BaBID) research study: Surpassed 2,250 participants by March 2025, advancing maternal and child health research in collaboration with Sheffield Hallam University.

National Institute for Health and Care Research (NIHR) contract performance: Consistently exceeded recruitment and study targets, achieving significant milestones including first European and UK patient recruitment in renal research studies.

Academic and innovation partnerships: Joined INSIGNEO and the South Yorkshire Digital Health Hub, and actively participated in regional Integrated Care Boards.

Public engagement: Expanded our People and Public Involvement (PPI) work through the Doncaster Voices community, ensuring local insight shapes our research priorities.

The Trust remains dedicated to educational excellence and research innovation, actively contributing to regional and national leadership while prioritising the needs of our communities.

Our Staff Survey results

This year, over 4,500 colleagues—62% of Team DBTH—shared their views through the annual NHS Staff Survey, well above the national average response rate. On behalf of the Board of Directors, we would like to thank everyone who took part.

The feedback provided plays a vital role in shaping our workplace and informs our ongoing commitment to the *DBTH Way*—creating a culture where all colleagues feel valued, supported, and empowered to provide outstanding care.

While results showed a dip in some areas, this mirrors wider national trends and follows significant progress made in 2023. Despite this, DBTH continues to perform above the sector average in four of the seven NHS People Promises, and remains close to the benchmark in the remaining three.

What's going well:

- Many colleagues feel their work makes a difference and that career progression is fair.
- The Trust is seen as inclusive, with leaders who respect and support individual differences.
- Learning and development opportunities are widely available and appraisals are taking place.
- Positive relationships with managers are helping support work-life balance and flexible working.

Focus areas:

- Supporting wellbeing and managing workload more effectively.
- Encouraging open feedback and ensuring colleagues feel heard when raising concerns.
- Creating more opportunities for colleagues to contribute ideas and shape improvements.
- Strengthening teamwork, leadership development, and recognising achievements across the organisation.

A full breakdown of the results and ongoing actions is available further on in this report. We remain committed to learning from feedback and continuing to make DBTH the best possible place to work and receive care.

Looking ahead

As we move into the third year of our People Strategy, our focus includes:

- Continuing to embed our strategic priorities across all services
- Further embedding the DBTH Way into everyday interactions and people processes
Delivering year two actions in our Flexible Working and Speaking Up workstreams
- Enhancing how we use feedback to guide change, including through regular survey cycles
- Refreshing and launching our updated induction process, now known as DBTH Welcome

- Increasing work experience placement capacity and continuing to act as an anchor organisation
- Further embedding the Scope for Growth framework and succession planning templates into all departments
- Bringing to a successful conclusion the next cohort of our Board Development Delegate Programme
- Implementing the Safe Learning Environment Charter as an early adopter site

We're proud of the steps we've taken together — and even prouder of the commitment and care shown by colleagues across the Trust. Thank you to every member of #TeamDBTH for your continued support and contributions. Through your work, we are building a culture where people thrive, feel valued, and are proud to belong.

Partnerships - “We work together to enhance our services with clear goals for our communities.”

In 2024/25, Doncaster and Bassetlaw Teaching Hospitals (DBTH) continued to strengthen its partnerships and improve corporate governance. This work has supported joined-up care, robust leadership, and new ways of working with our system partners to deliver the best possible outcomes for our communities.

Working with partners to improve care

- **Montagu Elective Orthopaedic Centre of Excellence (MEOC):** Now fully operational, MEOC marked its first year with a number of key milestones, including setting a South Yorkshire record by completing five joint replacements in a single day, and consistently high-quality surgical outcomes. Delivered in collaboration with Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust, MEOC continues to improve access to elective orthopaedic care across South Yorkshire and Bassetlaw. Over 1,500 people have received surgery at the centre to date.
- **Virtual Ward expansion:** In partnership with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), we expanded our Virtual Ward offer, allowing more patients to receive hospital-level care and monitoring in the comfort of their own homes. In total, more than 2,000 patients were supported by the service across 12 specialties. DBTH is also part of the Paediatric Virtual Ward programme piloted within the Acute Federation, helping to avoid unnecessary admissions and support recovery at home for younger patients.
- **Montagu Community Diagnostic Centre (CDC):** Based at Montagu Hospital, the CDC carried out nearly 4,500 endoscopy procedures this year, with average wait times of just 7–14 days. The service has been praised by patients for its accessibility, same-day results, and welcoming environment. The Centre also achieved JAG accreditation in recognition of its high-quality care.
- **South Yorkshire and Bassetlaw Pathology Partnership:** Pathology services across five acute Trusts - including DBTH - formally came together on 1 April 2024 to form a single networked service. This collaboration improves equity, consistency, and innovation in diagnostics, while offering career development opportunities and sustainable service models.
- **Yorkshire and Humber Care Record:** In early 2025, DBTH fully implemented this digital platform across all services. It provides clinicians with secure, real-time access

to patient information from across the region, enabling faster, safer, and more co-ordinated care.

- **AHP-led innovation in care:** Working with Active Together and Yorkshire Cancer Research, we have developed the role of Allied Health Professionals in the prehabilitation and rehabilitation of cancer patients, working alongside colleagues in Doncaster Culture and Leisure Trust (DCLT) to maximise health before treatment and support optimal recovery post-treatment.

We also implemented a new rotation scheme for newly qualified occupational therapists between DBTH and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). This approach strengthens recruitment and retention in more vulnerable professions and helps streamline patient care across organisational boundaries.

- **Collaborative procurement and mutual aid:** Through participation in system-level initiatives as part of the South Yorkshire Acute Federation, DBTH helped deliver over £1.16 million in savings via collaborative procurement, and supported more than 560 patients to receive elective care faster through mutual aid arrangements across partner Trusts.

You can read more about some of our partnership work via the South Yorkshire Acute Federation's Annual Report for 2024/25:

https://syics.co.uk/application/files/5617/4738/7239/AF_Annual_report_2025_v7.pdf

Pounds: “We are efficient and spend public money wisely.”

The 2024/25 financial year has been marked by strategic financial management and significant investments in infrastructure at Doncaster and Bassetlaw Teaching Hospitals. Below are the highlights from the year under the "Pounds" category, reflecting our commitment to financial sustainability and innovation.

- **Financial Performance:** For the eighth year running, we achieved our financial plan. In September 2024, we alerted colleagues to the fact that, due to ongoing challenges, our financial forecasting suggested a significant deficit without substantial course correction (initial forecast of £50.1 million). We were open and transparent about this, and managed to affect change effectively, coming in on plan.

We delivered a £2.4 million deficit in line with the commitment we made in our financial plan. Additionally and with agreed support from NHS England, we successfully managed our cash flows, ending the year with £41 million cash in hand.

- **Capital Plan Delivery:** We executed a substantial £49 million capital plan, ensuring the continued enhancement and expansion of our facilities and services.
- **Cost Improvement Programme (CIP):** The Trust delivered its £21.2M planned level of efficiency improvement although some of this was through non-recurrent means.

These accomplishments reflect our dedication to maintaining financial health, investing in our infrastructure, and implementing strategies that support both quality improvement and innovation.

Significant changes and developments since 1 April 2025

In April 2025, we extended our mechanical thrombectomy stroke pathway to seven days a week, operating 8am to 6:30pm daily. Delivered in partnership with Sheffield Teaching Hospitals, the service enables rapid, life-saving treatment for patients experiencing large vessel occlusion strokes. The extension marks progress towards our goal of offering 24/7 access by the end of the year.

The same month, we launched *Take C.A.R.E when transferring patients*—a Trust-wide campaign to improve the safety, communication, and consistency of patient transfers. Centred around four steps—Comfort, Alert, Risk Assessment, and Engage—the initiative aims to reduce avoidable incidents and improve experience during what can be vulnerable moments for patients.

Both developments reflect our commitment to safer, more compassionate care across every stage of the patient journey.

Performance overview and analysis in 2024/25

Throughout the year, colleagues at the Trust have concentrated on several key priorities outlined in our Operational Plan, including:

- **Quality and safety:** Enhancing the overall quality and safety of services, particularly in maternity and neonatal care, and reducing health inequalities in line with the Core20PLUS5 approach.
- **Urgent and emergency care:** Improving ambulance response and Emergency Department waiting times by supporting admission avoidance and hospital discharge, and maintaining increased acute bed and ambulance service capacity.
- **Elective care:** Reducing elective long waits and improving performance against core cancer and diagnostic standards.
- **Community and primary care access:** Facilitating easier access to community and primary care services, particularly general practice and dentistry.
- **Mental health services:** Improving access to mental health services to ensure more individuals receive the treatment they need.
- **Staff experience and retention:** Enhancing staff experience, retention, and attendance by implementing elements of the NHS People Promise.

The full Operational Plan for 2024/25 is available at:

<https://www.dbth.nhs.uk/dbth-operational-plan-2024-25/>

In the following sections, we detail our performance in these areas, illustrating our commitment to delivering high-quality, patient-centered care while navigating operational and financial challenges.

Our activity in 2024/25

In the 2024/25 financial year, colleagues at the Trust have demonstrated exceptional dedication and resilience in delivering patient care amidst a particularly busy and challenging period. Notably, March 2025 was recorded as the Trust's busiest ever month for Urgent and Emergency Care services, with 18,629 patients seen, highlighting the growing demand on our services.

During the winter months, particularly in December, we saw a marked increase in activity and acuity levels, a trend that is consistent with broader pressures across the NHS.

The following section provides a comparison of our patient care activities, illustrating the number of individuals treated across emergency, inpatient, and outpatient services, as well as the number of babies delivered.

This data underscores the unwavering commitment of our staff to meet increased demand while maintaining high-quality care standards throughout the year.

It is important to note that as people live longer, we are not only seeing more patients, but also treating more complex episodes of care. Advances in medical treatment and technology mean that more individuals are surviving illness and injury, which in turn increases the demand for both urgent and long-term care. This is reflected in the increasing number of patients we are seeing and the greater complexity of care being provided.

2024/25 Highlights:

- We cared for 209,821 emergency patients.
- We cared for 551,036 outpatient patients.
- We cared for 127,893 inpatient patients.
- We delivered 4,280 babies.

Comparison with 2023/24:

- Emergency patients: +11,159 (+5.6%). Meaning we saw more emergency patients this year compared to last year.
- Outpatients: +39,573 (+7.7%). We saw more outpatients this year, reflecting increased demand for services.
- Inpatients: -3,059 (-2.3%). We saw slightly fewer inpatients this year compared to last year.
- Babies delivered: -292 (-6.4%). The number of babies delivered decreased slightly this year compared to last year.

Site Breakdown (2024/25) per patient contacts:

- Doncaster Royal Infirmary: 594,205 patients
- Bassetlaw Hospital: 208,274 patients
- Montagu Hospital: 85,845 patients
- External Clinics: 4,706 patients

This data reflects the continued dedication of our teams across all sites to provide exceptional care, even as we navigate significant pressures within the healthcare system. We

will continue to adapt and innovate to meet the needs of our communities and ensure we are providing the best possible care for our patients.

Performance analysis 2024/25

As an organisation, we strive to provide timely access to care for all our patients. In this section, you can find a brief summary of our operational performance against a number of national standards, highlighting some of our achievements from the past 12 months.

Urgent and Emergency Care

During 2024/25, average daily attendances to our Emergency Departments were 571, a 5.1% increase compared to the previous year.

In March 2025, 74.8% of our patients were admitted, transferred or discharged from our Emergency Departments within 4 hours from arrival.

Bed occupancy remained high throughout the year, above 92%, and all our available inpatient beds were open during the winter period to support patient flow from the Emergency Department through to a ward.

We have continued to work in collaboration with partners across Doncaster Place during 2024/25 to deliver the Urgent and Emergency Care Improvement Plan, recognising that timely access to urgent and emergency care requires a co-ordinated approach across the health and social care system.

In February 2025 we opened Bassetlaw Emergency Village which increases the emergency department capacity and provides facilities for paediatric patients to be observed at Bassetlaw Hospital rather than being transferred to Doncaster Royal Infirmary.

Elective Care

Our focus in 2024/25 has been to continue to reduce the number of patients experiencing long waiting times, following the COVID-19 pandemic and backlog created as a result.

By March 2025 we had virtually eliminated the longest waiting times in all but two specialties. In total we had 146 patients at the end of March 2025 waiting over 65 weeks.

In February 2025, 60.5% of our patients were treated within 18 weeks from referral, compared to 59.3% nationally.

- Diagnostics Waiting Times and Activity – 78.95% (March Performance)
- Cancer Faster Diagnosis Standard (FDS) – 81.4% (Full Year)

Diagnostics

During the year we have made improvements to reducing our waiting times in a number of our diagnostics tests.

Cancer

The number of urgent suspected cancer referrals has remained high throughout 2024/25 yet we achieved our plan to reduce the number of people waiting over 62 days on a cancer pathway by the end of the year.

We have consistently delivered the 28-day faster diagnosis standard, ensuring the majority of patients are diagnosed, or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. In February 2024/25, we achieved the faster diagnosis standard for 81.4% of our patients.

Looking ahead in 2025/26

Our Operational Plan for 2025/26 has been developed through careful analysis of our performance in the previous year, alongside our strategic priorities and long-term ambitions.

Colleagues across the Trust have contributed to shaping this plan, ensuring it addresses the areas most important to our patients, communities, and teams.

In the coming year, our key areas of focus will include:

Quality and safety: Continuing major quality improvement initiatives, fully delivering the Ockenden recommendations in maternity care, and appointing patient safety partners to enhance our governance arrangements.

Reducing health inequalities: Embedding targeted support for underserved communities through enhanced prevention programmes, partnership working, and dedicated training frameworks.

Urgent and emergency care: Improving performance in our emergency departments by reducing ambulance handover delays, expanding same-day emergency care, and working towards achieving the national four-hour standard by March 2026.

Elective recovery: Reducing elective waiting times by streamlining outpatient processes, maximising capacity—including through Community Diagnostic Centres—and achieving the 18-week elective care standard.

Diagnostics: Expanding diagnostic capacity with the opening of a new imaging suite at Montagu Community Diagnostic Centre, further enhancing patient access and turnaround times.

Workforce development: Strengthening workforce planning, embedding flexible working practices, improving colleague wellbeing, and addressing workforce inequalities to boost retention and satisfaction.

Financial sustainability: Delivering targeted efficiency programmes, closely managing income and expenditure, and aligning capital investment strategically to support sustainability.

Digital transformation: Accelerating our digital maturity by enhancing electronic patient records, expanding robotic process automation, and leveraging digital tools to improve patient experience and operational efficiency.

System collaboration: Deepening our collaboration with local Integrated Care Boards, Place partnerships, and other NHS providers to optimise patient pathways, especially within cancer services, elective orthopaedics, community paediatrics, and urgent care.

Our Operational Plan for 2025/26 will be available on www.dbth.nhs.uk

Investment and infrastructure

Capital investment and estate development

Over the past few years, the Capital Planning Unit - part of the Directorate of Infrastructure, Estates and Facilities - delivered over £100 million in estate modernisation projects across DBTH.

In 2024/25, this work continued at pace, with £49.8 million invested in capital infrastructure. This included a combination of Operational and Public Dividend Capital (PDC) funding. As noted on the Trust website, we are proud of the capital investments that have directly contributed to improved patient care and the creation of high-quality facilities.

Project highlights from 2024/25 include:

- **Montagu Hospital:**
 - Completion of **Phase 3 of the Community Diagnostic Centre (CDC)** in February 2025. This new standalone facility houses CT, MRI and Ultrasound services, supported by upgraded high and low voltage substations to meet the increased electrical demand. This milestone concludes a multi-year, £26.2 million redevelopment programme at Montagu.
 - A new **stroke rehabilitation gymnasium suite**, opening early in the new financial year. Part of a wider £1.4 million investment, it features cutting-edge robotic equipment and virtual reality tools to support advanced therapies and stroke recovery.
- **Doncaster Royal Infirmary:**
 - A **£19.8 million redevelopment programme** is underway to relocate the Department of Critical Care (DCC) and refurbish key areas, including the Surgical Same Day Emergency Care (SSDEC) unit and Discharge Lounge.
 - The current Discharge Lounge is being transformed into the new SSDEC, with the lounge itself relocating to the former Hydrotherapy department. These works began in 2024/25, with completion expected in spring 2025. The new DCC facility will follow in summer 2026.

- **Bassetlaw Hospital:**

- In February 2025, a **new state-of-the-art complex** the Bassetlaw Emergency Care Centre opened, housing the Emergency Department, Children's Assessment Unit, and Acute Medical Unit. Located at the front of the hospital, the development features calming, patient-friendly environments, including single rooms with ensuite bathrooms, motion-activated lighting, and improved access routes.
- Surrounding infrastructure has also been upgraded, with reconfigured ambulance routes, additional parking (including Blue Badge spaces), and landscaped areas to promote wellbeing. A secure children's play area is also being installed.
- Public Dividend Capital for this scheme totalled £17.6 million, with the Trust funding the remaining amount—bringing the total cost, including the earlier Radiated, Aerated, Autoclaved Concrete (RAAC) scheme (which won the 2023 *Building Better Healthcare* award for Estates & Facilities Team of the Year), to £41.5 million.

- **Additional developments:**

- An additional **CT scanner at Bassetlaw**, funded by PDC, is being delivered at a cost of £1.15 million and completed in late spring 2025.
- At DRI, earlier capital schemes completed in previous years include modular theatres and inpatient wards, as well as a new Central Delivery Suite and Triage area in the Women's and Children's Hospital.

Throughout the year, our focus has remained on delivering large-scale, complex PDC schemes, alongside smaller projects critical to clinical operations, business continuity, and accreditation standards.

These projects align with the capital strategies developed by the Integrated Care Boards in South Yorkshire and Nottingham and Nottinghamshire. We continue to work closely with Place partnerships in Doncaster and Bassetlaw to ensure our investments are meeting local needs.

Key operational capital schemes in 2024/25 included:

Electrical infrastructure (Phase 4c) – £1,784,281 - Replacement of high-voltage (HV) and low-voltage (LV) switchgear and transformers within the East Ward Block at Doncaster Royal Infirmary (DRI).

Fire precaution works – £932,164 - Fire safety improvements across Doncaster Royal Infirmary, Bassetlaw Hospital, and Montagu Hospital, including upgrades to Ward M1 at DRI.

Lift refurbishment – £172,638 - Upgrade to the pharmacy lift at Doncaster Royal Infirmary.

Minor works (Care Quality Commission, Patient-Led Assessments of the Care Environment, staff accommodation) – £142,660 - Upgrades to staff areas and communal spaces, including refurbishment of D Block and changing facilities at DRI.

Estates management – £26,092 -Includes six-facet condition surveys and updates to the MiCAD (Management Information Computer Aided Design) system.

Divisional priorities – £573,483 -Infrastructure works aligned with annual planning across clinical and non-clinical divisions.

Audiology – £541,347 -Upgrades to the Audiology estate to improve accessibility and service delivery.

Roads and car parks – £94,274 - Health and safety improvements to roads and car parking facilities across Trust sites.

Data cabinet improvements – £84,629 -Risk reduction works in data cabinet locations to address issues such as overheating and inappropriate access.

Security and lighting – £96,965 -Upgrades to security systems and lighting, including installation of new closed-circuit television (CCTV) across multiple sites.

Control of Legionella bacteria – £65,979 - Ongoing upgrades to mitigate water safety risks, including removal of dead legs and storage vessel upgrades.

Asbestos abatement – £48,353 -Safe removal or encapsulation of asbestos identified on the Trust's asbestos register.

East Ward Block cold water tank replacement – £186,079 - Replacement of the main cold water supply tank serving the East Ward Block at DRI.

Bassetlaw boiler replacement – £162,570 - Replacement of three out of five main boilers serving Bassetlaw Hospital.

Trust-wide nurse call system upgrade – £162,627 - Replacement of outdated nurse call systems across multiple inpatient wards.

Refrigeration and heat exchanger upgrades (DRI) – £110,017 - Replacement of refrigeration systems and installation of plate heat exchangers to reduce water storage and associated Legionella risk.

Women's and Children's roof upgrade (DRI) – £707,470 - Replacement and upgrade of the roof membrane for the Women's and Children's Hospital at Doncaster Royal Infirmary.

Space utilisation works – £161,978 - Office reconfigurations across sites to support evolving service and operational needs, as directed by the Space Utilisation Group.

Bassetlaw Same Day Emergency Care (SDEC) – £972,078 - Refurbishment of the former Accident and Emergency (A&E) department following the relocation to the new Emergency Department, creating a dedicated Minor Injuries and Same Day Emergency Care facility.

A note on the future of Doncaster Royal Infirmary

In last year's Annual Report, we shared an update on our long-term plans to improve and modernise Doncaster Royal Infirmary (DRI). While the Trust's bid to secure funding for a new hospital was unsuccessful in May 2023, we remain committed to delivering meaningful improvements to the site and are actively pursuing an ambitious refurbishment programme.

We are pleased to report progress towards the proposed relocation of the Department of Critical Care to a new, purpose-built facility on the ground floor of the site. While plans remain subject to funding approval, this development represents a key milestone in our vision for a safer, more modern DRI.

In early 2025, we welcomed the Minister for Health, Karyn Smith, to the hospital to outline the challenges facing our estate and to discuss the critical need for investment. We will continue to work closely with the Government and our partners to advocate for Doncaster and secure the resources needed to fulfil our long-term ambitions.

The proposed improvements focus on four key areas of the site, targeting infrastructure risks and areas with the greatest impact on patient care—particularly for our most acutely ill patients. If approved, the works would also address around 50% of the current maintenance backlog, estimated at approximately £50 million.

The proposed programme includes:

- **Relocation of the Department of Critical Care to the ground floor** – Providing modern, accessible facilities for the most unwell patients and enabling further redevelopment of the East Ward Block.

- **Construction of a new ward block** – Located in front of the East Ward Block, this would modernise clinical accommodation and improve patient flow.
- **Installation of two new modular theatres** – To maintain surgical capacity during refurbishment of the existing theatre suite.

Once enabling works are complete, further developments could include:

- **Full refurbishment of the East Ward Block** – Modernising inpatient facilities and clinical environments within the main tower block.
- **Full refurbishment of the Women's and Children's Hospital** – Enhancing care environments for women, babies, and families.
- **Creation of additional on-site car parking and staff accommodation** – Improving accessibility and colleague experience.

If approved, the full programme would be delivered in multiple phases at an estimated total cost of £360 million. While funding has not yet been secured, these proposals represent a clear, deliverable vision for the future of Doncaster Royal Infirmary—ensuring we can continue to provide outstanding care in facilities that match the quality of our services.

The full plan can be viewed at: www.dbth.nhs.uk/dri-refurbishment-plan

Sustainability and the Trust's Green Plan

The NHS has set an ambitious target to become the world's first net zero national health service, aiming to achieve net zero for directly controlled emissions (*NHS Carbon Footprint*) by 2040, and for emissions it can influence (*NHS Carbon Footprint Plus*) by 2045.

As one of the largest employers in Doncaster and Worksop, operating across three major sites, we acknowledge the significant environmental footprint created by our activities—through carbon emissions, air pollution, and the waste we generate.

In recognition of this, and in support of the NHS' net zero ambitions, the Trust has outlined its sustainability strategy in the *Green Plan*, available here:

www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy

Throughout 2024/25, we continued to make progress against the objectives set out in the Green Plan. Highlights include:

Carbon reduction: Following the 2024 carbon footprint assessment, we are pleased to report an estimated reduction of approximately 6,550 tonnes of carbon dioxide equivalent (tCO₂e) since the launch of the Green Plan—demonstrating our commitment to sustainability and reducing our environmental impact.

Sustainable developments: Major new facilities, including the Montagu Elective Orthopaedic Centre of Excellence (MEOC), the Bassetlaw Emergency Village (BEV), and the Montagu Community Diagnostic Centre (CDC), were designed with low-carbon technologies, decarbonised heating systems, and renewable energy generation—ensuring they are sustainable, modern clinical environments for patients, staff, and visitors.

Renewable electricity: We maintained our commitment to procuring 100% clean, renewable electricity to power our buildings and services.

Green Flag recognition: The memorial gardens at Doncaster Royal Infirmary and Bassetlaw Hospital once again received Green Flag Awards, recognising their positive contributions to biodiversity and wellbeing. Restoration work was also completed on the memorial garden at Montagu Hospital, which is now scheduled for Green Flag assessment in 2025.

Anaesthetic gas emissions: We continued work to reduce the environmental impact of volatile anaesthetic gases and nitrous oxide, including the active removal of piped nitrous oxide infrastructure across all sites.

LED lighting expansion: Energy efficiency improved through the continued rollout of LED lighting, helping to reduce electricity consumption across the estate.

Waste reduction: Our commitment to sending zero waste to landfill remains in place. Improved waste management practices avoided nearly 90 tCO₂e in emissions this year.

Clinical sustainability initiatives: Service-led efforts continued to grow, including a Greener Theatre Group, sustainability improvements in Endoscopy, and a Greener Dialysis initiative—reducing emissions in dialysis services by approximately 4,000 kgCO₂e per year.

Looking ahead, we plan to install electric vehicle (EV) charging points at each of our sites in 2025 and will expand on-site renewable energy generation at Doncaster Royal Infirmary through the installation of additional solar panels.

In 2025, we will also refresh our Green Plan to set out updated objectives for the next three years, aligned with national guidance from NHS England.

Through these actions, we remain committed to reducing emissions, improving environmental sustainability, and contributing to a healthier, more resilient healthcare system - supporting our vision of *“Healthier together – delivering exceptional healthcare for all.”*

The Trust’s Task Force on Climate-Related Financial Disclosures (TCFD) can be found further on within the report.

Health inequalities

Doncaster and Bassetlaw Teaching Hospitals (DBTH) is committed to embedding the reduction of health inequalities in all aspects of our work.

In March 2024, we launched our inaugural Tackling Health Inequalities Strategy, approved by the Trust Board in November 2023. This strategy aligns with national and local plans and outlines six priority areas: <https://www.dbth.nhs.uk/tackling-health-inequalities/>

Prevention: Collaborating with the Healthy Hospital Programme Team, we are reviewing data through a health inequalities lens. Additionally, we are involved in developing an alcohol care team for DBTH, co-ordinated by our Integrated Care Board (ICS) colleagues.

1. **Elective Care Pathways/Recovery:** We have contributed to the review of the Access Policy to ensure health inequalities are considered. Plans are underway to address Did Not Attend (DNA) rates and assess the impact of the Montagu Elective Orthopaedic Centre of Excellence (MEOC) on health inequalities.
2. **Urgent and Emergency Care pathways:** A project is planned to examine high-intensity users in urgent and emergency care and the effectiveness of initiatives like Making Every Contact Count.
3. **Maternity and best start in life:** Efforts are focused on strengthening relationships with maternity colleagues to support existing work related to health inequalities.
4. **Children and young people:** We aim to build relationships with paediatric teams to support initiatives addressing health inequalities among younger populations.
5. **Research and Innovation:** As of February 2024, Dr. Kelly Mackenzie has taken on a joint role as Clinical Senior Lecturer at the University of Sheffield and Honorary Consultant in Public Health at DBTH. Plans are in place to develop research projects explicitly targeting health inequalities.

These priorities are supported by a foundation and five pillars:

Foundation: Enhancing communication, awareness, and education on health inequalities for staff, patients, and the community. A training matrix has been developed, including:

1. *Baseline Training:* Completion of Statutory and Essential Training (SET) with initial health inequalities input via the Equality, Diversity, and Inclusion (EDI) module.
2. *Level One:* In-depth understanding through e-learning modules accessible to all staff.

3. *Level Two*: A package developed by the Health Inequalities Team to help participants identify relevant health inequalities, piloted with two teams and planned for wider rollout.
4. *Level Three*: Currently under development, this training will provide a step-by-step guide on addressing identified health inequalities, closely linked to the Quality Improvement (QI) approach.

Pillars:

Understanding our communities: Ensuring access to timely population health data and incorporating community voices to better understand and address health inequalities.

Connecting people: Collaborating with partners to align efforts and prevent siloed working, adopting a whole-system approach.

Model of delivery: Transitioning to a needs-led, compassionate social model of care, utilizing co-production to improve or develop services based on community needs.

Access to and experience of services: Focusing on the Core20PLUS5 approach to provide targeted support for specific groups, ensuring equitable access and experiences.

Leadership and accountability: Establishing strong leadership and clear governance structures to embed health inequalities considerations throughout the organisation.

To support the delivery of our strategy, we have introduced a three-tier framework guiding efforts to:

1. Increase support or develop new services focusing on prevention.
2. Improve existing services.
3. Influence the wider determinants of health in our role as an Anchor Institution.

In November 2023, NHS England published its first Statement on Information on Health Inequalities, outlining data collection and reporting requirements for NHS bodies. In response, we have provided a supplement alongside our Annual Report summarizing these data. While we have presented most of the requested data, some external data source access issues remain.

The key takeaway is the variability across demographics such as deprivation, ethnicity, age, and gender. As a Trust, we recognise the need to routinely break down activity data by these demographics and understand the broader population context to identify and address over- or under-representation.

At DBTH, we believe that factors like ethnicity, or place of birth should not determine access to healthcare. The launch of our Tackling Health Inequalities Strategy provides a clear plan to

progress this work and ensures collaborative efforts with partner organisations to address broader health inequalities challenges.

The Trust's full Health Inequalities Strategy can be viewed:

<https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/>

Financial performance

NHS England has directed that foundation trusts' financial statements must comply with the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM), as agreed with HM Treasury.

Our financial statements have been prepared in accordance with the 2024/25 FT ARM and adhere to International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual, to the extent that these are meaningful and appropriate to NHS Foundation Trusts. Accounting policies are applied consistently to items considered material in relation to the accounts.

This marks the fifth year that the accounts of the Trust's charitable funds, and the Wholly Owned Subsidiary have been consolidated with the accounts of the Foundation Trust to produce 'group' accounts, in line with the guidance above. The comments below refer to the financial performance of the Foundation Trust, with separate annual reports for both the Charity, and the Wholly Owned Subsidiary (Doncaster and Bassetlaw Healthcare Services Ltd) to be published at a later date.

2024/25 in Review

In a year marked by increasing elective and non-elective treatments, rising inflation, industrial action, and staffing challenges, the financial performance of the Trust has reflected these pressures.

Clinical Income: The Trust's clinical income increased by £64.8 million in the year, as it received additional funds to support increased clinical activity, and inflationary cost pressures within the sector.

Overall Deficit: The Trust reported an overall deficit of £32.4 million, which includes £32 million of impairments resulting from the annual valuation exercise. Excluding these and other technical adjustments, the Group's deficit stands at £2.4 million (compared to a £23.7m deficit in 2023/24). This position was in line with the planned deficit for the year.

Summary of Financial Performance: Detailed in the annual accounts, the key financial metrics are as follows:

- **Working Capital:** Cash balances held by the Trust as of 31 March 2025 were £40.9 million (31 March 2024: £36.3 million).
- **Loan Repayments:** The Trust made loan repayments of £0.5 million during the year (2023/24: £1.8 million).
- **Public Dividend Capital (PDC) Dividend:** A charge of 3.5% of average relevant net assets is payable to the Department of Health as a PDC dividend. The dividend payable in 2024/25 was £7.6 million (2023/24: £7.6 million).
- **Income:** The Trust received a total income of £641 million in 2024/25, an increase of £73 million from the previous year.
- **Revenue Expenditure:** Operating expenses for the year totalled £668 million, a £38 million increase from the previous year. The majority of expenditure was on pay budgets (staffing) at £420.5 million (increase of £35.3m compared to 2023/24, with nursing and medical staffing being the largest areas of expenditure).
- **Capital Expenditure:** Expenditure on larger items with a lifespan of more than one year, such as buildings and equipment, was £49 million, of which £27.8 million was funded by the Department of Health and Social Care, primarily for estate improvements. Major areas of capital expenditure included:
 - Critical Infrastructure: £10 million
 - Community Diagnostic Centre: £6.3 million
 - Digital Transformation: £8.6 million.

Joint Forward Plans and Capital Resource Plans

At the start of the 2024/25 financial year, the Trust agreed on its capital plan with the South Yorkshire Integrated Care System (ICS) and partners. Throughout the year, the Trust engaged with the ICS and its partners to deliver the jointly agreed capital plans.

Additionally, the Trust's business planning process was conducted in conjunction with Place and ICS-based partners to ensure alignment. This planning included setting out how the system would meet national planning guidance expectations and defining each organisation's role. The Trust actively participated in developing the One Doncaster Plan, which outlines key priorities at Place for the next five years.

As an organisation, we are also an active partner in developing the Joint Forward View Five Year ICS plan, ensuring all our corporate strategic plans and strategies align with the ICS and Place initiatives

Principal risks, opportunities and uncertainties and factors affecting future performance

The Trust has identified several principal risks and opportunities that may impact the achievement of our strategic objectives:

Focusing on patients awaiting treatment:

Addressing the backlog of patients awaiting treatment remains a priority. We are collaborating with Place and system partners to enhance care delivery and reduce waiting times, aligning with the government's strategic shifts towards community-based care, preventive measures, and digital integration.

Delivering our financial plan and efficiency programs:

While a comprehensive budget-setting process has been undertaken, risks such as unanticipated demand growth may affect financial performance. We are committed to implementing cost reduction and efficiency plans to mitigate these challenges.

Ensuring appropriate estates infrastructure:

A significant portion of our estate dates back to the 1960s and requires substantial investment to meet legal requirements and maintain a safe environment. In 2024/25, our Capital Programme focused on safety improvements. We continue to seek additional funding for further developments, particularly at Doncaster Royal Infirmary.

Workforce availability and agency cap management:

Recruiting, retaining, and developing sufficient clinical staff remains a challenge. We are exploring innovative programs, leveraging our teaching hospital status, and increasing international recruitment. Efforts to reduce reliance on agency staff are ongoing, supported by robust governance structures.

Additional risks:

Other risks include cyber attacks, patient harm, critical lift failures, and compliance with standards, all of which have mitigation strategies in place.

Opportunities in 2025/26:

We are embracing the government's three strategic shifts in health and care:

- **From hospital to community care:** By aiming to relocate services to community settings, such as high street locations, we aim to make healthcare more accessible and address health inequalities.
- **From analogue to digital:** Implementing digital solutions, including an Electronic Patient Record system, will enhance care delivery and operational efficiency.
- **From treatment to prevention:** Focusing on preventive measures will improve population health outcomes and reduce the burden on acute services.

Additionally, we are exploring the use of artificial intelligence to support innovative and effective ways of working, enhancing patient care and operational efficiency.

Through strong partnerships within our Integrated Care System and Place partners, we aim to implement these strategic shifts, enhancing care delivery and addressing health inequalities within our communities.

Going Concern

These accounts have been prepared on a going concern basis.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the South Yorkshire Integrated Care System (ICS).

The ICS has stated its immediate strategic plans, focusing on delivering the objectives set out in NHS England's 2025/26 priorities and operational planning guidance, and its response to the NHS long-term plan. The ICS plans assume the continued provision of services by the Trust. No circumstances were identified causing the Directors to doubt the continued provision of NHS services. The ICS plans align activity, workforce, mental health and capital submissions and fully account contracting arrangements.

No circumstances were identified causing the directors to doubt the continued provision of NHS services.

This year, with an adjusted performance deficit of £2.4m, the Trust performed in line with its plan. This position recognises a significant level of financial and operational efficiencies that have been achieved in the year.

The Group has reported a cash position at 31 March 2025 of £42.2m, which includes a capital creditors balance of £27.7m. The underlying cash challenge is expected to continue into 2025/26 and for the remainder of the going concern period to 30 June 2026.

For 2025/26, the Trust submitted a break-even financial plan to NHS England. This is based on a significant level of expected financial efficiencies, in the region of 6% of overall expenditure. These financial efficiencies are still being worked upon and represent an element of risk for the Trust.

Should these efficiencies either not be achieved, or achieved in a non-cash releasing way, the Trust may have to utilise the financing facilities offered by the Department of Health and Social Care, as it has done in previous years.

NHS operating and financial guidance is not yet issued for 2026/27, and so the Trust has based its assessment for the first quarter of 2026/27 on the same assumptions used to build the 2025/26 financial plan. Key assumptions include:

- A continuation of income and expenditure flows and performance in line with 2025/26 plans
- A continued need to deliver financial efficiencies

In conclusion, these assumptions, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

A handwritten signature in dark ink, appearing to read 'Richard Parker', followed by a period.

Richard Parker OBE
Chief Executive
30 June 2025

Accountability Report

Welcome to the Accountability Report section of DBTH's Annual Report. This section outlines the composition of our Board, details on remuneration, and an overview of our staffing and oversight committees.

We aim to provide transparency and insight into the governance and workforce that drive our Trust forward. Thank you for your interest in our commitment to accountability and excellence.

A handwritten signature in dark ink, appearing to read 'Richard Parker', with a stylized flourish at the end.

Richard Parker OBE
Chief Executive
30 June 2025

Directors' Report

The Board of Directors at Doncaster and Bassetlaw Teaching Hospitals (DBTH) is responsible for setting and advancing the Trust's strategic direction. Comprising both Executive and Non-Executive Directors, the Board develops and monitors strategic aims, ensuring performance aligns with key objectives and indicators.

Collectively, the Board reviews and challenges reports to fulfill its responsibilities and provide assurance to the Council of Governors. The composition is designed to balance the skills and experience of both Executive and Non-Executive Directors, with ongoing assessments throughout the year and during any director-level vacancies. The Trust's constitution allows for slight variations in numbers as needed, maintaining a majority of Non-Executive Directors.

A strong unitary Board is fundamental to the Trust's success. Its effectiveness is closely monitored by the Governors, who hold the Non-Executive Directors, and through them, the Board, accountable. The Board continually evaluates its performance through individual and collective appraisals, ultimately answering to the Council of Governors on behalf of the Trust's members.

Composition of the Board

During 2024/25, the following persons were members of the Board of Directors:

Name	Position	Length of service at 31 March 2025	Term of office from	Attendance at Board meetings
Suzy Brain England OBE	Chair of the Board	8 years 3 months	1.1 2017	6 of 6
Mark Day	Non-Executive Director (Senior Independent Director)	2 years and 11 months	1.5.2022	2 of 6
Kath Smart	Non-Executive Director	7 years	1.4.2018	5 of 6
Mark Bailey	Non-Executive Director	5 Years 2 months	1.2.2020	5 of 6

Hazel Brand	Non-Executive Director	2 years 9 months	1.7.2022	6 of 6
Joanne Gander	Non-Executive Director	2 years 9 months	25.7.2022	5 of 6
Dr Emyr Jones	Non-Executive Director	2 years 1 month	20.2.2023	6 of 6
Lucy Nickson	Non-Executive Director	2 years 1 month	1.3.2023	6 of 6
Richard Parker OBE	Chief Executive			5 of 6
Zara Jones	Deputy Chief Executive			6 of 6
Zoe Lintin	Chief People Officer			5 of 6
Karen Jessop	Chief Nurse			5 of 6
Jon Sargeant	Chief Financial Officer			5 of 5
Sam Wilde	Chief Finance Officer			2 of 2
Denise Smith	Chief Operating Officer			5 of 6
Dr Nick Mallaband	Acting Executive Medical Director			6 of 6

All Non-Executive Directors are considered independent in accordance with the criteria set out in NHS England's Code of Governance.

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

The Chair of the Board's other principal commitment is as Chair of Keep Britain Tidy. She also serves as the Chartered Directors Lead Examiner for the Institute of Directors and was co-opted to the Board of Doncaster Chamber of Commerce in 2017/18.

In 2023/24, the Trust introduced *Scope for Growth*, a succession planning tool designed to support inclusive talent development. This approach was further embedded during 2024/25, helping to identify and nurture individuals with the potential to progress into leadership roles. Alongside this, we ran a successful cohort of the *Board Delegate Programme*, encouraging colleagues from diverse backgrounds to consider and prepare for senior and Board-level positions.

In addition, the Board participated in a number of development days throughout the year, with sessions focused on specific topics and strategic planning to support continuous improvement and effective leadership.

Balance of the Board

Non-Executive Directors are appointed to bring specific skills, knowledge, and perspectives to the Board, ensuring a balanced, comprehensive, and effective membership.

The Board of Directors considers the range and depth of skills and experience among its members to be appropriate and well aligned to the strategic and operational needs of the Trust.

Brief details of all Directors who served during 2024/25 are as follows:

Chair of the Board (as of 31 March 2025):

Suzy Brain England OBE C.Dir is an experienced board chair, Non-Executive Director, consultant, mentor, and counsellor. She currently serves as Chair and Trustee of Keep Britain Tidy, sits on the Institute of Directors' Accreditation and Standards Committee, and is the founder of Cloud Talking mentoring services. Suzy brings extensive board-level experience across sectors including health, housing, enterprise, and finance.

Awarded an OBE for public service—particularly for her role as Chair of the Department for Work and Pensions' Decision Making Standards Committee—Suzy began her career as a journalist and was previously Chief Executive of the Earth Centre in South Yorkshire.

Non-Executive Directors (as of 31 March 2025):

Joanne Gander is a retired registered nurse with extensive experience across health and care systems, most recently serving as Director of Clinical and Product Assurance at NHS Supply Chain. She has held senior roles at NHS England and North East Lincolnshire Care Trust Plus. As Clinical Non-Executive Director, Jo chairs the Quality Committee and serves as one of the Trust's Maternity and Neonatal Safety Champions. Her focus is on patient safety and ensuring consistently high-quality care experiences.

Kath Smart became Deputy Chair in February 2023 and brings significant public sector expertise. A Doncaster resident and CIPFA-qualified accountant, Kath has held senior roles within the NHS, local government, and housing. She currently chairs Acis Group and serves as a Non-Executive Director with various organisations. At DBTH, she brings strong financial oversight and governance experience, having previously chaired the Audit Committee at RDaSH.

Mark Bailey joined DBTH as a Non-Executive Director in February 2020. A former Group Director at Rolls-Royce plc, Mark has over 30 years of private sector experience in business growth, digital transformation, and customer service. He chairs the Trust's People Committee and Doncaster and Bassetlaw Health Care Services Ltd. He also serves as a Non-Executive Director at Derbyshire Community Health Services NHS FT and is a Visiting Fellow at Cranfield University.

Mark Day is a Chartered Director with executive leadership experience in NHS finance and estates, including as Chief Operating Officer of a £2.5 billion national property company. A

former employee of Doncaster Health Authority, he now works as a healthcare business consultant and serves as an independent lay member on Cornwall Council's Audit Committee. Mark is the Trust's Senior Independent Director. Mark departed the Trust in March 2025.

Hazel Brand is a former Lead Governor and Head of Communications at DBTH. Originally trained as an Occupational Therapist, Hazel moved into health journalism and later communications, supporting the Trust through major changes for nearly two decades. Since retirement, she has served on Bassetlaw District Council and holds the Non-Executive lead for Freedom to Speak Up at the Trust.

Dr Emyr Wyn Jones is a retired Consultant Physician in Diabetes and Endocrinology who worked at Doncaster Royal and Mexborough Hospital NHS Trust for 24 years. He has held senior clinical and executive roles and contributed nationally as a Medical Advisor to the National Audit Office and Clinical Lead at NHS Digital. At DBTH, he is a Clinical Non-Executive Director, Deputy Chair of the Quality Committee, and a Maternity and Neonatal Safety Champion.

Lucy Nickson is a registered nurse with a career spanning over 30 years in both NHS and charitable healthcare sectors. She has held senior leadership roles in end-of-life care, community nursing, and performance management across the East Midlands. Currently Chief Executive of Day One Trauma Support, Lucy brings deep expertise in patient-centred care, charity leadership, and service development.

Executive Directors (as of 31 March 2025):

Richard Parker OBE, Chief Executive, was appointed in January 2017 after serving as Director of Nursing, Midwifery and Quality. Since qualifying as a nurse in 1985, Richard has held several senior NHS roles including Chief Operating Officer at Sheffield Teaching Hospitals. He holds an MBA in Health and Social Services and was awarded an OBE in 2018 for services to health and social care.

Jon Sargeant, Chief Finance Officer, joined the Trust in 2016. He served as Deputy Chief Executive and Executive Director for Recovery, Innovation, and Transformation until early 2023. Jon retired in January 2025.

Dr Tim Noble, Executive Medical Director, joined DBTH in 2006 as a Consultant Respiratory Physician and has held multiple leadership roles including Deputy Medical Director. He was appointed Medical Director in March 2020. During 2024/25, Dr Nick Mallaband acted as Executive Medical Director.

Dr Nick Mallaband, Acting Executive Medical Director, joined DBTH as a Consultant in Acute Medicine in 2011, playing a key role in developing the service across both sites. He has since held senior roles including Divisional Director and Medical Director of Workforce. Appointed to his current role in 2023, Nick has a strong interest in acute care, education, and digital transformation.

Zoe Lintin, Chief People Officer, was appointed in June 2022. A Fellow of the Chartered Institute of Personnel and Development (CIPD), Zoe brings a strong background in HR, OD, and leadership development. She also holds regional and national roles with HPMA and CIPD and is a qualified coach and accredited mediator.

Denise Smith, Chief Operating Officer, was appointed in January 2023. She has more than 25 years of NHS experience across primary and secondary care, including as Chief Operating Officer at The Queen Elizabeth Hospital, King's Lynn.

Karen Jessop, Chief Nurse, joined the Trust in January 2023. Previously Deputy Chief Nurse at Sheffield Teaching Hospitals, Karen has over 25 years of nursing and midwifery experience. She holds a Master's degree in Health Care Leadership and has a background in critical care and surgical services.

Zara Jones, Deputy Chief Executive, was appointed in October 2023. She previously served as Executive Director of Strategy and Planning at Derbyshire ICS, overseeing acute, community, and mental health portfolios. Zara brings experience in strategic leadership, commissioning, and partnership working.

Sam Wilde, Chief Finance Officer, joined DBTH in late 2024 from Lincolnshire Community Health Services NHS Trust, where he was Director of Finance and Business Intelligence. A Chartered Management Accountant with an MBA, Sam brings senior financial experience from both the NHS and private sector. His role covers finance, estates and facilities, IT and digital transformation, and the Project Management Office.

Registers of interests

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

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

Cost allocation and charging

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

Donations

The Trust made no donations to political parties or other political organisations in 2024/25 and no charitable donations in 2024/25.

Better Payments Practice Code

The Trust has adopted the Public Sector Payment Policy, which requires the payment of non-NHS trade creditors in accordance with the CBI prompt payment code and government accounting rules. The target is to pay these creditors within 30 days of receipt of goods or a valid invoice (whichever is the later), unless other payment terms have been agreed with the supplier.

Non NHS	Number	Value £'000
Total bills paid in the year	97,510	£326,783
Total bills paid within target	52,777	£266,467
Percentage of total bills paid within target	54.1%	81.5%

NHS	Number	Value £'000
Total bills paid in the year	3,156	£39,096
Total bills paid within target	2,871	£36,167

Percentage of total bills paid within target	91%	92.5%
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Invoices are not paid within 30 days, usually due to being held in query and invoice validation as well as cash flow management. Better Payment Practice Code achievement is also below target as a result of the lengthy time invoices are validated by the Trust's third party accounting services provider.

Quality Governance

The most recent formal inspection of Use of Resources, carried out in 2019/20, concluded that the Trust was performing well, with a rating of *Good*. However, the latest overall Care Quality Commission (CQC) inspection—received towards the end of 2023/24—resulted in a revised overall rating of *Requires Improvement*.

The Board of Directors continues to closely monitor the quality of care across the organisation. A suite of quality measures and objectives is reviewed monthly through the Business Intelligence Report and the Nursing Workforce Report. Risks to quality are identified, managed, and monitored through established risk management and assurance processes, as outlined in our Annual Governance Statement.

Quality governance is supported by the work of the Board's committees—particularly the Quality Committee—which plays a central role in overseeing quality performance. This includes reviewing internal audit findings, scrutinising key reports, and ensuring robust challenge to drive service improvement and maintain high standards of care.

The Board remains proactive in assessing the impact of any proposed changes to services, including cost improvement plans, to ensure that service quality and patient safety are not compromised. These considerations are embedded into all aspects of Board decision-making.

There are no material inconsistencies to report between the Annual Governance Statement, quarterly and annual Board statements, the Board Assurance Framework, the Annual Report, and CQC findings.

Engaging with patients and the public remains central to our improvement efforts. We continue to gather feedback through the Friends and Family Test, patient surveys, and involvement in service development initiatives.

The Trust also works closely with Healthwatch Doncaster and Healthwatch Nottinghamshire, as well as our public Governors, to strengthen engagement and ensure the patients' voice is heard.

Income disclosures

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

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

Remuneration Report

Annual Statement on Remuneration

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

During 2024/25 the Trust continued to build on the benchmarking work undertaken in previous years, comparing executives' remuneration to that of market trends and neighbouring Trusts.

Remuneration policy – Executive Directors

It is the policy of the Nominations and Remuneration Committee of the Board of Directors to consider all reviews and proposals regarding executive remuneration on their own merits. This means that the recruitment market will be taken into account when seeking to appoint new directors. It also means that salaries will be set to ensure that the Trust is able to recruit and retain individuals with the required competencies and skills to support delivery of the Trust's strategy.

Executive Directors do not have any performance related components within their remuneration, and do not receive a bonus.

The committee does not routinely apply annual inflationary uplifts or increases, and only applies uplifts of any kind where it is advised by NHSE, or where this is thought to be justified by the context.

The primary aim of the Remuneration Committee is to ensure that executive remuneration is set at an appropriate level to ensure good value for money while enabling the Trust to attract and retain high quality executives.

The committee considers the pay and conditions of other employees when setting the remuneration policy, but does not actively consult with employees. The committee also considers the remuneration information published annually by NHS Providers when making decisions regarding appropriate remuneration levels.

Three Executive Directors earn more than £150,000, and the Nominations and Remuneration Committee – Board of Directors has given detailed consideration to the context of this salary and the performance of the individuals in order to satisfy itself that this remuneration is reasonable.

Remuneration policy – senior managers

As at 31 March 2025, three senior managers other than the Executive Directors are not remunerated according to Agenda for Change Terms and Conditions of service.

As part of the appraisal process, the remuneration of these managers may reduce or increase on the basis of performance, including delivery of personal objectives and CIP targets. The starting salary for these managers is generally market-based, within the pay strategy set by the Trust. With the exception of remuneration, all other Agenda for Change terms and conditions, including those relating to payment for loss of office, are applied to these managers.

The committee considers the pay and conditions of other employees when setting the remuneration policy, but does not actively consult with employees. The committee also considers the remuneration information published annually by NHS Providers when making decisions regarding appropriate remuneration levels. All work is taken in respect to the Equality Analysis policy when making decisions.

All other managers are remunerated in accordance with Agenda for Change terms and conditions of service. Approval to pay remuneration outside of Agenda for Change terms and conditions may only be granted by the Chief People Officer or Deputy Director of People and Organisational Development.

For managers who are paid according to Agenda for Change terms and conditions, the Trust is under an obligation to pay increments and uplifts in accordance with national pay agreements. The Trust does not propose to introduce any new obligation which could give rise to, or impact on, remuneration payments or payments for loss of office.

The Trust intends to maintain this remuneration policy for 2025/26.

Remuneration policy – Other employees

Other than the senior managers and Executive Directors referred to above, all employees are paid according to either the Agenda for Change or Medical and Dental Terms and Conditions of service.

Early Termination Liability

Depending on the circumstances of the early termination the Trust would, if the termination were due to redundancy, apply redundancy terms under Section 16 of the Agenda for Change Terms and Conditions of Service or consider severance settlements in accordance with HSG94 (18) and HSG95 (25).

Future Policy Table

Salary/Fees		Taxable Benefits	Annual Performance Related Bonus	Long Term Related Bonus	Pension Related Benefits
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	N/A	N/A	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the Trust's objectives
How the component Operates	Paid monthly	None disclosed	N/A	N/A	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	As set out in the Remuneration table. Salaries are determined by the Trust's Remuneration Committee	None disclosed	N/A	N/A	Contributions are made in accordance with the NHS Pension Scheme

Framework used to assess performance	Trust appraisal system	None disclosed	N/A	N/A	N/A
Performance Measures	Based on individual objectives agreed with line manager	None disclosed	N/A	N/A	N/A
Performance period	Concurrent with the financial year	None disclosed	N/A	N/A	N/A
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	None disclosed	N/A	None paid	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered. In addition there is provision for recovery of payments in relation to Mutually Agreed Resignation Scheme (MARS) payments where individuals are subsequently employed in the NHS	None disclosed	Any sums paid in error may be recovered	None paid	N/A

Nominations and Remuneration Committee of the Board of Directors

The membership of the committee in 2024/25 consisted of the Chair and Non-Executive Directors with attendance by the Chief Executive, and Chief People Officer (both of whom withdraw if their remuneration or appointment is considered) where appropriate. The committee was convened on three occasions during the year to discuss appointments and the remuneration of Executive Directors.

Name	Role	Attendance
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Suzy Brain England OBE	Chair of the Board	3 of 3
Kath Smart	Non-Executive Director (Deputy Chair of the Board)	2 of 3
Joanne Gander	Non-Executive Director	1 of 3
Mark Bailey	Non-Executive Director	3 of 3
Hazel Brand	Non-Executive Director	3 of 3
Mark Day	Non-Executive Director	2 of 3
Dr Emyr Jones	Non-Executive Director	3 of 3
Lucy Nickson	Non-Executive Director	3 of 3

Fair pay comparison

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

Pay ratio for highest paid director (excluding pension benefits) - subject to audit

	2023/24			2024/25		
Percentile	25th	Median	75th	25th	Median	75th
Salary component of pay	£247,500	£247,500	£247,500	£242,500	£242,500	£242,500
Total pay and benefits excluding pension	£25,806	£31,970	£44,780	£27,554	£34,228	£45,611
Pay ratio	9.59:1	7.74:1	5.53:1	8.80:1	7.08:1	5.32:1

The banded remuneration of the highest paid director in the financial year 2024/25 was £240k-£245k (2023/24: £245k-£250k), and the decrease between 2023/24 and 2024/25 was 2%, based on the mid-points of the pay bandings (as per DHSC GAM guidance). This decrease is as a result of the highest paid director pay in 2023/24 reflecting an adjustment for a previously deferred remuneration review that was completed in 2023/24.

This is 4.6 times higher than the salary and allowances of all employees on an annualised basis, divided by the FTE number of employees. (2023/24: 4.9 times).

This was 7.08 times (2023/24: 7.74 times) the median remuneration of the workforce, which is £34,228 (2023/24: £31,970).

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £5 to £514k (2023/24: £95 to £434k). This increase in the higher end of the range is due to additional medical sessions being performed.

25 employees received remuneration in excess of the highest-paid director in 2023/24 (2023/24: 23 employees).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employers' pension contributions and the cash equivalent transfer value of pensions.

Expenses

	2023/24 No. in office	2023/24 No. receiving expenses	2023/24 Expenses Paid (£)	2024/25 No. in office	2024/25 No. receiving expenses	2024/25 Expenses Paid (£)
Non-Executive Directors	8	4	£3,434.35	7	2	£1,074.50
Executive directors	8	4	£912.72	9	4	£849.16
Governors	39	0	£0.00	39	0	£0.00

Senior Managers Service Contracts

All directors have a notice period of six months; this does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director. All other employees have notice periods between one and three months depending on the seniority of the role.

Name	Position	Date of contract (date commenced in post as senior manager)	Unexpired term as at 31 March 2025
Suzy Brain England OBE	Chair of the Board	1.1.2017	Nine months
Kath Smart	Non Executive Director	1.4.2018	Two years
Mark Bailey	Non Executive Director	1.2.2020	Ten months
Mark Day	Non Executive Director	1.5.2022	Left the Trust 31 March 2025
Hazel Brand	Non Executive Director	1.7.2022	Four months
Joanne Gander	Non Executive Director	25.7.2022	Four months
Dr Emyr Jones	Non Executive Director	20.2.2023	Eleven months
Lucy Nickson	Non Executive Director	1.3.2023	Eleven months
Richard Parker OBE	Chief Executive	14.10.2013	N/A
Dr Tim Noble	Executive Medical Director	1.4.2020	N/A
Zoe Lintin	Chief People Officer	1.6.2022	N/A
Karen Jessop	Chief Nurse	10.1.2023	N/A
Denise Smith	Chief Operating Officer	3.1.2023	N/A

Zara Jones	Deputy Chief Executive	25.09.2023	N/A
Dr Nick Mallaband	Acting Executive Medical Director	26.9.2023	N/A
Sam Wilde	Chief Financial Officer	31.1.2025	N/A
Jon Sargeant	Chief Financial Officer	2.10.2016	Left the Trust in January 2025.

Directors' Remuneration - subject to audit

Name and Title	2023/ 24 Salary and fees (bands of £5k)	2023/ 24 Taxable Benefits (to the nearest £100)	2023 /24 Annual Bonuses (bands of £5k)	2023 /24 Long Term Bonuses (bands of £5k)	2023 /24 Pension Benefits (bands of £2.5k)	2023/ 24 Total (bands of £5k)	2024/25 Salary and fees (bands of £5k)	2024/25 Taxable Benefits (to the nearest £100)	2024/25 Annual Bonus (bands of £5k)	2024/25 Long Term Bonus (bands of £5k)	2024/ 25 Pension Benefits (bands of £2.5k)	2024/25 total (bands of £5k)
Suzy Brain England OBE – Chair of the Board	55-60					55-60	55-60	1,100				55-60
Mark Bailey – Non-Executive Director	10-15	500				15-20	10-15	700				15-20
Kathryn Smart – Non-Executive Director	15-20					15-20	15-20					15-20
Mark Day – Independent Director	10-15	100				15-20	15-20	200				15-20

Name and Title	2023/ 24 Salary and fees (bands of £5k)	2023/ 24 Taxable Benefits (to the nearest £100)	2023 /24 Annual Bonu s (bands of £5k)	2023 /24 Long Term Bonu s (bands of £5k)	2023 /24 Pensi on Benefi t (bands of £2.5k)	2023/ 24 Total (bands of £5k)	2024/25 Salary and fees (bands of £5k)	2024/25 Taxable Benefit s (to the nearest £100)	2024/25 Annual Bonus (bands of £5k)	2024/25 Long Term Bonus (bands of £5k)	2024/ 25 Pensi on Benefi t (bands of £2.5k)	2024/25 total (bands of £5k)
Hazel Brand – Non-Executive Director	10-15					10-15	10-15					10-15
Joanne Gander – Non-Executive Director	10-15					10-15	10-15					10-15
Dr Emyr Jones – Non-Executive Director	10-15					10-15	10-15					10-15
Lucy Nickson – Non-Executive Director	10-15	100				10-15	10-15	300				10-15
Dr Tim Noble – Executive Medical Director	210-2 15					210-2 15	180-185				42.5-4 5	225-230

Name and Title	2023/ 24 Salary and fees (bands of £5k)	2023/ 24 Taxable Benefits (to the nearest £100)	2023 /24 Annual Bonuses (bands of £5k)	2023 /24 Long Term Bonuses (bands of £5k)	2023 /24 Pension Benefits (bands of £2.5k)	2023/ 24 Total (bands of £5k)	2024/25 Salary and fees (bands of £5k)	2024/25 Taxable Benefits (to the nearest £100)	2024/25 Annual Bonus (bands of £5k)	2024/25 Long Term Bonus (bands of £5k)	2024/ 25 Pension Benefit (bands of £2.5k)	2024/25 total (bands of £5k)
Richard Parker OBE – Chief Executive (3)	245-250					245-250	240-245					240-245
Jon Sargeant – Chief Financial Officer (1)	155-160					155-160	145-150					145-150
Sam Wilde - Chief Finance Officer (2)							55-60				2.5-5	60-65
Zoe Lintin – Chief People Officer	145-150					145-150	150-155				27.5-30	180-185
Denise Smith – Chief Operating Officer	145-150					145-150	150-155					150-155

Name and Title	2023/ 24 Salary and fees (bands of £5k)	2023/ 24 Taxable Benefits (to the nearest £100)	2023/ 24 Annual Bonuses (bands of £5k)	2023/ 24 Long Term Bonuses (bands of £5k)	2023/ 24 Pension Benefits (bands of £2.5k)	2023/ 24 Total (bands of £5k)	2024/25 Salary and fees (bands of £5k)	2024/25 Taxable Benefits (to the nearest £100)	2024/25 Annual Bonus (bands of £5k)	2024/25 Long Term Bonus (bands of £5k)	2024/25 Pension Benefits (bands of £2.5k)	2024/25 total (bands of £5k)
Karen Jessop – Chief Nurse	140-145				62.5-65	200-205	145-150					145-150
Zara Jones – Deputy Chief Executive	75-80					75-80	155-160				45-47.5	200-205
Dr Nick Mallaband – Acting Executive Medical Director	100-105				2.5-5	105-110	215-220				55-57.5	275-280

(1) Individual left role as substantive Director on 31st January 2025, but remained in employment throughout 2024/25. Salary reflects the full year of employment, as recommended within the Group Accounting Manual although pension movements are prorated for the time spent as Director.

(2) Individual started employment at the Trust in November 2024, but started the role as substantive Director on 31st January 2025. Salary reflects the full period of employment at the Trust, as recommended within the Government Accounting Manual although pension movements are prorated for the time spent as Director.

(3) In 2023/24, salary and fees included a backdated pay award of £10k - £15k

Downward valuations of pension related benefits are shown as nil movements in the relevant column.

All Executive Directors who are currently within the NHS Pension Scheme are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

The basis of calculation for pension related benefits is in line with section 7.69 of the Annual Report Manual (ARM), and follows the 'HMRC method' which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981. The calculation required is:

Pension benefit increase = $((20 \times PE) + LSE) - ((20 \times PB) + LSB)$

PE is the annual rate of pension that would be payable to the director, if they became entitled to it at the end of the financial year.

PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year. LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year. LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Pension benefits

	Real increase/ (decrease) in Pension age			Real increase/(decrease) in pension related lump sum at pension age			Total accrued pension at pension age at 31 March 2024			Lump sum at pension age related to accrued pension at 31 March 2024			Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer value at 31 March 2025	Employers contribution to stakeholder pension
	(Bands of £2500)			(Bands of £2500)			(Bands of £5000)			(Bands of £5000)						
	£000k			£000k			£000k			£000k			£000k	£000k	£000k	£000k
Richard Parker (1)	0	-	0	0	-	0	0	-	0	0	-	0	-	-	-	-
Jon Sargeant (1)		-		0	-	0	0	-	0	0	-	0	1,476	-	-	-
Tim Noble	2.5	-	5	0	-	2.5	80	-	85	210	-	215	1,781	65	1,989	-
Nicolas Mallaband	2.5	-	5	2.5	-	5	25	-	30	70	-	75	469	43	561	-
Zoe Lintin	0	-	2.5	0	-	0	35	-	40	90	-	95	699	22	786	-
Denise Smith	0	-	2.5	0	-	0	45	-	50	120	-	125	1,068	-	1,140	-
Karen Jessop		-		0	-	0	50	-	55	135	-	140	1,114	-	1,143	-
Sam Wilde	0	-	2.5	0	-	0	35	-	40	0	-	0	498	2	589	-
Zara Jones	2.5	-	5	0	-	2.5	40	-	45	105	-	110	726	35	830	-

(1) Nil figures as individual is in receipt of pension benefits. Due to updated guidance from NHS England, no values are required to be reported

Cash Equivalent Transfer Value (CETV)

The CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. On 1 October 2008, there was a change in the factors used to calculate CETVs as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine CETV from Public Sector Pension Schemes came into force on 13 October 2008. In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors. The new CETV factors have been used in the above calculations and are lower than the previous factors we used. As a result the value of the CETVs for some members has fallen since 31 March 2010.



Richard Parker OBE
Chief Executive
30 June 2025

Governance Report

Responsibility for preparing this annual report and ensuring its accuracy sits with the Board of Directors. The principal responsibilities and decisions of the Board of Directors and Council of Governors are as shown below. The process for resolution of conflict between the Board of Directors and Council of Governors is detailed in the Trust Constitution.

The respective roles of the Board of Directors and Council of Governors are as follows:

Board of Directors	Council of Governors
● Appoint the Chief Executive ● Operational management ● Strategic development ● Capital development ● Business planning ● Financial, quality and service performance ● Trust-wide policies ● Risk assurance and governance ● Strategic direction of the Trust (taking account of the views of the Council of Governors).	● Hold the Non-Executive Directors to account for the performance of the Board of Directors. ● Appoint and determine the remuneration of the Chairman and Non-Executive Directors ● Appoint the external auditors ● Promote membership, and governorship, of the Trust ● Establish links and communicate with members and stakeholders ● Seek the views and represent the interests of members and stakeholders ● Approve significant transactions, mergers, acquisitions, separations, dissolutions, and increases in non-NHS income of over 5%.

Board of Directors

Although the Board remains accountable for all its functions, it delegates to management the implementation of Trust policies, plans and procedures and receives sufficient information to enable it to monitor performance.

In addition to the responsibilities listed above, the powers of each body, and those delegated to specific officers, are detailed in the Trust's Reservation of Powers to the Board and Delegation of Powers.

Performance evaluation of directors

The Chair conducts the performance appraisals of the Chief Executive and Non-Executive Directors. The Senior Independent Director conducted the performance appraisal of the Chair in 2024/25. The Council of Governors receives the objectives of the Chair and

Non-Executive Directors, and governors and directors feed into the appraisal process by providing commentary regarding the performance of the Chair and Non-Executive Directors.

The performance review of Executive Directors is carried out by the Chief Executive, with input from the Chair, Non-Executive Directors and Governors.

Performance evaluation of the Board and its committees

Each Board Committee undertook a self-effectiveness review during 2024/25, with outcomes reported back to the respective committees and then to the Audit and Risk Committee (ARC) for oversight at its April meeting. A full Board effectiveness review is currently underway and is due to be completed in early 2025/26.

Audit and Risk Committee (ARC)

The Audit and Risk Committee's role is to provide the Board of Directors with a means of independent and objective review of internal controls and risk management arrangements relating to:

- Financial systems
- The financial information used by the Trust
- Controls and assurance systems
- Risk management arrangements
- Compliance with law, guidance and codes of conduct
- Counter fraud activity

The Committee has Board-approved Terms of Reference, reviewed on a regular basis. It has four members – all Non-Executive Directors, including the Chair of the Committee. One member (the chair) has recent and relevant financial experience and is a qualified accountant.

The committee maintains a formal work plan and action log to ensure that areas of concern are followed up and addressed by the Trust. The Committee reviews the effectiveness of both the internal auditors and the external auditors on an annual basis and tenders the contracts when required by its Standing Orders.

Name	Role	Meeting attendance
Kath Smart – Chair	Non-Executive Director	5 of 5
Emyr Jones	Non-Executive Director	5 of 5

Mark Bailey	Non-Executive Director	4 of 5
Mark Day	Non-Executive Director	2 of 4
Joanne Gander	Non-Executive Director	4 of 5
Lucy Nickson	Non-Executive Director	1 of 1

As internal auditors, 360 Assurance, attend all meetings of the Audit and Risk Committee, in order to report on progress against the annual audit plan and present summary reports of all internal audits conducted. Internal audit's main functions are to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively by:

- Reviewing the Trust's internal control system.
- Delivery of a risk based audit plan to provide assurances to management and ARC.
- Examining relevant financial and operating information.
- Reviewing compliance by the Trust with applicable laws or regulations.
- Identifying, assessing and recommending controls to mitigate significant risks to the Trust.

ARC undertakes an annual effectiveness review of both the Internal and External Audit provision, this was carried out in June 2024, prior to the re-appointment of the auditors being carried out

For 2024/25, the Trust paid audit fees to the external auditor of £25,000 for the Wholly Owned Subsidiary audit and £15,000 for the Charitable Funds Statutory Audit. Value for non-audit work payments stand at zero.

Staff Report

We can only achieve our goals through the dedication, innovation, hard work and values of our people. Recruiting and retaining the right colleagues is essential—but equally important is supporting their health and wellbeing, helping them to grow their skills, and enabling them to deliver their best work every day.

We are proud to be an inclusive organisation, with great people providing great care, day in and day out.

All colleague policies and procedures can be found here:

<https://www.dbth.nhs.uk/about-us/our-publications/publication-scheme/our-policies-and-procedures/>

Keeping our colleagues informed and engaged

We engage with our colleagues in a number of ways, combining formal mechanisms with a broad range of communication channels. This includes consultation with Staff Side representatives, regular feedback opportunities, and the use of both digital and informal methods to keep everyone updated, involved and informed.

Here are some of the key platforms we use:

- **The Hive:** Our intranet received around 2.2 million page views and 5.3 million interactions last year. It features all essential Trust information, including news and updates.
- **All-colleagues emails:** Used sparingly to avoid fatigue, these emails are sent to 7,900 users and help to mark key moments and drive action.
- **DBTH Staff App:** With 7,000 users and around 2.9 million interactions last year, the app gives colleagues another way to access The Hive and receive key updates via push notifications.
- **Buzz, Round-Up, and Managers' Brief:** These newsletters provide regular updates to colleagues. In 2024/25, the Buzz (Tuesdays) received 330,000 views, the Round-Up (Fridays) 170,000, and the Managers' Brief 25,000 views. The average read time is around five minutes.
- **DBTH Staff Facebook Group:** With 7,500 members, this is one of our most active spaces, with 8,000 posts and over 211,000 interactions last year. On average, 6,900 colleagues check the group daily, with the most popular times being Wednesday and Friday evenings.
- **Trust website:** Our public-facing site saw 2.2 million page views and 5.8 million interactions across the year.
- **Informal channels:** We recognise that many colleagues share updates via informal routes such as WhatsApp. All our communications are designed to be easy to copy, link or screenshot, helping colleagues to cascade updates quickly and effectively within their teams in a method that suits.

Reward and Recognition

We know that appreciation matters. Our recognition schemes and events aim to thank colleagues for their hard work and dedication, helping to build pride and morale across the organisation.

- **Star Awards:** Our year-round recognition scheme invites nominations for colleagues who go above and beyond. Monthly winners receive a certificate, gift voucher and a place in the shortlist for our annual Star Awards celebration. In 2024/25 our annual award ceremony received a record number of nominations and attendance.
- **Celebration events:** We run a range of recognition activities throughout the year, marking professional days and cultural events with gestures of thanks—ranging from tea and cake delivered by the Executive Team to tailored events and giveaways.
- **Long Service Awards:** These events recognise continuous NHS service milestones of 10, 20, 30, 40 and 50 years. In 2024/25 we hosted a special afternoon tea for 100 long-serving colleagues.
- **Staff Lottery:** For a small monthly fee, colleagues can join our lottery, with 11 winners every month and prizes from £50 to £1,000. A special £6,000 draw is also held twice a year. In 2024/25, we significantly increased the number of participants thanks to the introduction of a streamlined sign-up process.

Health and Wellbeing

We are committed to attracting and retaining skilled colleagues by supporting their physical and mental health. Our comprehensive well-being package helps colleagues feel valued, cared for and supported.

With the ongoing cost-of-living crisis continuing to affect many, financial well-being has become an area of increased focus. We've introduced a number of initiatives to help colleagues better manage their money.

In 2024/25, we offered a series of webinars facilitated by external organisations including The Money Helper and Utility Warehouse, providing practical advice on saving money and planning for the future. Our weekly Wellbeing Wednesday sessions covered a range of financial topics—from budgeting and getting on the property ladder to reducing energy bills—with input from partners such as the Doncaster Energy Team, Yorkshire Water, Nottinghamshire County Council, and Citizens Advice Bureau.

We also welcomed HSBC for on-site 'Financial Health Check Clinics', which were open to all colleagues, regardless of bank affiliation, and partnered with Blue Light Discounts to offer exclusive savings.

Accolades

- Awarded **Gold** in the South Yorkshire *Be Well @ Work* awards
- **Winner**, NHS Employers Wellbeing Award at the HPMA Awards, for 'Mission Menopause' (in collaboration with South Yorkshire Integrated Care Board)
- **Shortlisted**, NHS Employers Wellbeing category at the HPMA Awards, for our innovation and impact
- **Shortlisted**, Supporting Team category at the DBTH Star Awards
- **Accredited** as a Menopause Friendly Employer

Women's health

From pregnancy to menopause, we understand the unique health needs of our female colleagues. Support includes:

- Free emergency period products available on-site
- Staff smear clinics offering evening and weekend appointments
- Comprehensive menopause support, including our Menopause Policy (launched in 2023), drop-in clinics, a WhatsApp peer support group, 20 trained Menopause Advocates, and a menopause library

Staff Survey 2024

Our most recent Staff Survey reflects the positive steps we're taking to improve colleague well-being.

- 58% of respondents agreed: "The Trust takes positive action on health and well-being".
- 68% agreed: "My immediate manager takes a positive interest in my health and well-being".

Vivup

Our Employee Assistance Programme, delivered by Vivup, provides colleagues with 24/7 support, 365 days a year. This includes access to counselling for issues such as anxiety and depression, as well as a Listening Line and a Bereavement Support Line. Vivup also offers help with domestic abuse, financial concerns, and provides lifestyle discounts and payroll-based pay schemes.

Wellbeing Champions

We're proud to have around 30 Wellbeing Champions across the Trust, promoting support services and encouraging participation in activities. In 2024, we introduced bi-monthly sessions to offer further training and support for Champions in their roles.

Additional support

Our health and well-being offer continues to evolve and currently includes:

- Complementary therapies
- Reiki
- Dr Bike clinics
- Yoga sessions
- *Know Your Numbers* health checks
- Visits from therapy dogs
- Wellbeing trolleys
- An annual *Wellbeing Calendar* packed with activities and awareness events

Education

In our continued commitment to providing and securing the highest quality education and training for all colleagues, including all our learners, we have further embedded the DBTH Education Quality Framework. This framework complements our overarching People Strategy and aligns with the NHSE Quality and Outcomes Framework, offering a mechanism to triangulate educational data across programmes and professional and clinical groupings.

Our multidisciplinary and inclusive Education Department leads and supports all training areas, including Statutory and Essential Training (SET), Role Specific Training (ReST), upskilling for new roles, and ongoing professional development. We remain aligned to national standards and improvement work, including StatMand, and are proud to be trailblazers for the Safe Learning Environment Charter. Additionally, we continue to provide high-quality clinical placements for a wide range of pre-registration learners, postgraduate doctors in training, and those seeking broader work experience.

Education Leads, aligned with clinical and corporate directorates, work closely with senior leaders to ensure that our education provision reflects both current and future workforce needs. The Learning Needs Analysis (LNA) tool has been integrated into our annual business planning process, ensuring that our education provision and commissioning align directly with business needs.

As a Trust, we have maximised available education funding—both internally and externally—to support our colleagues in these areas while meeting the quality standards outlined in our education contracts. The apprenticeship levy has further enabled us to expand our educational offerings across all workforce areas, from entry-level to postgraduate study. DBTH remains a leading employer for apprenticeships, with a rolling average of 3.5% of our workforce engaged in apprenticeships during 2024/25. This commitment to ‘growing our own’ and investing in our people is further supported by significantly low attrition rates among apprentices. We will continue to be responsive to the new national Skills Bill, ensuring we maximise opportunities for colleagues across DBTH.

Building on our partnerships with local education providers, including schools and Further Education Institutes (FEIs), and recognising our 'Anchor' organisation status within our local communities, we have continued to offer a wide range of work experience placements. These include T Level students, clinical attachments, virtual workshops, career events, and bespoke opportunities such as poster designing and supporting local events, ensuring learners and citizens in Bassetlaw and Doncaster are 'work-ready'.

Following the success of our 'Foundation School in Health' partnerships with Hall Cross Academy (Doncaster) and Retford Oaks Academy (Bassetlaw), we hosted two additional 'We Care Into the Future' events, with over 1,700 Year 8 students attending and exploring the wide range of employment and educational opportunities available at DBTH. These initiatives have garnered national interest, with other NHS providers beginning to replicate our model.

Recognised for our forward-looking approach to health and wider care careers, DBTH formalised its partnership with Doncaster College through the 'Healthcare Education Strategic Alliance'.

Additionally, our Director of Education and Research is a member of the Education and Skills Strategy Board. DBTH co-chairs the Doncaster Health and Care Centre of Excellence, contributing to the Education and Skills Strategy 2030's commitment to establishing Centres of Excellence ecosystems.

DBTH remains committed to providing clinical placements for over 1,000 pre-registration students from various Higher Education Institutes (HEIs) across South Yorkshire and beyond. These placements cover a wide range of programmes, including Medicine, Nursing, Midwifery, Allied Health Professionals, Healthcare Scientists, and Pharmacists, along with elective placements and return-to-practice opportunities. We also continue to support postgraduate doctors in training in collaboration with NHSE, ensuring our clinical service provision aligns with training needs.

Providing clinical placements for both pre-registration and postgraduate trainees remains a core aspect of our educational mission. We take pride in our reputation for high-quality clinical education, as reflected in learner feedback and confirmed by annual external assessments, including the Senior Leaders Engagement (SLE) meeting and The University of Sheffield's Medical School annual assessment.

Research

DBTH remains committed to becoming a leading centre of research excellence, enhancing both patient care and workforce development. In 2024/25, we successfully completed Year 1

of our Research and Innovation Strategy (2023-2028), which integrates seamlessly with our broader organisational goals, including the Clinical Quality, People, and Health Inequalities Strategies. This alignment has reinforced our objectives, fostering the growth of research talent and innovation leadership across DBTH.

Key to our success is the inclusion of the Nursing, Midwifery, and Allied Health Professionals Research and Innovation Framework, which acknowledges the need for tailored support to non-medical healthcare professionals alongside medical colleagues. This framework, alongside the R&I Strategy, has led to considerable growth in research capabilities and expertise within our workforce.

In the area of maternal and child health, we have made significant strides. The Born and Bred in Doncaster (BaBiD) research study has reached over 3,350 recruits, with 1,013 new participants (mothers and babies) annually. Our ongoing collaboration with Sheffield Hallam University continues to strengthen this area, with key research contributions from Professor Hora Sultani and Dr. Frankie Fair.

DBTH has also met its annual contract requirements with the National Institute for Health and Care Research (NIHR) Regional Research Delivery Network (RRDN), receiving commendations for patient recruitment and the wide range of studies offered. Among the notable achievements is the expansion of rheumatology research, with clinical trials evaluating new treatments for patients with systemic lupus erythematosus (SLE). Additionally, in renal research, we proudly recruited the first European patient for the ALXN1210-IgAN-320 trial, exploring a novel drug for immunoglobulin A nephropathy.

Paediatric research has also seen substantial progress, particularly in the BronchStart study, which focuses on bronchiolitis in children. In line with our strategic commitment to maternal and child health, we hosted our inaugural Maternal and Child Health conference, which is informing real-world evaluations aimed at reducing maternal inequalities. We are also leading two NIHR-funded projects tackling maternal health disparities, in collaboration with the University of Sheffield, City of Doncaster Council, and University of Bournemouth.

Our research portfolio continues to grow, with DBTH expanding its partnerships with local academic and innovation institutions. Notably, our membership with INSIGNEO (University of Sheffield) has enabled research into surgical innovations, while the South Yorkshire Digital Health Hub is exploring pump prime funding for research stemming from the BaBiD study. We are also collaborating with Sheffield Teaching Hospitals and Manchester University Foundation Trust to redesign healthcare for patients with multimorbidities.

As part of our ambition to develop Doncaster as a University City, we continue to strengthen our collaborative efforts with the City of Doncaster Council and Rotherham, Doncaster and South Humber NHS Trust (RDaSH). Our work with the Doncaster Voices community is a key part of our People and Public Involvement (PPI) approach, which helps to shape and prioritise our research and innovation activities. Additionally, DBTH remains a key partner within the South Yorkshire and North Nottinghamshire Integrated Care Boards, contributing to regional research and innovation strategies.

DBTH is proud to lead the way regionally and nationally with our inclusive, multi-professional approach to education and research. We continue to share our experiences with other NHS providers and are recognised for integrating education and research into our organisational culture, supported by strong leadership and alignment with our strategic priorities.

Health and safety

At Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), we are committed to maintaining a safe and secure environment for our patients, colleagues, and visitors.

We do this by embedding strong systems and processes that ensure the effective management of health and safety (H&S). Our approach includes proactive risk identification, the application of a structured hierarchy of controls to mitigate those risks, and the use of Datix, the Trust's electronic incident reporting system. We actively promote a no-blame culture to encourage open reporting, reflection, and learning, reducing the likelihood of future incidents.

This report provides an overview of Health and Safety management across the Trust for the reporting period 2024/25.

The Trust's Health and Safety Committee meets quarterly, producing a formal biannual report to the Finance and Performance Committee (F&P). Any areas of concern can then be escalated to the Trust Board via the Chair's assurance report.

In addition, the Director of Infrastructure submits an annual declaration of compliance against the NHS Premises Assurance Model (PAM), specifically addressing patient safety and experience in line with NHS England requirements and the Care Quality Commission's Key Lines of Enquiry (KLOEs).

Throughout the reporting year, incidents involving or posing a risk of injury to staff, visitors, or contractors were reported through Datix. Some of these met the threshold for reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and were submitted to the Health and Safety Executive (HSE). Table 1 presents a breakdown of incidents by subcategory and site for the period April 2024 to March 2025.

Table 1: Breakdown of incidents into Subcategory and Site April 2024 – March 2025

	Doncaster Royal Infirmary	Bassetlaw Hospital	Montagu Hospital	External to DBH	Total
Accident caused by some other means	44	17	6	2	69
Collisions	12	11	0	1	24
Exposure to electricity, hazardous substance, infection etc	19	6	1	0	26
Injury caused by physical or mental strain	15	3	1	0	19
Moving and Handling Incidents	40	7	0	1	48
Sharps related incident, including knives	80	32	12	1	125
Slips/trips/falls (includes faints)	54	23	10	2	91
Transport related incident	0	0	0	0	0
Total	264	99	32	7	402

In July 2024, DBTH was awarded the Royal Society for the Prevention of Accidents (RoSPA) Silver Award for Health and Safety performance between January and December 2023. The

RoSPA Awards recognise excellence in health and safety across all sectors, celebrating organisations that show a strong commitment to protecting lives. This award reflects DBTH's ongoing dedication to maintaining high safety standards and supporting the wellbeing of patients, colleagues, and visitors.

A new internal Health and Safety Alert process has been introduced, based on models used by the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England's Estates and Facilities Alerts (EFA). The system includes a mechanism for recipients to submit evidence confirming completion of any required actions, which are then reported to the Trust's Health and Safety Committee for assurance.

Internal Safety Alerts are issued to raise awareness of specific hazards, risks, or unsafe situations. They are a key tool in helping prevent incidents by providing colleagues with clear, practical guidance. By sharing this information Trust-wide, we aim to reduce the recurrence of similar events and strengthen our overall safety culture.

The Health and Safety Advisor and Head of Compliance met with the Health and Safety Executive's (HSE) safety culture team to explore the 'Achieving Safety Culture Excellence Now and Tomorrow' (ASCENT) programme. This work will help the Trust better understand and influence safety attitudes. A follow-up meeting has taken place, and the HSE's Human Factors Team is now developing a bespoke training package for DBTH, planned for rollout during 2025/26.

A new annual Health and Safety Audit has been approved and circulated across the organisation. The Health and Safety Advisor tracks all responses and resulting action plans, with quarterly updates provided to the Trust's Health and Safety Committee.

In partnership with Occupational Health, Health and Wellbeing, People and Organisational Development, and the Trust Nurse Advocate, the Health and Safety Advisor has developed a 'Manager's Toolkit' to support teams in managing work-related stress. This will be rolled out in 2025 and aligns with the aims of a newly established Occupational Health Working Group.

As part of our proactive approach to Health and Safety, the Trust has introduced a Health and Safety Champions scheme. Ten colleagues volunteered to take part and are currently completing an IOSH Managing Safely course, due to finish in April 2025. These colleagues will work closely with the Health and Safety Advisor to identify and address local safety issues. There are plans to expand this group and link with the Just Culture and Speak Up teams.

Regular reviews of the Trust's Control of Substances Hazardous to Health (COSHH) system, 'Alcumus Sypol', are being carried out. The Health and Safety Advisor has also updated guidance on The Hive, created a COSHH awareness presentation, and launched a new COSHH e-learning package. A Trust-wide review of COSHH storage areas has been completed, with digital locks installed and new operating procedures displayed to ensure safe and compliant storage practices.

The Health and Safety Advisor now attends the bi-monthly Health and Wellbeing Committee, presenting updates on incident trends and analysis. This includes fire, health and safety, and security-related data, following a request from the Audit and Risk Committee for improved oversight and information sharing.

Fire Safety

Fire safety at DBTH is governed both externally and internally. It complies with national legislation, including the Regulatory Reform (Fire Safety Order) 2005, Building Regulations, and the new Building Safety Act 2022. Internally, the Trust follows its Fire Safety Policy and associated procedures, in line with NHS Fire Code and Health Technical Memoranda (HTM 05).

Governance is provided by the Fire Task and Finish Group (FTFG), the Fire Safety Committee (FSC), and the Health and Safety Committee (HSC), with fire safety risks recorded on the Trust's risk register. The capital fire safety improvement programme is driven by findings from fire risk assessments, items on the risk register, and a joint action plan agreed with South Yorkshire Fire & Rescue Service (SYFRS), particularly focused on the East Ward Block and the Women's and Children's Hospital at DRI.

The 2024/25 capital works have now been completed. These included fire safety improvements to Ward M1 in the Women's and Children's Hospital and projects led by the Fire Task and Finish Committee. Planning for the 2025/26 phase is underway, pending funding confirmation.

A presentation was delivered to the Trust Leadership Team outlining the overall fire improvement strategy, including completed works at the East Ward Block and Women's and Children's Hospital, key actions from the Fire Task and Finish Group, and the future direction of fire safety at DBTH. This includes prioritising high-dependency areas such as Theatres, ITU, and SCBU, and addressing actions related to the current Enforcement Notice. These plans are supported but may be affected by space availability for decanting and proposals linked to the East Ward Block's Strategic Outline Case.

DBTH Fire Safety Strategy – Summary

1. Statutory Guidance and Legislation

- Our approach is guided by the Building Regulations 2010, the Regulatory Reform (Fire Safety) Order 2005 (FSO), and the Building Safety Act 2022, introduced post-Grenfell.
- NHS-specific guidance includes the Health Technical Memorandum (HTM 05) series and internal protocols for fire safety management and training.

2. Regulatory Context and Assurance

- Improvement Notices were issued in 2015 by South Yorkshire Fire & Rescue for the East Ward Block and the Women's and Children's Hospital.
- These were rescinded in 2021 following an agreed programme of work. A supporting business case, first produced in 2018, is now reviewed and updated annually.

3. Key Fire Safety Works (2015–2025)

- **East Ward Block (DRI):** Comprehensive works in critical care and the basement, including fire doors, fire stopping, smoke dampers, and upgraded fire alarm systems.
- **Women's and Children's Block (DRI):** Evacuation improvements across multiple levels and building-wide fire alarm upgrades.
- **Trust-wide Investment:** £16.9 million has been invested in fire safety improvements since 2015.

4. Outstanding Enforcement Notice Actions

- Work remains ongoing at various levels in both the East Ward Block and Women's and Children's Block at DRI to address residual enforcement notice requirements.

5. Other Trust-wide Improvements

- Key upgrades delivered at Bassetlaw (compartmentation and theatre works), Montagu (panel upgrade), and across DRI (alarm system upgrades in multiple blocks).

6. Fire Task and Finish Programme

- A Trust-wide initiative delivering:
 - Fire risk assessments
 - Fire compartmentation and door surveys
 - Fire alarm upgrades
 - Fire damper installation

- Record-keeping improvements via MiCAD

7. Next Steps

- **DRI:** Continue with enforcement notice mitigation—East Ward Block works (subject to decant/SOC) and Women’s & Children’s residual areas.
- **Trust-wide High Dependency Areas:** Planned improvements for theatres, intensive care, and neonatal units across DRI, Bassetlaw, and Montagu hospitals.

Task force on climate-related financial disclosures (TCFD)

NHS England’s *NHS Foundation Trust Annual Reporting Manual* has adopted a phased approach to incorporating the Task Force on Climate-related Financial Disclosures (TCFD) recommended disclosures as part of sustainability reporting requirements for NHS bodies. This stems from HM Treasury’s TCFD-aligned disclosure guidance for public sector annual reports.

These TCFD recommendations, as interpreted and adapted for the public sector by HM Treasury’s TCFD-aligned disclosure application guidance, will be implemented on a phased basis up to the 2025/26 financial year.

Local NHS bodies are not required to disclose Scope 1, 2, and 3 greenhouse gas emissions under the TCFD framework, as these are calculated nationally by NHS England. For the 2024/25 financial year, the phased approach incorporates disclosure requirements under the governance, risk management, and metrics and targets pillars. These disclosures are outlined below, with cross-referencing to relevant sections of the Annual Report and Accounts and other external publications.

Governance Pillar

Board oversight of climate-related issues: The Chief Finance Officer (CFO) is the designated board-level Net Zero Lead for the Trust. The Trust’s Finance and Performance Committee, a committee of the Board, receives a biannual update on Green Plan/Net Zero delivery. This includes progress against key objectives outlined in the Green Plan, updates on system-wide initiatives, and details of other climate-related issues. This information is then used to inform strategic planning processes at Board level.

Management’s role in assessing and managing climate-related issues: The Director of Infrastructure and the Operational Director of Estates and Facilities serve as the operational

sustainability leads for the Trust, reporting to the CFO. Together, they oversee the implementation of the Green Plan.

A multi-disciplinary Sustainability Steering Group meets quarterly to monitor progress against Green Plan delivery and assess climate-related issues. Additionally, the Trust participates in a monthly Sustainability Meeting hosted by the South Yorkshire Integrated Care Board (ICS), where system-level climate risks and initiatives are discussed.

Insights from both the ICS Sustainability Meeting and the Trust's Sustainability Steering Group inform tactical and strategic decision-making, with updates reported via the biannual reports to the Finance and Performance Committee.

Risk Management Pillar

Identifying and assessing climate-related risks: The Trust is currently undertaking a climate change risk assessment to identify risks relevant to the geographical location of each site. Once complete, this assessment will define climatic risks and proposed control measures, informing the development of a climate adaptation plan. These risks will also be entered into the Trust's risk register and managed through the organisation's standard risk management processes. The aim is to complete this work during the 2025/26 financial year.

Horizon scanning is used by both the Trust's Sustainability Steering Group and the ICS Sustainability Meeting to identify emerging climate-related risks, guided by advice from NHS England and other public bodies.

Managing climate-related risks: The Trust's Green Plan sets out a comprehensive range of sustainability objectives aimed at managing and reducing climate-related risks. Oversight of Green Plan delivery rests with the Finance and Performance Committee:

<https://www.dbth.nhs.uk/about-us/green-plan/>

Where required, new or emerging risks are addressed via the Trust's risk management process, ensuring appropriate oversight and assurance. As noted above, a climate adaptation plan will be developed in 2025/26, informed by the ongoing climate risk assessment, outlining further mitigation and control measures.

How processes for identifying, assessing, and managing climate-related risks are integrated into the organisation's overall risk management: The processes for identifying, assessing, and managing climate-related risks are aligned with the Trust's overarching risk management framework, feeding into both operational and strategic planning and decision-making.

Metrics and Targets Pillar

Metrics used to assess climate-related risks and opportunities in line with the Trust's strategy and risk management process: The Trust uses a wide range of metrics to assess climate-related risks and opportunities. These include data on energy and water consumption, use of volatile anaesthetic gases and nitrous oxide, waste generation, and fleet vehicle emissions.

This data is reported annually through the Estates Return Information Collection (ERIC) and is also published on NHS England's Model Hospital platform to support benchmarking and trend analysis: <https://model.nhs.uk/>

Additionally, data is collected and shared by NHS England's Greener NHS Team via the Greener NHS Dashboard, further supporting analysis and benchmarking.

The proposed Green Plan refresh in 2025 will include a new suite of performance metrics, in line with NHS England guidance. These metrics will support the monitoring of progress against Green Plan delivery and enhance the assessment of climate-related risks and opportunities.

Targets used by DBTH to manage climate-related risks and opportunities: The Trust's current targets are detailed within its existing Green Plan: <https://www.dbth.nhs.uk/about-us/green-plan/>

As part of the 2025 Green Plan refresh, the Trust will review and refine these targets to ensure they are SMART - Specific, Measurable, Achievable, Relevant, and Time-bound. This will ensure each key objective related to climate risk and opportunity is supported by clear, robust targets.

Workforce statistics as at 31 March 2025 (not subject to Audit)

In 2024/25, the Trust's staff turnover figure stood at 11%.

Please note, staff turnover information can be viewed here:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>
(not subject to audit)

	FTE (Perm)	FTE (Other)	FTE (Total)
Total staff employed as at 31 March 2025	5,742.64	388.22	6,130.86
Medical and dental	345.4	218.54	563.95
Administration and estates	1,699.64	61.90	1761.54
Nursing, midwifery and health visiting staff	1,834.65	37.77	1,872.42
Scientific, therapeutic and technical staff	578.49	14.71	593.19
Healthcare science staff	45.50	3	48.50
Other	1,238.96	52.30	1,291.26

This year's full-time equivalent (FTE) figure is lower than last year (2023/24: 6,728), mainly due to how we've coded certain staff groups in our internal systems.

We've removed a category called "Exec Team Board" from the count, which includes resident and recharge doctors who are on our systems but don't actually work within the Trust. It looks like they were included in last year's figures, but they wouldn't normally be counted in either FTE or headcount.

There's also a small drop in FTE linked to staff who've transferred to other organisations through TUPE processes.

To ensure consistency, we've only included colleagues on permanent, fixed-term or locum contracts (with locums being doctors working regular hours, not bank or agency). We've also included those currently on maternity leave, secondment or career breaks — but we've excluded anyone whose post ended before 31 March.

Finally, last year's data grouped healthcare assistants in with nurses. However, based on how we internally code staff groups, the category "Nursing, Midwifery and Health Visiting" is

meant for registered professionals only. So, this year, we’ve moved healthcare assistants and similar roles into the “Other” category, which better reflects the structure we use.

Sickness absence

Metric	2024/25 Actual	2024/25 Target	Benchmarking data
Staff Sickness Absence Rate	5.8%	5%	2023/24 the rate was 5.77%. In 2023/24 the regional average was 4.65%

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital	
Average FTE 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
6,320	85,479	13.5	2,306,781	138,666

Staff Costs

Note, as per guidance, this information excludes Non-Executive Directors/Lay Governing Body Members but includes executive Board members.

	Total £000	Permanently employed total £'000	Other total £'000
Salaries and wages	301,980	288,864	13,116
Social security costs	31,428	31,428	-
Apprenticeship Levy	1,499	1,499	
Pension cost – defined contribution plans	33,532	33,532	-

employer's contributions to NHS Pensions			
Pension cost – defined contribution plans employer's contributions to NHS Pensions paid by NHS England on provider's behalf	21,883	21,833	
Pension cost - other	138	138	-
Temporary staff – external bank	31,118	-	31,118
Total Staff costs	421,578	377,344	44,234

Equality, diversity and inclusion (EDI) - (not subject to audit)

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), we are committed to building an inclusive culture where every colleague feels they belong and are valued.

We celebrate diversity and expect all colleagues to treat one another with kindness and respect, upholding the values of the DBTH Way. Our ambition is to reflect the diversity of the communities we serve—both in our overall workforce and across leadership roles—by nurturing and supporting the talent within our organisation. We recognise the equal importance of all protected characteristics, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Further information on our equality priorities, actions and compliance with the Equality Act is available on our Equality and Diversity page at www.dbth.nhs.uk.

On 8 June 2023, NHS England launched its first Equality, Diversity and Inclusion (EDI) Improvement Plan, recognising that a diverse and inclusive workforce leads to better care for patients. In response, we developed our own DBTH EDI Improvement Plan, reviewing all current EDI workstreams and aligning our actions to the six high impact priorities and associated success metrics. As of March 2025, all actions were delivered within the set timescales.

We have now refreshed our EDI Improvement Plan with new priorities and measurable outcomes for 2025 and 2026, while ensuring all remaining actions remain on track. This work is also closely linked to our Health Inequalities Strategy, approved by the Board in March 2024, which sets out how we aim to reduce avoidable disparities in access, experience, and outcomes for our patients and communities.

We use our internal communications to highlight key cultural events and awareness days, providing opportunities for colleagues to engage through learning sessions, guest speakers, and team activities. We also participate in local events, including the Doncaster PRIDE celebration, and continue to work closely with our community partners to support inclusion across the borough.

In 2023, City of Doncaster Council's Ethnic Culture Fusion Network (EFCN) became a core member of our EDI Committee. We are also a key member of the Doncaster Anti-Racism Steering Group, which brings organisations together to share resources and take a joined-up approach to becoming actively anti-racist as employers and service providers. This work is co-ordinated through the Doncaster Place Strategic Workforce Group.

Our efforts are having an impact. The 2024 NHS Staff Survey shows continued improvements in the workplace culture and colleague experience at DBTH since 2021, with results that consistently exceed the national average for acute trusts. While we are proud of the progress made, we remain committed to doing more to ensure fairness, equity, and inclusion for every colleague.

Our Trust values—set out in our strategic direction—reflect our aim to eliminate discrimination, promote equality of opportunity, value diversity, and foster positive relationships. We are committed to ensuring fair and equitable treatment for all. By recognising and celebrating the diversity our colleagues bring, we aim to provide the best possible care for our patients and a supportive and inclusive workplace for everyone.

Our Fair Treatment for All Policy clearly outlines our expectations: we do not tolerate discrimination, victimisation, harassment, bullying, or unfair treatment of any kind—on any grounds.

Equality Information as at 31 March 2025 – Executive and Senior Directors

Gender (Directors Only)	Headcount	Headcount %
Female	9	64.29%
Male	5	35.71%

Senior managers

Gender	Headcount	Headcount %
Female	68	63.26%
Male	38	36.74%

Organisational equality information

Gender	Headcount	FTE	Headcount %
Female	6,068	4,956.81	80.85%
Male	1,309	1,174.05	19.15%

	7,377	6,130.86	
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Age	Headcount	FTE	Headcount %
16 - 20	97	84.28	1.37%
21 - 25	529	489.78	7.99%
26 - 30	806	718.18	11.71%
31 - 35	957	801.92	13.08%
36 - 40	924	782.06	12.76%
41 - 45	848	724.99	11.83%
46 - 50	709	616.76	10.06%
51 - 55	848	720.59	11.75%
56 - 60	836	650.36	10.61%
61 - 65	617	419.33	6.84%
66 - 70	160	94.07	1.53%
71 & above	46	28.54	0.47%

Ethnicity	Headcount	FTE	Headcount %
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Any Other	115	107.78	1.56%
Asian	676	626.83	9.16%
Black	295	271.10	4%
Chinese	27	23.64	0.37%
Mixed	92	80.45	1.25%
White	6,063	4,931.50	82.19%
Not Disclosed	109	89.56	1.48%
Disability	Headcount	FTE	Headcount %
No	6,562	5,471.19	89.24%
Not Declared	355	281.27	4.59%
Prefer Not To Answer	28	22.35	0.36%
Unspecified	3	2.27	0.04%
Yes	429	353.78	5.77%
Sexual Orientation	Headcount	FTE	Headcount %
Bisexual	80	67.11	1.09%
Gay or Lesbian	107	99.53	1.62%

Heterosexual or straight	5,788	4,840.20	78.95%
Other sexual orientation not listed	11	8.85	0.14%
Undecided	9	7.48	0.12%
Unspecified	1	1.00	0.02%
Not Disclosed	1,381	1,106.69	18.06%

Gender Pay Gap

As of 31 March 2025, Doncaster and Bassetlaw Teaching Hospitals (DBTH) employed 7,217 colleagues, comprising 5,871 women and 1,346 men. This represents a gender split of approximately 81% women and 19% men - broadly consistent with the previous year.

In 2024/25, the overall gender pay gap, calculated in favour of men, stands at 37.6%, up from 33.3% in 2023/24.

A breakdown by hourly pay quartile provides further insight into the distribution of male and female colleagues across pay bands:

- **Upper hourly pay quartile:** In 2024/25, men made up 35% of this quartile and women 65%, compared to 33.8% men and 66.2% women in 2023/24. This quartile includes many senior clinical roles and remains a key contributor to the overall gender pay gap.
- **Upper middle pay quartile:** The gender split remains heavily weighted towards women, with 85.7% women and 14.3% men in 2024/25—broadly consistent with 86.6% women and 13.4% men in 2023/24. This reflects the gender profile in professions such as Nursing, Allied Health, and Administration.
- **Lower middle pay quartile:** In 2024/25, the distribution remained largely unchanged at 86.5% women and 13.5% men, compared to 86.3% women and 13.7% men the previous year.
- **Lower hourly pay quartile:** Women accounted for 88.6% and men 11.4% in 2024/25, a slight shift from 87.6% women and 12.4% men in 2023/24.

The full breakdown of pay distribution is detailed in the *Quartile Pay* section of this report. These figures continue to highlight structural imbalances across pay bands and will help inform ongoing efforts to promote fairness, equity, and inclusive development across the organisation.

Bonus pay

As of 31 March 2024, 12.4% of men and 1% of women received a bonus payment. These bonuses are linked to Clinical Excellence Awards (CEAs), which reward consultants for delivering safe, high-quality care and service improvements. Over the past three years, we have awarded CEAs equally to all eligible consultants, regardless of gender.

Reducing the gender pay gap

We are committed to narrowing the gender pay gap through targeted action and inclusive practices. Our work includes:

Flexible working: We promote flexible working arrangements to support career development, particularly for colleagues balancing work and home responsibilities.

Gender diversity and inclusion: Our comprehensive improvement plan supports gender equality, including leadership development programmes aimed at increasing diversity at senior levels. The Board Development Delegate Programme offers opportunities for those with protected characteristics to move into executive or non-executive roles, while our Reciprocal Mentoring Programme is now in its fourth cohort.

Training and awareness: We provide learning opportunities to improve understanding of gender issues across the workforce. This is supported by our LGBTQ+ Staff Network and Internationally Educated Colleagues Network, which promote inclusion and offer peer support.

Clear goals and accountability: We have established measurable goals and benchmarks to track our progress and hold ourselves accountable, as outlined in the DBTH EDI Improvement Plan.

Organisation's structure and principal activities

As well as being an acute foundation trust with one of the busiest emergency services in the country, we are a Teaching Hospital, supported by the University of Sheffield and Sheffield Hallam University and have strong links with Health Education England.

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

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

We serve a population of more than 440,000 across South Yorkshire, North Nottinghamshire and the surrounding areas and we run three hospitals: Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital, as well as outpatient services at Retford Hospital and our external clinics.

Our Supply Chains

Our supply chains include the sourcing of all products and services necessary for the provision of high quality care to our service users.

Slavery and Human Trafficking Statement 2024/25

Slavery and human trafficking remains a hidden blight on society. We all have a responsibility to be alert to the risks in our business and in the wider supply chain. Employees are expected to report concerns and management is expected to act upon them.

Our Policies on Slavery and Human Trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.

Due Diligence Processes for Slavery and Human Trafficking

We expect that our supply chains have suitable anti-slavery and human trafficking policies and processes. Most of our purchases are against existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract which have the requirement for suppliers to have in place suitable anti-slavery and human trafficking policies and processes.

We expect each element in the supply chain to, at least, adopt 'one-up' due diligence on the next link in the chain as it is not always possible for us (and every other participant in the chain) to have a direct relationship with all links in the supply chain.

Our standard Invitation To Tender (ITT) documentation includes a question asking whether suppliers are compliant with section 54 (transparency in supply chains etc.) of the Modern Slavery Act 2015. If they are, they are required to provide evidence. If they are not, they are required to provide an explanation as to why not. In addition, our standard contract contains the following provisions:

The Supplier warrants and undertakes that it will:

- I. Comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains;
- II. Notify the authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;
- III. At all times conduct its business in a manner that is consistent with any anti-slavery policy of the authority and shall provide to the authority any reports or other information that the authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the authority in accordance with its anti-slavery policy.

Supplier Adherence to Our Values

We have zero tolerance to slavery and human trafficking. We expect all those in our supply chain and contractors to comply with our values. The Trust will not support or deal with any business knowingly involved in slavery or human trafficking.

Training

Senior members of staff within our Procurement Team are duly qualified as Fellows of the Chartered Institute of Procurement and Supply and have passed the Ethical Procurement and Supply Final Test.

This statement is made pursuant to section 54 (1) of the Modern Slavery Act 2015 and constitutes the Trust's slavery and human trafficking statement for the current financial year.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of trade union facility time within their organisation.

<i>Number of employees who were relevant union officials during the relevant period</i>	<i>Full-time equivalent employee number (Trust Total)</i>
10	8.3

<i>Percentage of time</i>	<i>Number of employees</i>
0%	0
1-50%	9
51-99%	0
100%	1

Provide the total cost of facility time	£16,546
Provide the total pay bill	£421,578,000
Provide the percentage of the total pay bill spent on facility time calculated as: (total cost of facility time / total pay bill x100)	0.0039%

Time spent on paid union activities as a percentage of total facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours x100)	0.00
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NHS Staff Survey

The NHS staff survey is conducted annually and questions align to the seven elements of the NHS 'People Promise', and retains the two previous themes of engagement and morale.

These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2024/25 survey among trust staff was 62% (2022/23: 67%).

On behalf of the Board of Directors, I want to say a heartfelt thank you to all colleagues who took the time to complete this year's NHS Staff Survey. Your feedback helps us understand where we're doing well—and where we need to do better.

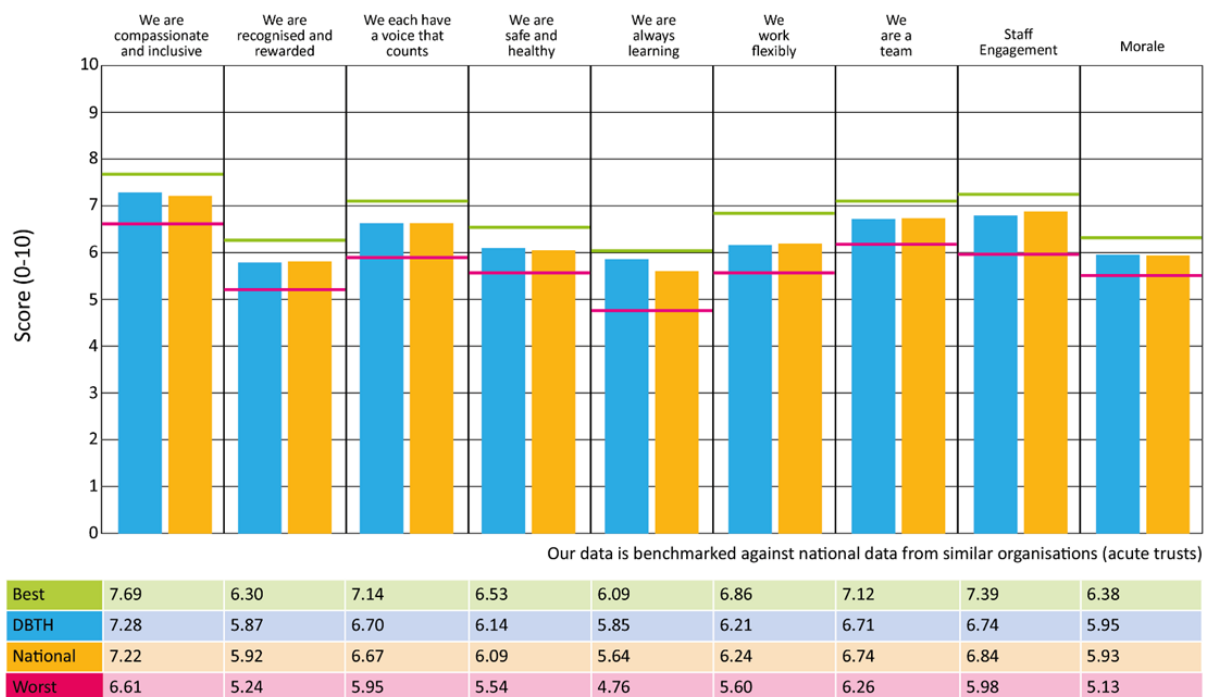
Theme	DBTH Score	2023 Score	2023 comparison	National Score	National comparison
We are compassionate and inclusive	7.28	7.40		7.22	
We are recognised and rewarded	5.86	6.00		5.90	
We each have a voice that counts	6.70	6.80		6.68	
We are safe and healthy	6.14	6.20		6.09	
We are always learning	5.84	5.90		5.69	
We work flexibly	6.20	6.20		6.22	
We are a team	6.71	6.80		6.74	
Staff Engagement	6.74	6.80		6.85	
Morale	5.95	6.10		5.93	

 Same or Better  Worse  Slightly lower (less than 0.05 difference)

Over 4,500 colleagues shared their views, representing 62% of our workforce—well above the national average response rate of 49%.

This is a clear sign that our teams are engaged and want to shape the future of DBTH together.

These insights continue to shape our approach to the 'People' priority within our Trust Strategy. At the heart of this is the DBTH Way—ensuring all colleagues feel valued, supported and confident in their roles so we can deliver the highest quality care.



What we're doing well

Despite a slight overall decline compared to our strong 2023 results, the survey highlighted key strengths that we can be proud of:

- **Feeling valued:** Colleagues feel their work makes a difference, with fair opportunities for progression and supportive line managers.
- **Inclusive culture:** DBTH continues to be seen as a place where individuals are respected and diversity is embraced.
- **Learning and development:** Appraisals are taking place, and many colleagues feel they have opportunities to grow their skills.
- **Supportive leadership:** Team leaders are approachable, and flexible working is improving across departments.

We also continue to outperform the sector average in four of the seven NHS People Promise themes, and in the remaining three, we are only slightly below—demonstrating our ongoing commitment to improving the colleague experience.

Where we need to improve

Alongside the positives, we recognise where improvements are needed and are taking steps to address them:

- **Workload and wellbeing:** Some colleagues report challenges with workload and resources. We're enhancing signposting and access to wellbeing support.
- **Speaking up:** While results exceed the national average, we want all colleagues to feel confident that concerns will be listened to and acted on.
- **Ideas and innovation:** We're working to ensure every colleague feels included in shaping improvements and decision-making.
- **Teamworking:** We'll continue to strengthen collaboration and mutual support across teams.
- **Flexible working:** While progress has been made, we're looking at how we can offer more consistent options.
- **Leadership development:** We're growing our development offer to build confidence and support at all levels.
- **Recognition and reward:** While many feel appreciated, we want to do more to celebrate great work across the organisation.

Countering fraud, bribery and corruption

While those who commit fraud against the NHS are a small minority, their actions have a serious impact on us all. The NHS is estimated to be vulnerable to over £1.3 billion pounds a year. Fraud against the NHS takes taxpayers' money away from patient care and puts it into the hands of criminals.

The Trust takes the protection of our valuable resources from fraud very seriously and to combat fraud, we have an in-house collaborative counter fraud arrangement with five other local NHS Trusts. As part of this arrangement we have a dedicated Local Counter Fraud Specialist (LCFS) permanently on site, supported by a small team of counter fraud specialists dedicated to preventing, deterring and detecting fraud.

Our Chief Finance Officer (CFO) is nominated to lead counter fraud work and was supported by the Trust's LCFS. We also have an appointed Counter Fraud Champion (CFC) who assists in raising the profile of counter fraud work and has a detailed understanding of the risks that fraud poses to the Trust. Our fraud risks are recorded in line with Government methodology and our own risk management processes. The CFO, CFC and the LCFS worked closely to ensure that our efforts to prevent, deter and detect fraud were fully co-ordinated and effective.

The Trust has a robust Counter Fraud, Bribery and Corruption Policy and Response Plan which provides a framework for responding to suspicions of fraud and provides advice and information on various aspects of fraud investigations. The Trust also has a Standards of Business Conduct Policy which sets out the expectations we have of all our staff where probity is concerned and as part of this, we provide a web-based declaration system available online or via an app for staff to make relevant declarations. The Trust website contains a [statement from the Chief Executive](#) in relation to ensuring that our organisation is free from bribery and corruption.

To ensure we have the right culture and that our staff can recognise and report fraud, we have this year enhanced our fraud awareness training to include it as part of our Statutory and Essential Training (SET)+ program. Dependent upon role and responsibility, all staff must now complete and remain compliant with one of three levels of fraud awareness training on offer.

In addition to continuing to raise awareness of fraud against the NHS throughout the year, in November 2024 we also held our annual Fraud Awareness Month, and we continued to be an official supporter of [International Fraud Awareness Week](#) in the same month. In the past year it was evident that criminals have used countless online tactics to perpetrate fraud and as such we have continued to actively publish through our staff communication network important advice and guidance to ensure vigilance to such threats.

The [NHS Counter Fraud authority](#) (NHSCFA) provides the national framework through which NHS Trusts seek to minimise losses through fraud. The Trust is required to comply with the [Government Functional Standard GovS 013: Counter Fraud](#) initiated by the Cabinet Office and in this reporting year, the Trust has continued to maintain full compliance against these standards. We also continue to maintain our contractual obligations regarding counter fraud arrangements with our ICSSs.

In pursuance of our proactive approach to spotting and disrupting fraud, we have a well-publicised system in place for staff to raise any concerns of suspected fraud. They can do this via our LCFS, or the CFO or via the NHS Fraud and Corruption reporting line on **0800 028 40 60** (online at <https://cfa.nhs.uk/reportfraud>). Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels.

Expenditure on consultancy

The Trust incurred consultancy expenditure of £212,000 (2023/24: £370,000).

Staff Exit packages for 2024/25 - subject to audit

There were no staff exit packages agreed, and none in 2023/24.

High paid and off pay-roll arrangements

For all off-payroll engagements as of 31 March 2025, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2025	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

The Trust undertakes a risk-based assessment on new and existing off-payroll engagements, to seek assurance that each individual is paying the right amount of tax.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025, for more than £245 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
The number that were engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
The number that were reassessed for consistency/ assurance purposes during the year	0
The number that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

Finance and Performance Committee

The remit of the committee is to provide assurance on the systems of control and governance specifically in relation to operational performance, workforce and financial planning and reporting.

Name	Role	Meeting attendance
Mark Day (Chair until December 2024)	Senior Independent Director	8 of 10
Denise Smith	Chief Operating Officer	9 of 10
Jon Sargeant	Chief Financial Officer	7 of 7
Sam Wilde	Chief Finance Officer	3 of 3
Kath Smart	Non-Executive Director	9 of 10
Mark Bailey (Chair from January 2025)	Non-Executive Director	9 of 10
Dr Emyr Jones	Non-Executive Director	8 of 10

In the year the Committee has, on behalf of the Board:

Provided assurance on:

- Current financial and operational performance.
- Financial forecasts, budgets and plans in the light of trends and operational expectations.
- Plans and processes for the implementation of Effectiveness and Efficiency Improvement plans.
- Any specific risks in the Board Assurance Framework relevant to the committee.
- Reviewed and developed strategy in relation to clinical site development, estates and facilities, IT and information and finance.

- Undertaken deep dives into key service areas, effectiveness and efficiency plans and areas of performance.

Quality Committee

The remit of the committee is to provide assurance on the systems of control and governance, specifically in relation to clinical quality and governance and organisational effectiveness.

Name	Role	Meeting attendance
Joanne Gander (Chair)	Non-Executive Director	5 of 6
Dr Emyr Jones	Non-Executive Director	5 of 6
Hazel Brand	Non-Executive Director	6 of 6
Lucy Nickson	Non-Executive Director	5 of 5
Dr Nick Mallaband	Acting Executive Medical Director	4 of 6
Karen Jessop	Chief Nurse	4 of 6
Zara Jones	Deputy Chief Executive	3 of 6

- The effectiveness of clinical governance, clinical risk management and clinical control
- Compliance with Care Quality Commission standards.
- Adverse clinical incidents, complaints and litigation and examples of good practice and learning.
- Patient experience in terms of care, comments, compliments and complaints.
- Workforce matters include workforce planning, staff engagement, training, education and development, staff wellbeing, equality and diversity, employee relations and HR and Operational Development systems and processes.
- Reviewed and developed strategy in relation to clinical site development, patient experience and person-centred-care, clinical governance, research and development, quality improvement and innovation, people and workforce development and communications and engagement.
- Undertaken strategic discussions and deep dives into quality, governance and workforce related issues.
- Carried out interrogations of key risks on the Trust's corporate risk register and board assurance framework.
- Ensured that the Trust has reliable, up-to-date information about what it is like being a patient experiencing care administered by the Trust.

People Committee

During the year, the Committee, on behalf of the Board, has:

- Reviewed key workforce matters, including workforce planning, colleague engagement, education and development, health and wellbeing, equality, diversity and inclusion, just culture, recruitment, and HR and OD systems and processes.
- Maintained oversight of the delivery of year two of the DBTH People Strategy (2023–2027).
- Reviewed findings from both the NHS Staff Survey and Learner Survey, and monitored progress against related improvement action plans.
- Oversaw further implementation of the DBTH Way and considered plans for further embedding this approach across the organisation.
- Received and reviewed updates relating to Freedom to Speak Up.

Name	Role	Meeting Attendance
Mark Bailey (Chair until December 2024)	Non-Executive Director	4 of 4
Mark Day	Senior Independent Director	1 of 5
Hazel Brand	Non-Executive Director	5 of 5
Lucy Nickson (Chair from January 2025)	Non-Executive Director	5 of 5
Zoe Lintin	Chief People Officer	5 of 5
Karen Jessop	Chief Nurse	3 of 5
Dr Nick Mallaband	Acting Executive Medical Director	1 of 5

Charitable Funds Committee

The Committee oversees and provides assurance on all charitable activities within the Trust. Doncaster and Bassetlaw Teaching Hospitals Charity publishes its own annual report and accounts, which will be available on <https://dbthcharity.co.uk/>.

Name	Role	Meeting Attendance
Mark Bailey	Non-Executive Director	2 of 4
Suzy Brain England	Chair of the Board	3 of 4
Hazel Brand	Non-Executive Director (Chair)	4 of 4
Mark Day	Senior Independent Director	3 of 4
Joanne Gander	Non-Executive Director	3 of 4
Karen Jessop	Chief Nurse	3 of 4
Emyr Jones	Non-Executive Director	3 of 4
Zara Jones	Deputy Chief Executive	2 of 2
Zoe Lintin	Chief People Officer	2 of 4
Nick Mallaband	Acting Medical Director	2 of 2
Lucy Nickson	Non-Executive Director	4 of 4
Richard Parker	Chief Executive	2 of 4

Jon Sargeant	Chief Financial Officer	4 of 4
Sam Wilde	Chief Financial Officer	1 of 1
Kath Smart	Non-Executive Director	3 of 4
Denise Smith	Chief Operating Officer	0 of 4

The Committee oversees and provides assurance on all charitable activities within the Trust. Doncaster and Bassetlaw Teaching Hospitals Charity publishes its own annual report and accounts, which will be available on <https://dbthcharity.co.uk/>.

Council of Governors

During 2024/25 the Council of Governors met on five occasions. Council of Governors meetings are held in public. The composition of the Council of Governors, including attendance at Council of Governors meetings is shown below.

Note, the Lead Governor post is Jackie Hammerton.

Name	Constituency / Partner Organisation	Meeting attendance
Andrew Middleton	Public - Bassetlaw	1 of 2
David Gregory	Public - Doncaster	5 of 5
David Northwood	Public - Doncaster	4 of 5
Denis Carr	Public - Bassetlaw	4 of 4
Eileen Harrington	Public - Doncaster	0 of 5
George Kirk	Public – Doncaster	0 of 5
Irfan Ahmed	Public - Doncaster	1 of 5
Jackie Hammerton	Public - Rest of England & Wales	3 of 5
Lynne Logan	Public - Doncaster	5 of 5
Lynne Schuller	Public - Bassetlaw	2 of 5
Marc Bratcher	Public Doncaster (end of term 20/9/2024)	0 of 2
Maria Jackson-James	Public - Rest of England & Wales	0 of 5

Debbie Benson	Public - Doncaster (from 21/9/2024)	1 of 2
Patrick Bond	Public - Doncaster (from 21/9 - 12/12/2024)	0 of 1
Eric Boocock	Public - Bassetlaw (from 21/9 - 18/11/2024)	0 of 1
Mark Bright	Public - Doncaster	5 of 5
Andrew Flynn	Public - Doncaster (from 21/9/2024)	2 of 2
Natasha Graves	Public - Doncaster	0 of 5
Clive Smith	Public - Doncaster (until 10/9/2024)	2 of 2
Colin Wallace	Public - Doncaster (from 21/9/2024)	2 of 2
Crystal Lucas	Public - Bassetlaw (from 10/1/2025)	1 of 1
Phil Mettam	Public - Bassetlaw (from 21/9/2024)	1 of 2
Mick Muddiman	Public - Doncaster (end of term 20/9/2024)	0 of 2
Peter Hewkin	Public - Bassetlaw (until 13/7/2024)	2 of 2
Rob Allen	Public - Doncaster (until 31/1/2025)	1 of 4
Sheila Walsh	Public - Bassetlaw	5 of 5
Dr Vivek Panikkar	Staff - Medical and Dental	3 of 5
Gavin Portier	Staff - Nursing & Midwifery	4 of 5
Kay Brown	Staff - Non-clinical	5 of 5

Joseph Money	Staff - Non-Clinical	4 of 5
Mandy Tyrrell	Staff - Nursing & Midwifery	4 of 5
Andria Birch	Partner Governor - Bassetlaw Community and Voluntary Service (BCVS)	0 of 5
Anita Plant	Partner Governor - Partially Sighted Society	0 of 5
Ainsley MacDonnell	Partner - Nottinghamshire County Council (end of term 15/11/2024)	0 of 5
Alexis Johnson	Partner - Doncaster Deaf Trust	1 of 5
Harriett Digby	Partner - Bassetlaw District Council	0 of 5
Jo Posnett	Partner - Sheffield Hallam University	2 of 5
Phil Holmes	Partner - City of Doncaster Council	2 of 5

These meetings have been held virtually with the focus and format of meeting reflecting the Council responsibilities. During 2025/26 the Council of Governors will be holding some meetings, including the 2024/25 Annual Members meeting in Public. Presentations are received from all NEDs, the Lead Governor, Chair and Chief Executive with an interactive question and answer session in addition to statutory COG business. The executive directors have not been required to attend all meetings but do attend where the nature of the business conducted requires their attendance. This allows Directors to prioritise service delivery.

Governor elections and terms of office

Governors serve three-year terms of office and are eligible to stand for re-election or re-appointment at the end of that period. There is a maximum of three terms.

Director	Role	Council of Governors meeting attendance
Suzy Brain England OBE	Chair of the Board	5 of 5
Kath Smart	Non-Executive Director	5 of 5
Mark Bailey	Non-Executive Director	4 of 5
Mark Day	Senior Independent Director	2 of 5
Hazel Brand	Non-Executive Director	5 of 5
Joanne Gander	Non-Executive Director	3 of 5
Lucy Nickson	Non-Executive Director	5 of 5
Dr Emyr Jones	Non-Executive Director	4 of 5
Richard Parker OBE	Chief Executive	5 of 5
Zara Jones	Deputy Chief Executive	4 of 5

Membership

The Trust has two categories of members:

- Public members - people who live within the areas covered by either of the three public constituencies:
 - Bassetlaw District
 - Doncaster Metropolitan Borough
 - Rest of England and Wales.
- Staff members - Trust staff automatically become members unless they decide to 'opt-out'.

There are four staff classes:

- Medical and Dental
- Nurses and Midwives
- Other healthcare professionals
- Non-clinical.

As of 31 March 2025, there were 13,295 members overall.

An analysis of our current membership body is provided below:

	Number of members at 31st March 2025
Public Constituency	5,707
Doncaster	3,187
Bassetlaw	1,798
Rest of England and Wales	722
Staff Constituency	7,497
Nurses and Midwives	2,155
Non-clinical	2,460
Other healthcare professionals	2,271
Medical and Dental	611
Total	13,295

The Trust held its virtual Annual Members' Meeting in September.

Throughout the year, we have continued to engage with our members and support Governors in seeking their views through a variety of methods, including:

- Regular communication with members via our virtual magazine, *Foundations for Health*, keeping them updated on Trust activities and Governor involvement.
- Providing opportunities for members to share feedback directly with the Trust via the Board Office.
- Hosting events focused on topics of interest to members, encouraging discussion and feedback on services.
- Supporting Governor attendance at local community events, including targeted outreach to schools and colleges to engage with younger audiences and encourage new membership.
- Promoting active participation in Governor Elections, aiming for contested elections and increased member involvement in the democratic process.

Members wishing to contact Directors or Governors can do so via the Foundation Trust Office by emailing dbth.TrustBoardOffice@nhs.net, calling 01302 644158, or writing to:

Trust Company Secretary

Doncaster Royal Infirmary
Armthorpe Road
Doncaster
DN2 5LT

Steps that Board members have taken to understand the views of governors and members

Both Executive and Non-Executive Directors regularly attend Council of Governors meetings to share updates from their areas of responsibility and to listen to the views of Governors. A number of additional steps have been taken to ensure the views of both Governors and members are understood and considered:

- Participation in regular Governor briefing sessions.
- Opportunities for Governors to raise queries and concerns through the Trust Board Office.
- Routine meetings and briefings between the Council of Governors, the Chief Executive and the Chair of the Board.

- Ongoing accessibility of the Chair of the Board, Trust Company Secretary, Senior Independent Director and Trust Board Office.
- Offer of 'buddying' arrangements between Non-Executive Directors and Governors to support closer engagement.
- Consultation with Governors on the development of forward plans and key issues affecting the Trust.
- Involvement of Governors in the appraisal process for the Chair and Non-Executive Directors, ensuring their views contribute to performance assessments.
- Sharing of key information including Board meeting minutes, reports, briefing papers and *Foundations for Health*, the members' magazine.
- Provision of regular updates to Governors via email to ensure they remain informed and engaged

NHS Foundation Trust Code of Governance

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain basis'.

The Code of governance for NHS provider trusts (the Code of governance) was published in October 2022 and has been applicable since 1 April 2023.

It replaces the previous NHS foundation trust code of governance issued by Monitor.

For the year ending 31 March 20205, the Board considered that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors is committed to high standards of corporate governance, understanding the importance of transparency and accountability and the impact of Board effectiveness on organisational performance.

The Trust carries out an on-going programme of work to ensure that its governance procedures are in line with the principles of the Code, including:

- Supporting governors to appoint Non-Executive Directors and external auditors with appropriate skills and experience.
- Ensuring a tailored and in-depth induction programme for any new Chair, Non-Executive Directors and Governors.
- Facilitating periodic external reviews of the Trust's governance arrangements.
- Working with governors in briefings and enabling governors to attend meetings, to improve the ways in which governors engage with and hold Non-Executive Directors to account for the performance of the Board.
- Ongoing review of compliance with the Code of Governance by the Council of Governors and Board of Directors when making decisions which impact on governance arrangements.

For details on the disclosures required by the Code of Governance, see below.

Ref.	Requirement	Disclosure
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICS, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	See page 59 and page 81
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	See page 81 and 83 onwards.
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	See page 81.

B.2.6	The board of directors should identify in the annual report each Non-Executive Director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a Non-Executive Director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment. • is an appointed representative of the trust's university medical or dental school Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the Non-Executive Director is independent, it needs to be clearly explained why.	See page 59.
B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	See page 81, 122, 123, 126, 128 and 130.
B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	See Council of Governors section, page 130.

C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	See page 119.
C2.8	The annual report should describe the process followed by the council of governors to appoint the chair and Non-Executive Directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	See Council of Governors section, page 130.
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	See page 61.
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	See page 157.
C.4.13	The annual report should describe the work of the nominations committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives - the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served - the gender balance of senior management and their direct reports.	See page 61 and 157.
C5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS	See page 130.

	foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	
D2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit • process and its approach to the appointment or reappointment of the external • auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	See page 149.
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	See page 3.
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	See page 56.
D2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	See page 56.

D2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	See page 56.
E.2.3	Where a trust releases an executive director, e.g. to serve as a Non-Executive Director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	See page 61.
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Page 130.
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Page 130.
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Page 130.

Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	N/A
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NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities).
- b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach, or suspected breach of its licence conditions.

Segmentation

The Trust ended the year in segment 3.

This segmentation information is the trust's position as at 31 March 2025. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website:

Statement of Accounting Officer's responsibilities

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust.

The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

Under the NHS Act 2006, NHS England has directed Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and

to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

A handwritten signature in dark ink, appearing to read 'Rt Hon Parker', followed by a period.

Richard Parker OBE

Chief Executive (acting in his capacity as Accounting Officer)

30 June 2025

Annual governance statement

Scope of responsibility

As Accounting Officer, I am responsible for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims, and objectives while safeguarding public funds and departmental assets for which I am personally accountable. This is in accordance with the responsibilities assigned to me. I ensure that the NHS Foundation Trust is administered prudently and economically, with resources applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to achieve policies, aims, and objectives. It can therefore only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Trust's policies, aims, and objectives. It evaluates the likelihood of those risks being realised and seeks to mitigate the impact should they be realised, managing them efficiently, effectively, and economically. The system of internal control has been in place in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

The Audit and Risk Committee and the Board annually reviews the effectiveness of the Trust's governance arrangements (system of internal control). This review covers all material controls, including financial, clinical, operational, organisational development and compliance controls and risk management systems. The review is confirmed in the Board papers and minutes which are published on the Trust's website.

Capacity to Handle Risk

The Chief Executive holds overall accountability and responsibility for risk management, while the Executive Directors are responsible for the risks relevant to their specific areas in line with the management and accountability arrangements in the Trust.

The role of each Executive Director is to ensure that appropriate arrangements are in place for the:

- Identification and assessment of risks and hazards.
- Elimination or reduction of risk to an acceptable level and within the Trusts risk appetite.

- Compliance with internal policies and procedures, and statutory and external requirements.
- Integration of functional risk management systems and development of the assurance framework.

The Trust Company Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and The Executive Medical Director for the Trust Risk Register.

Risk policies are regularly reviewed in light of current best practice advice to assess whether changes are required with the Trust Risk Management Policy being refreshed during 2024/25. Divisional Directors and Directorate Managers are responsible for maintaining the risk registers for their departments. Furthermore, managing risk is a fundamental duty of all employees, regardless of grade, role, or status.

The Trust uses the DatixWeb© integrated risk management system. Local risk management training needs are identified and in addition to one-to-one coaching by a trained risk practitioner, a suite of educational material has been developed, accessible via the Trust's intranet. A national risk management e-learning module is available to colleagues via the Electronic Staff Record (ESR) and is also mandated as part of role specific training for staff. This was implemented in Q4 and will be monitored throughout 2025/26 through the Audit and Risk Committee and the Risk Management Group. Staff can also contact the Trust Board Office and Trust Risk Manager for guidance on applying relevant risk management policies.

The risk and control framework

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The Board assures itself of the validity of its corporate governance statement through regular reviews of its governance processes, which are routinely reviewed by internal audit. During 2024/ 2025 the Board has reviewed the use and application of the Board Assurance Framework (BAF). The Risk Management Group has continued to function during the financial year to ensure appropriate oversight and scrutiny of the Trust Risk Register. Work has continued to ensure compliance with the Trust's risk management strategy. Since receiving a limited assurance internal audit rating for a follow up review of Risk Management, the Board has strengthened and improved its risk management processes. The improvements made have been recognised by Internal Auditors in the Head of Internal Audit Opinion.

Other sources of assurance include regulatory reviews, committee effectiveness reviews, Board and committee inspection of key performance metrics, consideration of the Board

Assurance Framework and Trust Risk Register, and reviews of key governance documents such as the constitution, standing financial instructions, Scheme of Reservation and Delegation and standing orders. Additionally, processes geared towards maintaining quality, such as ward walkabouts and quality impact assessments, contribute to assurance.

Governors receive assurances via the Council of Governors meetings and attendance at Board of Director meetings, They have open access to the Chair and are able to ask questions within the Council of Governors meetings and on-line via a governor questions Log. The Board is responsible for determining the organisation's risk appetite , which was reviewed in 2024/25 and ensuring that robust systems of internal control and management are in place, with risks to the achievement of organisational objectives appropriately managed. During 2024/25, this responsibility was supported through the assurance committees of the Board:

- **Audit and Risk Committee:** Reviews the effectiveness of the system of integrated governance, risk management and internal controls, to satisfy the Board that its approach to integrated governance remains effective and compliant.
- **Quality Committee:** Responsible for clinical risk, including clinical and quality governance, patient safety, and experience.
- **People Committee:** Reviews systems of control and governance specifically in relation to people matters.
- **Finance and Performance Committee:** Undertakes monthly scrutiny of financial reporting and progress against effectiveness and efficiency plans.
- **Charitable Funds Committee:** Oversees the Trust's charitable fundraising efforts.

The Board Assurance Framework was refreshed in mid year 2024 and formed a major part of the Board Development Sessions in Quarters 3 and 4. The ongoing BAF development was done in partnership with Internal Audit, who made recommendations to enhance clarity and consistency and the new template was agreed at the Board in March 2025. Each Board committee reviews the framework at least quarterly, ensuring that appropriate arrangements are in place for monitoring internal controls and risk management systems across their respective areas. The risk appetite was agreed in May 2024 and incorporated into the BAF to support the assurance and decision making effectiveness.

The Audit and Risk Committee has provided oversight of the Board Assurance Framework during 2024/25, reviewing its structure, alignment with the Trust's risk profile and compliance to the Trusts Risk Management Policy. This is reported to each quarterly Audit and Risk Committee meeting, together with the Trusts Risk Register.

The Board received the Risk report summarising key control areas and assurances, including proposed risk score changes and emerging risks.

Additionally, the committees receive assurance regarding compliance with Care Quality Commission (CQC) registration and information governance requirements. Data quality is part of the internal audit annual work plan, and risks to data security are managed through the Information Governance Policy and compliance with the Data Security and Protection Toolkit. The DSPT was reviewed during 2024/25 and found to have substantial assurance by audit colleagues.

Each Division and Department is responsible for maintaining its own risk register, a standing agenda item in Divisional governance team meetings. Any risk identified as 'extreme' is escalated via the Risk Management Group to the Trust Leadership Team for consideration regarding required actions.

To mitigate the risk of efficiency and effectiveness savings programmes adversely impacting the quality of care, all plans are reviewed and require approval and sign-off by the Acting Executive Medical Director and Chief Nurse.

Principal Risks to Compliance with Licence Condition FT4

The principal risks to compliance with licence condition FT4 are:

- Risks to the provision of accurate, comprehensive, timely, and up-to-date financial information to support board decision-making and oversight.
- Risk of failure to maintain sound financial governance and control processes.
- Failure to maintain fit-for-purpose board assurance and governance processes.

The Trust undertakes various activities to mitigate corporate governance risks, including regular audits and reviews of governance processes, reviews of its constitution and standing orders, and examination of reporting lines between the Board, committees, and other decision-making bodies. Significant risks to the achievement of governance standards are included within the assurance framework and Trust Risk Register and are reviewed in line with the outlined processes.

The Trust concluded 2024/25 in full compliance with the code of governance.

Significant Risks and Challenges

The Trust's key strategic risks and challenges are recorded within the Board Assurance Framework (BAF), which provides oversight of the highest-priority risks that could impact our ability to deliver safe, effective and sustainable care. In year these were fully reviewed by the Board, aligning to the strategy and priorities for the coming years.

This resulted in changes to existing key risks, where risks had been mitigated by completed actions, and new risks being identified (digital and cyber). These include:

- **Quality of Care:** 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.
- **Workforce:** If DBTH does 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.
- **Access to Care:** 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.
- **The Care Environment:** 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.
- **Financial sustainability:** 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.
- **Partnership and collaboration:** Due to insufficient resource, engagement, and governance arrangements, our partnerships do not deliver on the expected benefits, resulting in poor use of resources and inability to transform and enhance services.
- **Digital and Cyber:** 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.

Further details, including mitigating actions and progress, can be found in the Board Assurance Framework which is a working document and key pillar in the governance arrangements .

In addition to strategic risks, the Trust Risk Register captures operational risks to service delivery. These risks are actively monitored and managed through the Trust's governance and assurance processes, with progress and outcomes reviewed regularly through our management reporting systems, with Executive Team and Board oversight.

Assurance that staffing processes are safe, sustainable and effective

Our staffing governance processes align with National Quality Board guidance and NHSI's Developing Workforce Safeguards (2018). This ensures the Trust consistently employs qualified, competent, and experienced staff, with a systematic approach to determining staffing levels that complies with current legislation and guidance.

Optimal staffing is crucial for safe, high-quality patient care. We continuously review staffing levels and skill mix to meet real-time needs, supported by relevant policies and regular staffing meetings. These processes help address any shortfalls promptly.

We use tools such as the nursing and midwifery quality dashboard and ward monitoring systems to inform staffing levels, continuously monitoring patient outcomes and quality indicators. Twice a year, each inpatient area assesses patient care needs using evidence-based tools—Safer Nursing Care Tool (SNCT) for nursing and Birthrate+ for midwifery. These reviews, informed by professional judgement and outcome evaluations, are reported to the Board of Directors through the People Committee.

As part of the Trust's annual business planning cycle, workforce planning identifies staffing pressures, proposed service changes, and other factors affecting workforce provision. This work is closely aligned with the development of the Trust's annual operational plan for 2024/25, as well as the refreshed organisational strategy developed during the year. The Trust's enabling plans – spanning areas such as People, Quality, Maternity, Research, Health Inequalities and more – continue to play a central role in informing priorities, guiding decision-making, and supporting the effective delivery of services across the organisation.

Recruiting sufficient numbers of appropriately qualified clinical staff continues to be identified as a potential strategic risk to the Trust's strategic aims. The Trust Risk Register provides a mechanism for operational staffing risks to be escalated to the Board of Directors.

Recognising the value of all clinical staff, the Trust regularly undertakes capacity and demand reviews to ensure the sufficiency of staff and has methods of escalation in place should any concerns regarding staffing levels be raised. All identified risks are assessed and logged onto the Trust's Risk Register with mitigations put in place and closely monitored.

To address future leadership needs, the Trust has implemented recent guidance and policies on succession planning and Scope for Growth. These initiatives ensure that we are identifying future leaders and highlighting paths for succession. Our Leadership Prospectus for 2024/25, which will be updated for 2025/26, provides a range of options for aspiring managers.

Additionally, the Board Delegate Programme supports aspirant colleagues, further strengthening our leadership pipeline.

This runs alongside our usual education programmes, development posts, and apprenticeships, ensuring comprehensive support for all staff development needs.

Stakeholder Involvement

The Trust maintains an effective structure for public and stakeholder involvement, primarily through the Council of Governors. Our assurance framework is shaped by strong partnership working and regular engagement with external stakeholders, including the following:

- **Collaboration between Governors and Directors:** The Council of Governors regularly reviews performance, quality, finance, and associated risks through quarterly meetings. Additionally Governors have dedicated briefing sessions, informed by non-executive and executive directors.
- **Commissioner engagement:** We maintain consistent dialogue with commissioners through contract review meetings and other forums, with a shared focus on managing key system-wide risks.
- **Public participation in safety and experience:** Members of the public and patient representatives contribute to the management of risk through their involvement in groups such as the Patient Safety Review Group and the Patient Experience Committee, as well as participation in safety campaigns including *Sharing How We Care* and our patient experience film series.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). In line with NHS guidance on managing conflicts of interest, we also publish an up-to-date register of interests—including declarations of gifts and hospitality made by decision-making staff—which is available on our website: <https://dbth.mydeclarations.co.uk/home>

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure compliance with Scheme regulations, including accurate salary deductions, employer contributions, and timely updates to member Pension Scheme records.

Control measures are also in place to ensure compliance with obligations under equality, diversity, and human rights legislation.

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and developed a Green Plan following the Greener NHS programme guidance. In response to the NHS's ambitious objective to become the world's first 'net zero' national health service by 2040, with an 80% reduction by 2028 to 2032, the Trust has developed its Green Plan, detailing revised carbon emissions calculations and reporting. The Board-approved Green Plan ensures compliance with the Climate Change Act and Adaptation Reporting requirements.

Recent Initiatives and Improvements

- **Corporate Governance Refresh:** Following on from the internal Audit review of governance arrangements in 2023/24, the Board Committees, Terms of Reference, and supporting work plans were refreshed. This supported the alignment with the Trust Strategy and a focus on the risks and reporting structures that support the information flows for board assurance.
- **Embedding of CIVICA Declare:** Further integration of CIVICA Declare system, streamlining the management of declarations of interest. This digital system continues to strengthen accountability, and compliance with national requirements across all decision-making roles. As an on-line public resource, it further supports the transparency of the Trust.
- **Committee Effectiveness Reviews:** The end of year process for reviewing the effectiveness of all Board committees, provided useful insights for improvements. These were shared with the Audit and Risk Committee that oversees the process on behalf of the Board of Directors. Implementing the recommendations will support continuous improvement and ensure our committees operate efficiently and in line with their Terms of Reference.
- **Improved Board Oversight through Assurance Logs:** The use of Committee Chair Assurance Logs has been further embedded and refined over the year, providing clarity on key issues, decisions and risks, for the Board and also providing assurance for the Council of Governors.

Continuous Improvement

The Trust remains committed to continuously improving its use of resources through the implementation of best practices, informed by Quality Improvement methodology and solid delivery, as well as robust financial controls. By maintaining stringent oversight and regular reviews, the Trust ensures that resources are utilised in the most economical, efficient, and effective manner possible.

Review of the Economy, Efficiency, and Effectiveness of the Use of Resources

The following policies and processes ensure that resources are used economically, efficiently, and effectively:

- **Scheme of Delegation and Reservation of Powers to the Board:** This ensures that decision-making authority is clearly defined and appropriately assigned.
- **Standing Financial Instructions and Standing Orders:** These provide a framework for financial governance and operational procedures.
- **Competitive Procurement Processes:** These are used for procuring non-staff expenditure items to ensure value for money.

- **Materials Management and Best Practices:** These approaches maintain appropriate stock levels and minimise wastage.
- **Cost Improvement Plans and Efficiency Workstreams:** Managed by the Finance Directorate, these plans are designed to enhance efficiency without compromising the quality of patient care.
- **Grip and Control Measures:** These include tight controls on vacancy management, non-permanent staffing, and recruitment to ensure financial discipline.

Assurance and Monitoring

The Board gains assurance regarding financial and budgetary management from a bi-monthly finance report, and two key financial systems (cashflow and treasury management, and accounts payable) have been audited during 2024/25, both with an outcome of significant assurance. The Audit and Risk Committee receives reports on losses, compensations, and waivers of standing orders, among other financial matters.

The Finance and Performance Committee receives detailed monthly reports on the progress of effectiveness and efficiency plans. Risks to the Trust's financial objectives are reviewed and monitored regularly, similar to other risks.

Audits and Internal Controls

A range of internal and external audits provide further assurance on economy, efficiency, and effectiveness. These audits are reported to the Audit and Risk Committee.

The Head of Internal Audit provides an annual opinion on the overall adequacy and effectiveness of the Trust's risk management, control, and governance processes (for example the system of internal control). This opinion is based on a risk-based programme of work, agreed upon with management and approved by the Audit and Risk Committee. The opinion covers the period from 1 April 2024 to 31 March 2025 and is based on the audits completed within this timeframe.

For the period 1 April 2024 to 31 March 2025 Internal Audit provided the following:

I am providing an opinion of moderate assurance that there are areas for improvement in the framework of governance, risk management and control, and some inconsistent application of controls puts the achievement of the organisation's objectives at risk.

My position reflects the range of audit opinions provided in-year. We have completed four audits where improved performance (ie versus previous audits, or internal improvement work) was expected but not attained: Board Assurance Framework, Risk management follow-up, Bank and agency follow-up, Mortality data quality assurance. I acknowledge that

the Trust has progressed agreed actions in relation to these audits since the reports were issued. We raised two high-risk findings in respect of business continuity; this was an area of known risk but represents a fundamental system of control in NHS organisations. I have also reflected on the Trust's action implementation rate; overall this continues to strengthen versus previous years with a good focus on timely action implementation, however two out of seven high-risk actions have not been implemented on time. One of these remains open with a revised due date in the future.

Information governance

There have been no serious incidents relating to information governance in 2024/25, this includes data loss or confidentiality breach.

Additionally, information governance requirements are reviewed by various committees with data quality forming part of the internal audit annual work plan.

CQC Review

The Board had taken assurance from the CQC inspection outcome. Unannounced and announced inspections by the CQC took place across Trust sites in August 2023 and the Well Led inspection took place in October 2023 and the Trust received an overall rating of 'Requires improvement'.

Overall, the CQC rated effective, safe, responsive and well-led as 'requires improvement', and caring as 'good'. In rating the Trust, the CQC took into account the current ratings of the services not inspected.

The inspection report was published in April 2024. Many of the issues raised have been addressed or incorporated into wider improvement programmes across the Trust. Progress against the Care Quality Commission (CQC) action plan has been reported to the Board of Directors throughout the year in line with the governance and control processes outlined above.

Review of effectiveness

As Accounting Officer, I am responsible for reviewing the effectiveness of the system of internal control.

My review is informed by the work of internal auditors, clinical audit, executive managers, and clinical leads within the NHS Foundation Trust who oversee the development and maintenance of the internal control framework.

Additionally, I draw on performance information available to me and comments made by external auditors in their management letters and other reports.

I have been advised on the implications of my review by the Board, as well as the Audit and Risk, Finance and Performance, People, and Quality Committees. These groups ensure that any identified weaknesses are addressed and that continuous improvements to the system are implemented.

This year, the leadership team has continued its efforts to reduce our retained financial deficit, recover from the effects of the pandemic, and improve standards of care. We are actively reviewing our strategy, clinical strategy, and strategic objectives.

We remain engaged in developing accountable care partnerships at Place in Doncaster and Bassetlaw, as well as within the integrated care systems for South Yorkshire and Nottinghamshire.

Our commitment to effective governance is demonstrated through regular monitoring and updates to our Board governance structures, financial governance arrangements, and effectiveness and efficiency plans, alongside quality and effectiveness initiatives. Recognising that our organisation thrives due to the dedication of our fantastic staff, we have made concerted efforts throughout the year to engage with them on strategic direction and local health system changes.

Conclusion

Following my review, it is my opinion that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of its policies, aims, and objectives.

No significant internal control issues have been identified.

A handwritten signature in dark ink, appearing to read 'Rt Hon', followed by a stylized surname.

Richard Parker OBE
Chief Executive
30 June 2025

Independent auditor's report to the Council of Governors

Opinion

We have audited the financial statements of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2025 which comprise the Foundation Trust and Group Statement of Comprehensive Income, the Foundation Trust and Group Statement of Financial Position, the Foundation Trust and Group Statement of Changes in Equity, the Foundation Trust and Group Statement of Cash Flows and the related notes 1 to 46, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and of the Group as at 31 March 2025 and of Foundation Trust's and Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust and the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group or Foundation Trust's ability to continue as a going concern for a period to 30 June 2026.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or

conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's and the Group's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of Accounting Officer's responsibilities as set out on pages 138 and 139 the chief executive is the accounting officer of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group and the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the group or the Foundation Trust, or have no realistic alternative but to do so.

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the group and Foundation Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue

an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.
- We understood how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.
- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue and improper recognition of expenditure) and management override of

controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Foundation Trust's manual year end income accruals and contract income, challenging assumptions and corroborating the income to appropriate evidence. We also performed risk-based journal testing and tested variances in the agreement of balances exercise above an assigned testing threshold.
- To address our fraud risk around the manipulation of reported financial performance through improper recognition of expenditure we reviewed the Foundation Trust's manual year end expenditure accruals, challenging assumptions and corroborating the expenditure accruals to appropriate evidence. We also performed risk-based journal testing, tested variances in the agreement of balances exercise above an assigned testing threshold and performed completeness tests to ensure expenditure was recorded in the correct financial year.
- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately. We also tested and challenged the assumptions used in calculating accounting estimates and considered any significant and unusual transactions outside the normal course of business.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2022, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on

whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

Use of our report

This report is made solely to the Council of Governors of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. Our audit work has been undertaken so that we might state to the Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Hayley Clark
Ernst & Young LLP

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham
Date: 30 June 2025

Foreword to the accounts Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

A handwritten signature in brown ink, appearing to read 'Richard Parker'.

Richard Parker OBE
Chief Executive
30 June 2025

Statement of Comprehensive Income

	Note	Group		Trust	
		2024/25	2023/24	2024/25	2023/24
		£000	£000	£000	£000
Operating income from patient care activities	3	571,728	506,909	571,728	506,909
Other operating income	4	60,398	54,376	69,581	61,289
Operating expenses	7	(658,809)	(627,311)	(667,892)	(629,564)
Operating deficit from continuing operations		(26,683)	(66,026)	(26,583)	(61,366)
Finance income	12	2,116	1,705	2,044	1,704
Finance expenses	13	(304)	(241)	(304)	(241)
PDC dividends payable		(7,591)	(7,637)	(7,591)	(7,637)
Net finance costs		(5,779)	(6,173)	(5,851)	(6,174)
Other gains / (losses)	14	(34)	168	(2)	(286)
Corporation tax expense		(73)	(52)	-	-
Deficit for the year		(32,569)	(72,083)	(32,436)	(67,826)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Revaluations	8	1,234	3,271	1,234	3,271
Total comprehensive expense for the period		(31,335)	(68,812)	(31,202)	(64,555)
Deficit for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(32,569)	(72,083)	(32,436)	(67,826)
TOTAL		(32,569)	(72,083)	(32,436)	(67,826)
Total comprehensive expense for the period attributable to:					
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust		(31,335)	(68,812)	(31,202)	(64,555)
TOTAL		(31,335)	(68,812)	(31,202)	(64,555)

Adjusted Financial Performance

	2024/25	2023/24
	£000	£000
(Deficit) for the period for Trust	(32,436)	(67,826)
(Deficit) / surplus for the period for wholly owned subsidiary	215	(92)
(Deficit) for the period for non-charity aspects of the Group	(32,221)	(67,918)
Add back all I&E impairments	32,042	44,432
Remove capital donations/grants I&E impact	(2,244)	(192)
Adjusted financial performance (deficit)	(2,423)	(23,678)
Planned adjusted financial performance (deficit)	(2,428)	(26,796)

"Adjusted financial performance" is used for system reporting to NHS England.

It excludes technical non-recurrent adjustments to enable NHS England to monitor the underlying performance of the Trust.

Statement of Financial Position

	Note	Group		Trust	
		31 March	31 March	31 March	31 March
		2025	2024	2025	2024
		£000	£000	£000	£000
Non-current assets					
Intangible assets	17	9,236	8,954	9,236	8,954
Property, plant and equipment	18	277,301	277,808	277,301	277,808
Right of use assets	19	4,537	5,117	4,537	5,117
Other investments / financial assets	23	8,095	8,218	550	550
Receivables	26	2,738	2,989	2,738	2,989
Total non-current assets		301,907	303,086	294,362	295,418
Current assets					
Inventories	25	9,398	9,767	8,787	9,227
Receivables	26	27,986	25,891	33,953	29,023
Cash and cash equivalents	29	42,248	37,278	40,851	36,311
Total current assets		79,632	72,936	83,591	74,561
Current liabilities					
Trade and other payables	30	(90,743)	(94,888)	(90,559)	(92,380)
Borrowings	32	(1,467)	(1,927)	(1,467)	(1,927)
Provisions	35	(596)	(558)	(596)	(558)
Other liabilities	31	(5,020)	(3,726)	(5,020)	(3,726)
Total current liabilities		(97,826)	(101,099)	(97,642)	(98,591)
Total assets less current liabilities		283,713	274,923	280,311	271,388
Non-Current liabilities					
Borrowings	32	(10,620)	(11,727)	(10,620)	(11,727)
Provisions	35	(2,388)	(2,420)	(2,388)	(2,420)
Total non-current liabilities		(13,008)	(14,147)	(13,008)	(14,147)
Total assets employed		270,705	260,776	267,303	257,241
Financed by					
Public dividend capital		388,522	347,258	388,522	347,258
Revaluation reserve		61,153	59,919	61,153	59,919
Income and expenditure reserve		(182,372)	(149,936)	(182,372)	(149,936)
Charitable fund reserves	45	2,987	3,335	-	-
Doncaster & Bassetlaw Healthcare Services Ltd	46	415	200	-	-
Total taxpayers' equity		270,705	260,776	267,303	257,241

The notes on pages 7 to 50 form part of these accounts.

Signed

Date

30/06/2025

Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	DBHS Limited £000	Total £000
Taxpayers' and others' equity at 1 April 2024	347,258	59,919	(149,936)	3,335	200	260,776
(Deficit) / surplus for the year	-	-	(32,436)	(348)	215	(32,569)
Net Impairments	-	1,234	-	-	-	1,234
Public dividend capital received	41,264	-	-	-	-	41,264
Taxpayers' and others' equity at 31 March 2025	388,522	61,153	(182,372)	2,987	415	270,705

Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	DBHS Limited £000	Total £000
Taxpayers' and others' equity at 1 April 2023	271,208	56,648	(82,110)	7,500	292	253,538
(Deficit) for the year	-	-	(67,826)	(4,165)	(92)	(72,083)
Net Impairments	-	3,271	-	-	-	3,271
Public dividend capital received	76,050	-	-	-	-	76,050
Taxpayers' and others' equity at 31 March 2024	347,258	59,919	(149,936)	3,335	200	260,776

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024	347,258	59,919	(149,936)	257,241
(Deficit) for the year	-	-	(32,436)	(32,436)
Net Impairments	-	1,234	-	1,234
Public dividend capital received	41,264	-	-	41,264
Taxpayers' and others' equity at 31 March 2025	388,522	61,153	(182,372)	267,303

Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital	Revaluation reserve	Income and expenditure	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023	271,208	56,648	(82,110)	245,746
(Deficit) for the year	-	-	(67,826)	(67,826)
Net Impairments	-	3,271	-	3,271
Public dividend capital received	76,050	-	-	76,050
Taxpayers' and others' equity at 31 March 2024	347,258	59,919	(149,936)	257,241

Information on reserves

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential. If this is the case, a charge is made to the Statement of Comprehensive Income.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted.

DBHS Ltd reserve

This reserve comprises the ring-fenced funds held by Doncaster & Bassetlaw Healthcare Services Limited ("DBHS Ltd") which is a wholly owned subsidiary.

Statement of Cash Flows

	Note	Group		Trust	
		2024/25	2023/24	2024/25	2023/24
		£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(26,683)	(66,026)	(26,583)	(61,366)
Non-cash income and expense:					
Depreciation and amortisation	7.1	19,786	16,913	19,786	16,913
Net impairments	8	32,042	44,432	32,042	44,432
Income recognised in respect of capital donations	4	(3,042)	(675)	(3,042)	(675)
(Increase)/Decrease in receivables and other assets		(907)	11,376	(4,944)	9,632
(Increase) / decrease in inventories		369	(1,504)	440	(1,616)
(Decrease) in payables and other liabilities		(3,308)	(9,578)	(3,153)	(8,931)
(Decrease) in provisions		(42)	(293)	(42)	(293)
Movements in charitable fund working capital		(2,808)	3,557	-	-
Corporation tax paid		(52)	(21)	-	-
Other movements in operating cash flows		(23)	(31)	198	11
Net cash flows from / (used in) operating activities		15,332	(1,850)	14,702	(1,893)
Cash flows from investing activities					
Interest and dividends received		1,844	1,454	2,044	1,704
Purchase of intangible assets		(2,216)	(1,185)	(2,216)	(1,185)
Purchase of non-current assets and investment property		(43,193)	(59,070)	(43,193)	(59,070)
Sales of non-current assets and investment property		-	-	-	-
Receipt of cash donations to purchase capital assets		3,042	675	3,042	675
Net cash flows (used in) investing activities		(40,523)	(58,126)	(40,323)	(57,876)
Cash flows from financing activities					
Public dividend capital received		41,264	76,050	41,264	76,050
Movement on loans from DHSC		(543)	(1,833)	(543)	(1,833)
Capital element of lease liability repayments		(1,723)	(1,446)	(1,723)	(1,446)
Interest on loans		(209)	(231)	(209)	(231)
Interest element of lease liability repayments		(47)	(53)	(47)	(53)
PDC dividend paid		(8,581)	(8,897)	(8,581)	(8,897)
Net cash flows from financing activities		30,161	63,590	30,161	63,590
Increase in cash and cash equivalents		4,970	3,614	4,540	3,821
Cash and cash equivalents at 1 April		37,278	33,664	36,311	32,490
Cash and cash equivalents at 31 March	29	42,248	37,278	40,851	36,311

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2024/25, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the Group accounting manual 2024/25 accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the South Yorkshire Integrated Care System (ICS). The ICS has stated its immediate strategic plans, focusing on delivering the objectives set out in NHS England's 2025/26 priorities and operational planning guidance, and its response to the NHS long-term plan. The ICS plans assume the continued provision of services by the Trust. No circumstances were identified causing the Directors to doubt the continued provision of NHS services. The ICS plans align activity, workforce, mental health and capital submissions and fully account contracting arrangements.

This year, with an adjusted performance deficit of £2.4m, the Trust performed in line with its plan. This position recognises a significant level of financial and operational efficiencies that have been achieved in the year.

The Group reported a cash position at 31 March 2025 of £42.2m, which includes a capital creditors balance of £27.7m. The underlying cash challenge is expected to continue into 2025/26 and for the remainder of the going concern period to 30 June 2026.

For 2025/26, the Trust submitted a break-even financial plan to NHS England. South Yorkshire and Bassetlaw Integrated Care Board submitted an integrated financial plan to NHS England, incorporating the Trust's financial plan. This is based on a significant level of expected financial efficiencies. These financial efficiencies are still being developed and represent an element of risk for the Trust. Should these efficiencies either not be achieved, or achieved in a non-cash releasing way, the Trust may have to utilise the financing facilities offered by the Department of Health and Social Care, as it has done in previous years.

NHS operating and financial guidance is not yet issued for 2026/27, and so the Trust has based its assessment for the first quarter of 2026/27 on the same assumptions used to build the 2025/26 financial plan. Key assumptions include:

- a continuation of income and expenditure flows and performance in line with 2025/26 plans
- a continued need to deliver financial efficiencies

In conclusion, these assumptions, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the Corporate Trustee to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

The Trust has an investment of £550k of share capital in a wholly owned subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd currently provides out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen in Note 46. Its year end is the same as the Trust and Group.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In both 2023/24 and 2024/25 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Note 1.4.1 Revenue from contracts with customers (cont.)

Revenue from NHS contracts (cont)

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such, CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to Integrated Care Boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants. This is explained further in Note 1.4.2.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised when all conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1.5 Expenditure on employee benefits (cont.)

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are surplus and are measured at fair value where there are no restrictions preventing access to the market at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Note 1.7.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.4 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.5 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	Not depreciated	
Buildings, excluding dwellings	1	53
Dwellings	20	40
Plant & machinery	4	17
Transport equipment	9	9
Information technology	3	10
Furniture & fittings	8	10

Right of use assets (including land) are depreciated over the shorter of the useful life or the lease term.

Assets in the course of construction are not depreciated.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
All intangible assets	1	12

Note 1.9 Inventories

The Trust receives inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

The Trust has some inventories which are valued at the lower of cost and net realisable value, using the first-in first-out cost formula, with the rest being valued at weighted average cost.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets / liabilities measured at amortised cost are those held within a business model whose objective is to hold financial assets / liabilities in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Financial assets and financial liabilities at amortised cost

Financial assets / liabilities measured at amortised cost are those held within a business model whose objective is to hold financial assets / liabilities in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses. Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Note 1.11.2 Classification and measurement (cont.)

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11.4 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

Note 1.12.1 The Trust as lessee
Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022/23 and 3.51% to new leases commencing in 2023/24.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, which requires that Trust employs a revaluation model for subsequent measurement of right of use assets, in this instance the Trust considered the cost model to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.12.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 35.2 but it is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable. There are no such contingent assets.

Contingent liabilities are not recognised, but are disclosed in note 36, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital (PDC) and PDC Dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Foreign exchange

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction.

At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

The Trust performs all its transactions in Sterling.

Note 1.18 Corporation tax

As the Trust operates a wholly owned subsidiary, this entity is liable to corporation tax regulations. At present, the subsidiary does not have significant assets, and as such, deferred tax is not applicable. The subsidiary is liable to corporation tax in line with existing rates.

Note 1.19 Third party assets

The Trust does not hold any third party cash or cash equivalents.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks. The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. Details can be found in Note 42.

Note 1.22 Critical judgements in applying accounting policies and key sources of estimation uncertainty

Estimates and the underlying assumptions are reviewed on a regular basis by the Trust's senior management. Areas of estimation uncertainty or significant judgement made by management in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements are:

Income estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted. This is done utilising data extracted from the Trust's accounts payable system, allied with professional judgement of the Trust's expenditure profile and information from the Trust's departmental budget managers. The Trust is also required to account for the cost of annual leave carried forward, which is based on a statistically sound sample of staff.

Impairment of trade receivables

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables based on professional judgement and the type of debts typically held by the Trust.

Provisions

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated in the case of provisions for injury benefit claims and early retirements. The level of this provision is also based on information provided by the Government Actuaries Department. Other provisions that may arise are employee related claims and legal claims, which are based on information received from the Trust's insurers and internally generated information.

Valuation of property, plant and equipment

For Trust assets which are held for their service potential and are in use, they are valued at their current value in existing use.

For non-specialised assets, this is interpreted as market value in existing use, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV).

For specialised assets, this is interpreted as depreciated replacement cost on a modern equivalent asset basis, defined in the Royal Institution of Chartered Surveyors (RICS) Red Book. This establishes the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusts this value to take account of age and obsolescence. This obsolescence includes physical obsolescence (the wearing out of the asset over time) and functional obsolescence (the design and layout make it less fit for purpose than a more modern asset).

When revaluing an asset adopting the DRC approach, all of the construction and building materials cost of providing a modern equivalent asset have to be assessed using the prices at the date of valuation (ie 31 March 2025), before allowing for the depreciation of the asset.

The Trust has an ageing property portfolio, in a poor state of repair due to ongoing capital spending restrictions, which therefore impacts on the assumptions made in the valuation.

For land, this valuation methodology is performed on an alternative site basis, whereby the value is determined based on the cost of purchasing notional replacement sites in the same locality as the existing sites, taking into account the Trust's requirements to serve the local population. The application of valuation methodologies are covered in the accounting policies at Note 1.7.

In order to significantly reduce the risk of material misstatement for the land and buildings portfolio, the Trust commissions annual valuations from a RICS registered valuer. Generally, the Trust has a desktop valuation each year, and a full valuation every five years. The Trust commissioned a desktop property revaluation exercise as at 31 March 2025, following a full revaluation exercise as at 31 March 2024.

The Trust estimates the useful lives of property, plant and equipment based on the period over which the assets are expected to be available for use. The estimated useful lives of property, plant and equipment per Note 1.7.6 are reviewed periodically and are updated if expectations differ from previous estimates due to physical wear and tear, technical, legal or other limits on the use of the relevant assets.

Asset lives applied to the land and property portfolio are provided by the Trust's externally appointed and professionally qualified valuers.

Note 1.22 Critical judgements in applying accounting policies and key sources of estimation uncertainty contd Other areas

There are no other critical judgements, key assumptions concerning the future, or other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

Note 1.25 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 2 Operating Segments

The Trust Board, as the chief operating decision maker as defined by IFRS 8, consider that all of the Trust's activities fall under the single segment of 'Provision of Healthcare'. They consider that this is consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments. No further segmental analysis is therefore required.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature) - Trust and Group

	2024/25 £000	2023/24 £000
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	133,601	124,812
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	384,434	334,623
High cost drugs income from commissioners	26,633	27,531
Community services		
Income from other sources (e.g. local authorities)	678	1,057
All services		
Private patient income	3,016	3,216
Consultants / Agenda for Change pay offer central funding	1,483	231
Additional pension contribution central funding	21,883	13,428
Other clinical income	-	2,011
Total income from activities	571,728	506,909

Note 3.2 Income from patient care activities (by source) - Trust and Group

	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	53,994	47,164
Integrated care boards	511,954	453,406
NHS Foundation Trusts	17	53
Local authorities	678	1,057
Non-NHS: private patients	3,016	3,216
Non-NHS: overseas patients (chargeable to patient)	701	547
Injury cost recovery scheme	1,338	1,145
Non NHS: other	30	321
Total income from activities	571,728	506,909
Of which:		
Related to continuing operations	571,728	506,909

Note 3.3 Overseas visitors (relating to patients charged directly by the provider) - Trust and Group

	2024/25	2023/24
	£000	£000
Income recognised this year	701	547
Cash payments received in-year	87	152
Amounts added to provision for impairment of receivables	290	588
Amounts written off in-year	468	632

Note 4 Other operating income

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Research and development (contract)	851	901	851	901
Education and training (excluding notional apprenticeship levy income)	24,777	21,181	24,777	21,181
Non-patient care services to other bodies	27,812	27,416	37,415	34,985
Other contract income	1,547	1,534	1,547	1,534
Education and training - notional income from apprenticeship fund	1,382	1,316	1,382	1,316
Rental revenue from operating leases	567	571	567	571
Donations/grants of physical assets (non-cash) - received from other bodies	3,042	675	3,042	675
Charitable and other contributions to expenditure	-	16	-	16
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	-	110	-	110
Charitable fund incoming resources	420	656	-	-
Total other operating income	60,398	54,376	69,581	61,289
Of which:				
Related to continuing operations	60,398	54,376	69,581	61,289

Note 5.1 Income from activities arising from commissioner requested services - Trust

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	571,728	506,909
Income from services not designated as commissioner requested services	<u>69,581</u>	<u>61,289</u>
Total	<u>641,309</u>	<u>568,198</u>

For the Trust, commissioner requested services are all patient care activities.

Note 5.2 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings relating to services designated as commissioner requested services. Equipment that has been disposed, has been disposed of during the normal course of business.

Note 6 Fees and charges (Group)

The Group does not have any material fees or charges in either 2024/25 or 2023/24.

Note 7.1 Operating expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	15,182	4,733
Purchase of healthcare from non-NHS and non-DHSC bodies	12,227	17,484
Staff and executive directors costs	415,571	379,623
Remuneration of non-executive directors	170	169
Supplies and services - clinical (excluding drugs costs)	41,451	42,030
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	-	110
Supplies and services - general	8,076	6,608
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	53,906	48,501
Consultancy costs	174	370
Establishment	3,365	3,555
Premises	24,346	26,549
Transport (including patient travel)	2,118	2,280
Depreciation on property, plant and equipment	17,805	14,586
Amortisation on intangible assets	1,981	2,327
Net impairments	32,042	44,432
Movement in credit loss allowance: contract receivables / contract assets	(302)	427
Increase in other provisions	454	353
Change in provisions discount rate(s)	(58)	(63)
Audit fees payable to the external auditor		
audit services - statutory audit	294	243
audit services - audits of subsidiaries	90	43
Internal audit costs	70	64
Clinical negligence	17,794	16,782
Legal fees	1,038	608
Insurance	928	494
Research and development	880	590
Education and training	6,891	7,479
Car parking and security	1,373	1,426
Other	1	-
Other NHS charitable fund resources expended	942	5,508
Total	658,809	627,311
Of which:		
Related to continuing operations	658,809	627,311

Note 7.2 Other auditor remuneration (Group)

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any subsidiary of the Trust	90	43
Total	90	43

The value above is an estimated value as the Group is currently going through a tender process for the audit of its subsidiary.

The statutory audit fees for the Trust's audit of £294k include additional fees of £5k in relation to the 2023/24 financial statements audit. The audit fees for the subsidiaries of £90k are comprised of £58k of additional fees relating to the 2023/24 financial statements audit and £32k of estimated fees for the 2024/25 financial statement audits.

Note 7.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2,000k for 2023/24 and 2024/25.

Note 8 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	32,042	44,432
Total net impairments charged to operating surplus / deficit	32,042	44,432
Revaluation / impairments (and reversals) of property, plant and equipment (credited) / charged to the revaluation reserve	(1,234)	(3,271)
Total net impairments	30,808	41,161

The impairments in 2023/24 and 2024/25 arose due to a revaluation exercise on all land and buildings under the modern equivalent asset basis, as a result of changes in market value.

Note 9 Employee benefits (Group)

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	301,980	275,927
Social security costs	31,428	29,943
Apprenticeship levy	1,499	1,404
Employer's contributions to NHS pensions	33,532	30,826
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	21,883	13,428
Pension cost - other	138	111
Temporary staff (including agency and external bank)	31,118	34,866
Total gross staff costs	421,578	386,505
Total staff costs	421,578	386,505
Of which		
Costs capitalised as part of assets	1,128	1,375
Disclosed within:		
Staff and executive directors costs	415,571	379,623
Research and development	878	564
Education and training	4,001	4,943
	420,450	385,130

Note 9.1 Retirements due to ill-health (Group)

During 2024/25, there were 7 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £314k (£263k in 2023/24). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

There are no Director long term incentive schemes, other pension benefits, guarantees or advances.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

c) Alternative pension schemes

As a result of "automatic enrolment", the Trust has taken steps to ensure those members of staff who are not eligible for the NHS Pension Scheme, are enrolled into a pension scheme. The Trust treats such pension arrangements as a defined contribution pension and as such, no actuarial assumptions are required to measure the obligation or the expense and there is not possibility of any actuarial gain or loss.

Note 11 Operating leases (Group)

Note 11.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust is the lessor.

The Trust has a number of leasing arrangements for the use of land and buildings, mainly with other NHS organisations. The only significant leasing arrangement not with another NHS organisation is with Parkhill Hospital at Doncaster Royal Infirmary.

	2024/25 £000	2023/24 £000
Operating lease revenue		
Minimum lease receipts	567	571
Total	567	571
	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due:		
- not later than one year;	571	571
Total	571	571

Note 12 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2024/25 £000	2023/24 £000
Interest on bank accounts	1,844	1,454
NHS charitable fund investment income	272	251
Total finance income	2,116	1,705

Note 13.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2024/25	2023/24
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	206	224
Interest on lease obligations	50	52
Total interest expense	256	276
Unwinding of discount on provisions	48	(35)
Total finance costs	304	241

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

In 2023/24 and 2024/25, the Trust and Group does not have any liability or expense in relation to this legislation.

Note 14 Other gains (Group)

	2024/25	2023/24
	£000	£000
(Losses) on disposal of property, plant and equipment	(2)	(286)
Gains / (losses) on charitable fund investment revaluations	(32)	454
Total gains on disposal of assets	(34)	168
Total other gains	(34)	168

Note 15 Trust income statement and statement of comprehensive income

The Trust's (deficit) for the period was (£32,436k) (2023/24: (£64,826k)). The Trust's total comprehensive income/(expense) for the period was (£31,202k) (2023/24: (£64,555k)).

Note 16 Discontinued operations (Group)

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations. The Trust does not have any operations that are classified as discontinued in either 2023/24 or 2024/25.

Note 17.1 Intangible assets - 2024/25

Group and Trust	Software licences £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2024	26,029	27	26,056
Additions	2,216	-	2,216
Reclassifications	47	-	47
Disposals	-	-	-
Valuation / gross cost at 31 March 2025	28,292	27	28,319
Amortisation at 1 April 2024	17,102	-	17,102
Provided during the year	1,981	-	1,981
Disposals	-	-	-
Amortisation at 31 March 2025	19,083	-	19,083
Net book value at 31 March 2025	9,209	27	9,236
Net book value at 1 April 2024	8,927	27	8,954

Note 17.2 Intangible assets - 2023/24

Group and Trust	Software licences £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2023	24,874	27	24,901
Additions	1,185	-	1,185
Disposals	(30)	-	(30)
Valuation / gross cost at 31 March 2024	26,029	27	26,056
Amortisation at 1 April 2023	14,805	-	14,805
Provided during the year	2,327	-	2,327
Disposals	(30)	-	(30)
Amortisation at 31 March 2024	17,102	-	17,102
Net book value at 31 March 2024	8,927	27	8,954
Net book value at 1 April 2023	10,069	27	10,096

Note 18.1 Property, plant and equipment - 2024/25

Group and Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024	8,299	201,693	3,000	29,376	68,841	250	17,801	5,654	334,914
Additions	-	18,804	-	8,962	6,086	-	9,575	405	43,832
Additions - donated	-	-	-	-	3,042	-	-	-	3,042
Impairments charges to operating expenses	-	(40,222)	-	-	-	-	-	-	(40,222)
Impairments charged to the revaluation reserve	-	(2,982)	(97)	-	-	-	-	-	(3,079)
Revaluations / reversal of impairments credited to the revaluation reserve	-	4,269	44	-	-	-	-	-	4,313
Reclassifications	-	25,494	-	(25,494)	(10)	-	(47)	10	(47)
Disposals	-	-	-	-	(593)	-	-	(22)	(615)
Valuation/gross cost at 31 March 2025	8,299	207,056	2,947	12,844	77,366	250	27,329	6,047	342,138
Accumulated depreciation at 1 April 2024	-	-	-	-	40,370	239	11,496	5,001	57,106
Provided during the year	-	8,051	129	-	4,999	3	3,190	154	16,526
Impairments charges to operating expenses	-	(8,051)	(129)	-	-	-	-	-	(8,180)
Disposals	-	-	-	-	(593)	-	-	(22)	(615)
Accumulated depreciation at 31 March 2025	-	-	-	-	44,776	242	14,686	5,133	64,837
Net book value at 31 March 2025	8,299	207,056	2,947	12,844	32,590	8	12,643	914	277,301
Net book value at 1 April 2024	8,299	201,693	3,000	29,376	28,471	11	6,305	653	277,808

Note 18.2 Property, plant and equipment - 2023/24

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	8,299	218,142	2,518	17,401	64,720	250	15,174	5,530	332,034
Additions	-	11,433	-	35,918	5,365	-	2,652	198	55,566
Additions - donations of physical assets (non-cash)	-	-	-	-	675	-	-	-	675
Impairments charges to operating expenses	-	(54,439)	(179)	-	-	-	-	-	(54,618)
Impairments charged to the revaluation reserve	-	(4,918)	(96)	-	-	-	-	-	(5,014)
Revaluations / reversal of impairments credited to the revaluation reserve	-	7,916	369	-	-	-	-	-	8,285
Reclassifications	-	23,559	388	(23,943)	-	-	-	(4)	-
Disposals	-	-	-	-	(1,919)	-	(25)	(70)	(2,014)
Valuation/gross cost at 31 March 2024	8,299	201,693	3,000	29,376	68,841	250	17,801	5,654	334,914
Accumulated depreciation at 1 April 2023	-	2,289	32	-	37,738	234	10,570	4,929	55,792
Provided during the year	-	7,769	96	-	4,265	5	951	142	13,228
Impairments charges to operating expenses	-	(10,058)	(128)	-	-	-	-	-	(10,186)
Disposals	-	-	-	-	(1,633)	-	(25)	(70)	(1,728)
Accumulated depreciation at 31 March 2024	-	-	-	-	40,370	239	11,496	5,001	57,106
Net book value at 31 March 2024	8,299	201,693	3,000	29,376	28,471	11	6,305	653	277,808
Net book value at 1 April 2023	8,299	215,853	2,486	17,401	26,982	16	4,604	601	276,242

Note 18.3 Property, plant and equipment financing - 2024/25

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2025									
Owned - purchased	8,299	206,617	2,947	12,844	27,744	8	12,620	861	271,940
Owned - donated/granted	-	439	-	-	4,846	-	23	53	5,361
NBV total at 31 March 2025	8,299	207,056	2,947	12,844	32,590	8	12,643	914	277,301

Note 18.4 Property, plant and equipment financing - 2023/24

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2024									
Owned - purchased	8,299	201,693	3,000	29,376	25,801	11	6,305	653	275,138
Owned - donated/granted	-	-	-	-	2,670	-	-	-	2,670
NBV total at 31 March 2024	8,299	201,693	3,000	29,376	28,471	11	6,305	653	277,808

Note 19.1 Right of Use Assets - 2024/25

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2024	5,134	799	523	1,240	7,696
Lease additions and restatements	446	135	118	-	699
Valuation/gross cost at 31 March 2025	5,580	934	641	1,240	8,395
Accumulated depreciation at 1 April 2024	1,346	458	300	475	2,579
Provided during the year - right of use asset	637	217	177	248	1,279
Accumulated depreciation at 31 March 2025	1,983	675	477	723	3,858
Net book value at 31 March 2025	3,597	259	164	517	4,537
Net book value at 1 April 2024	3,788	341	223	765	5,117

Note 19.2 Right of Use Assets - 2023/24

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2023	4,702	799	523	1,240	7,264
Lease restatements	432	-	-	-	432
Valuation/gross cost at 31 March 2024	5,134	799	523	1,240	7,696
Accumulated depreciation at 1 April 2023	667	201	126	227	1,221
Provided during the year - right of use asset	679	257	174	248	1,358
Accumulated depreciation at 31 March 2024	1,346	458	300	475	2,579
Net book value at 31 March 2024	3,788	341	223	765	5,117
Net book value at 1 April 2023	4,035	598	397	1,013	6,043

Note 19.3 Right of Use Assets - Summary Information - 2024/25

The financial impact of the Right of Use Assets can be summarised by the following table, in line with paragraph 53 and 54 of IFRS 16:

	Note	2024/25	2023/24
Depreciation charge for RoU assets by class of underlying asset			
- Property (land and buildings)	19	637	679
- Plant & machinery		217	257
- Transport equipment		177	174
- Information technology		248	248
Total		1,279	1,358
Interest expense on lease liabilities	32	(47)	(53)
Expense relating to short term leases		-	-
Expense relating to leases of low value assets (excluding short term)		-	-
Expense relating to variable lease payments not in the liability		-	-
Income from subleasing		-	-
Total cash outflow for leases	32	(1,723)	(1,446)
Additions / Adjustments to right of use assets	19	699	432
Gains or losses arising from sale and leaseback transactions		-	-
Net Book Value of Right of Use assets by the following asset classification;			
- Property (land and buildings)	19	3,597	3,788
- Plant & machinery		259	341
- Transport equipment		164	223
- Information technology		517	765
Total		4,537	5,117

Note 20 Donations of property, plant and equipment

Doncaster & Bassetlaw Teaching Hospitals Foundation Trust has received donated assets totalling £3,042k in 2024/25. In 2023/24, donated assets totalling £675k were received.

Note 21 Revaluations of property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 to ensure that property is stated at fair value. The default frequency of these valuations is currently every five years, in accordance with the FT ARM. However, interim valuations are also carried out as deemed appropriate by the Trust. Valuations are performed by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual. The Trust commissioned an desktop valuation of its land and buildings as at 31st March 2025, which was undertaken by Cushman & Wakefield.

In 2023/24 and 2024/25, the Trust undertook a revaluation based on a Modern Equivalent Asset basis on its land and buildings.

Note 22 Investment Property

The Trust does not hold any Land, Buildings or Dwellings on an Investment only basis.

Note 23 Other investments / financial assets (non-current)

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	8,218	7,908	550	550
Acquisitions in year	3,275	2,435	-	-
Movement in fair value through income and expenditure	(32)	454	-	-
Disposals	(3,366)	(2,579)	-	-
Carrying value at 31 March	8,095	8,218	550	550

The Group investments relate to investments made by Doncaster & Bassetlaw Teaching Hospitals Charitable Funds as part of a diverse investment portfolio.

Note 23.1 Other investments / financial assets (current)

The Trust does not hold either other investments or financial assets (current).

Note 24 Disclosure of interests in other entities

The Trust does not hold any interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 25 Inventories

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Drugs	2,908	2,866	2,297	2,326
Consumables	6,490	6,901	6,490	6,901
Total inventories	9,398	9,767	8,787	9,227

Inventories recognised in expenses for the year were £75,556k (2023/24: £66,597k). Write-down of inventories recognised as expenses for the year were £17k (2023/24: £0k).

Note 26.1 Receivables

	Group		Trust	
	2025	2024	2025	2024
	£000	£000	£000	£000
Current				
Contract receivables	16,050	19,362	17,495	21,159
Allowance for impaired contract receivables / assets	(1,781)	(2,863)	(1,781)	(2,842)
Prepayments (non-PFI)	3,348	2,668	2,457	2,668
PDC dividend receivable	1,909	919	1,909	919
VAT receivable	5,827	5,211	5,276	4,760
Clinician pension tax provision reimbursement funding from NHSE	37	23	37	23
Other receivables	2,596	518	8,560	2,336
NHS charitable funds: receivables	-	53	-	-
Total current receivables	27,986	25,891	33,953	29,023
Non-current				
Contract receivables	2,734	2,947	2,734	2,947
Clinician pension tax provision reimbursement funding from NHSE	725	722	725	722
Allowance for impaired contract receivables / assets	(721)	(680)	(721)	(680)
Total non-current receivables	2,738	2,989	2,738	2,989
Of which receivable from NHS and DHSC group bodies:				
Current	12,431	10,888	12,431	10,888
Non-current	725	722	725	722

Note 26.2 Allowances for credit losses

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - brought forward	3,543	-	3,522	-
New allowances arising	720	-	720	-
Changes in the calculation of existing allowances	178	-	178	-
Reversals of allowances (where receivable is collected in-year)	(1,200)	-	(1,200)	-
Utilisation of allowances (write offs)	(739)	-	(739)	-
Allowances as at 31 Mar 2025	2,502	-	2,481	-

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2023 - brought forward	3,613	-	3,613	-
New allowances arising	707	-	686	-
Reversals of allowances (where receivable is collected in-year)	(280)	-	(280)	-
Utilisation of allowances (write offs)	(497)	-	(497)	-
Allowances as at 31 Mar 2024	3,543	-	3,522	-

Note 27 Other assets

The Trust does not have any receivables classified as other assets.

Note 28 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 29 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	37,278	33,664	36,311	32,490
Net change in year	4,970	3,614	4,540	3,821
At 31 March	42,248	37,278	40,851	36,311
Broken down into:				
Cash at commercial banks and in hand	1,142	668	-	-
Cash with the Government Banking Service	41,106	36,610	40,851	36,311
Total cash and cash equivalents as in SoFP and SOCF	42,248	37,278	40,851	36,311

Note 30 Trade and other payables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Trade payables	17,600	16,862	18,946	18,644
Capital payables	27,696	24,015	27,696	24,015
Accruals	30,849	37,102	30,129	36,826
Annual leave accrual	733	387	733	387
Social security costs	8,138	7,930	8,138	7,930
Other taxes payable	72	52	-	-
Pension contributions payable	4,620	4,278	4,620	4,278
Other payables	297	300	297	300
NHS charitable funds: trade and other payables	738	3,962	-	-
Total current trade and other payables	90,743	94,888	90,559	92,380

Of which payables from NHS and DHSC group bodies:

Current	10,726	8,879	10,726	8,998
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Note 31 Other liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Deferred income: contract liabilities	5,020	3,726	5,020	3,726
Total other current liabilities	5,020	3,726	5,020	3,726

Note 32 Borrowings

	Group		Trust	
	31 March	31 March	31 March	31 March
	2025	2024	2025	2024
	£000	£000	£000	£000
Current				
Loans from DHSC	565	568	565	568
Lease liabilities	902	1,359	902	1,359
Total current borrowings	1,467	1,927	1,467	1,927
Non-current				
Loans from DHSC	7,874	8,417	7,874	8,417
Lease liabilities	2,746	3,310	2,746	3,310
Total non-current borrowings	10,620	11,727	10,620	11,727

Note 32.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	8,985	4,669	13,654
Cash movements:			
Financing cash flows - payments and receipts of principal	(543)	(1,723)	(2,266)
Financing cash flows - payments of interest	(209)	(47)	(256)
Non-cash movements:			
Additions	-	564	564
Application of effective interest rate	206	50	256
Carrying value at 31 March 2025	8,439	3,513	11,952

Note 32.2 Lease liabilities - maturity analysis

	31 March 2025 £000
Undiscounted future lease payments payable in:	
- not later than one year;	902
- later than one year and not later than five years;	2,118
- later than five years	777
Total gross future lease payments	3,797
Finance charges allocated to future periods	(149)
Total net lease liabilities	3,648
Of which:	
Current - due in not later than one year	902
Non current - due in over one year	2,746
	3,648

Note 33 Other financial liabilities

Neither the Group or Trust has any other financial liabilities.

Note 34 Finance leases**Note 34.1 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessor**

Neither the Group nor the Trust does not have any finance lease receivables as a lessor.

Note 34.2 Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as a lessee

Neither the Group nor the Trust does not have any finance lease payables as a lessee.

Note 35.1 Provisions for liabilities and charges analysis - Group and Trust

Group and Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Clinicians' pension reimbursement	Lease Dilapidations (previously charged to revenue)	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2024	927	836	232	745	238	2,978
Change in the discount rate	(41)	(17)	-	(7)	-	(65)
Arising during the year	134	177	190	6	-	507
Utilised during the year	(86)	(125)	(26)	(19)	-	(256)
Reversed unused	(68)	(63)	(134)	-	-	(265)
Unwinding of discount	22	26	-	37	-	85
At 31 March 2025	888	834	262	762	238	2,984
Expected timing of cash flows:						
- not later than one year;	104	193	262	37	-	596
- later than one year and not later than five years;	313	457	-	95	238	1,103
- later than five years.	471	184	-	630	-	1,285
Total	888	834	262	762	238	2,984

The provision for legal claims is in respect of employer's liability and public liability cases made against the Trust. This figure is based on information provided by NHS Resolution which at present represents the Trust's best assessment of the likely future costs associated with processing the claims. The eventual settlement costs and legal expenses may be higher or lower than that provided.

Pensions: early departure costs (2024/25: £888k, 2023/24: £927k) and Pensions: injury benefits (2024/25: £810k, 2023/24: £836k) are calculated based on information provided by the NHS Business Services Authority - Pensions Division. There are uncertainties surrounding these provisions as the amounts incorporate assumptions made concerning the life expectancy of the individuals.

Clinicians' pension reimbursement relates to where the Trust makes good any tax incurred relating to clinicians' pensions through their work in the NHS. This is funded via NHS England, which can be seen by an equal and opposite entry within Receivables.

Note 35.2 Clinical negligence liabilities

At 31 March 2025, £204,105k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust. (31 March 2024: £195,397k)

Note 36 Contingent assets and liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities				
NHS Resolution legal claims	55	67	55	67
Gross value of contingent liabilities	55	67	55	67
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	55	67	55	67

The contingent liabilities relate to personal litigation claims above the amount included in provisions up to the maximum excess amount for which the Trust is liable.

Note 37 Contractual capital commitments

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	-	1,892	-	1,892
Total	-	1,892	-	1,892

Note 38 Other financial commitments

The Group / Trust does not have any commitments to make payments under non-cancellable contracts.

Note 39 Defined benefit pension schemes

The Trust does not operate any material defined pension schemes other than the statutory NHS Pension Scheme.

Note 40 Financial instruments

Note 40.1 Financial risk management

International Financial Reporting Standard 7 ("IFRS 7") requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICBs) and the way those ICBs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating and changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit risk

Credit risk is the risk of financial loss to the Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Trust's trade receivables. As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

The carrying amount of financial assets represents the maximum credit exposure. Therefore the maximum exposure to credit risk at the reporting date for the Group was £69,983k (2023/24: £65,525k), being the total of the carrying amount of financial assets.

With regard to the credit quality of financial assets and impairment losses, the movement in the allowance for impairment in respect of trade receivables during the year is disclosed in note 40.2.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's financial assets that is currently subject to a variable rate is cash held in the Foundation Trust's main bank accounts and in a short term deposit account. The Trust is therefore not exposed to significant risk of fluctuations in interest rates.

The Trust's operating costs are incurred under contracts with Integrated Care Boards and other NHS or Government bodies, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from cash reserves, loans or through the issue of PDC. All major capital expenditure is supported by detailed financial assessment including the assessment of cash flow requirements and impact on liquidity and any funding is within the Trust's prudential borrowing limit, as set by NHS England. The Trust is not, therefore, exposed to significant liquidity risks.

Note 40.2 Carrying values of financial assets

Group	Held at fair		Held at fair value through OCI	Total book value
	Held at amortised cost	value through I&E		
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2025 under IFRS 9				
Trade and other receivables excluding non financial assets	19,640	-	-	19,640
Cash and cash equivalents	41,106	-	-	41,106
Consolidated NHS Charitable fund financial assets	1,142	8,095	-	9,237
Total at 31 March 2025	61,888	8,095	-	69,983

Group	Held at fair		Held at fair value through OCI	Total book value
	Held at amortised cost	value through I&E		
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2024 under IFRS 9				
Trade and other receivables excluding non financial assets	20,029	-	-	20,029
Cash and cash equivalents	36,610	-	-	36,610
Consolidated NHS Charitable fund financial assets	668	8,218	-	8,886
Total at 31 March 2024	57,307	8,218	-	65,525

The only Group financial assets held at fair value through the I&E are the Investments held within the NHS Charitable Fund. These have been valued in a consistent manner throughout.

Trust	Held at fair		Held at fair value through OCI	Total book value
	Held at amortised cost	value through I&E		
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2025 under IFRS 9				
Trade and other receivables excluding non financial assets	27,049	-	-	27,049
Cash and cash equivalents	40,851	-	-	40,851
Total at 31 March 2025	67,900	-	-	67,900

Trust	Held at fair		Held at fair value through OCI	Total book value
	Held at amortised cost	value through I&E		
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2024 under IFRS 9				
Trade and other receivables excluding non financial assets	23,709	-	-	23,709
Cash and cash equivalents	36,311	-	-	36,311
Total at 31 March 2024	60,020	-	-	60,020

Note 40.2 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025 under IFRS 9			
Loans from the Department of Health and Social Care	8,439	-	8,439
Obligations under leases	3,648	-	3,648
Trade and other payables excluding non financial liabilities	76,442	-	76,442
IAS 37 provisions which are financial liabilities	2,984	-	2,984
Consolidated NHS charitable fund financial liabilities	738	-	738
Total at 31 March 2025	92,251	-	92,251

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2024 under IFRS 9			
Loans from the Department of Health and Social Care	8,985	-	8,985
Obligations under leases	4,669	-	4,669
Trade and other payables excluding non financial liabilities	82,557	-	82,557
IAS 37 provisions which are financial liabilities	2,978	-	2,978
Consolidated NHS charitable fund financial liabilities	3,962	-	3,962
Total at 31 March 2024	103,151	-	103,151

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025 under IFRS 9			
Loans from the Department of Health and Social Care	8,439	-	8,439
Obligations under leases	3,648	-	3,648
Trade and other payables excluding non financial liabilities	77,068	-	77,068
IAS 37 provisions which are financial liabilities	2,984	-	2,984
Total at 31 March 2025	92,139	-	92,139

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2024 under IFRS 9			
Loans from the Department of Health and Social Care	8,985	-	8,985
Obligations under leases	4,669	-	4,669
Trade and other payables excluding non financial liabilities	86,413	-	86,413
IAS 37 provisions which are financial liabilities	2,978	-	2,978
Total at 31 March 2024	103,045	-	103,045

Note 40.3 Fair values of financial assets and liabilities

The book value (carrying value) of receivables is a reasonable approximation of the fair value of the asset.

The book value (carrying value) of payables is a reasonable approximation of the fair value of the asset.

Note 40.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
In one year or less	79,243	89,026	80,586	88,920
In more than one year but not more than five years	5,391	6,281	5,391	6,281
In more than five years	7,766	7,983	7,766	7,983
Total	92,400	103,290	93,743	103,184

Note 41 Losses and special payments

Group and Trust	2024/25		2023/24	
	number of cases Number	value of cases £000	number of cases Number	value of cases £000
Bad debts	230	478	558	692
Fruitless payments and constructive losses	-	-	1	-
Total losses - bad debts	230	478	559	692
Compensation under court order or legally binding arbitration award	21	60	13	71
Ex-gratia payments	11	5	25	14
Total special payments	32	65	38	85
Total losses and special payments	262	543	597	777

Note 42 Gifts

In 2023/24 and 2024/25, the Trust did not make any gifts.

Note 43 Related parties

The total value of receivables and payables balances held with related parties as at 31 March, together with the associated income and expenditure transactions during 2024/25 and 2023/24, is:

Group and Trust 2024/25	Receivables 31 March 2025 £000	Payables 31 March 2025 £000	Income 2024/25 £000	Expenditure 2024/25 £000
Other NHS bodies	12,431	12,337	591,602	50,018
Other bodies (including WGA bodies)	5,827	12,970	708	88,974
	18,258	25,307	592,310	138,992

Group and Trust 2023/24	Receivables 31 March 2024 £000	Payables 31 March 2024 £000	Income 2023/24 £000	Expenditure 2023/24 £000
Other NHS bodies	11,610	10,806	530,738	36,351
Other bodies (including WGA bodies)	5,229	12,516	1,072	94,519
	16,839	23,322	531,810	130,870

The Department of Health and Social Care ("the Department") is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities include NHS England, Integrated Care Boards, NHS Foundation Trusts, NHS Trusts, NHS Resolution, the NHS Business Services Authority and the NHS Purchasing and Supply Agency.

"Other bodies (including WGA bodies)" includes local authorities, HM Revenue & Customs and NHS Pension Scheme.

The Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs (including National Insurance Fund), NHS Pension Scheme and Doncaster Metropolitan Borough Council.

Note 44 Events after Balance Sheet Date

There are no such events to report

Note 45 NHS Charitable Fund

The Trust is the Corporate Trustee of the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Charitable Fund (registered charity number 1057917). The object is for funds to be used "for any purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Doncaster and Bassetlaw Hospitals NHS Foundation Trust".

Summary statement of financial activities

	Total Funds	
	2024/25	2023/24
	£000	£000
Incoming resources	420	656
Resources expended	(1,008)	(5,526)
Net outgoing resources	<u>(588)</u>	<u>(4,870)</u>
Investment Income	272	251
Gains/(losses) on revaluation and disposal of investment	(32)	454
Net movement in funds	<u>(348)</u>	<u>(4,165)</u>
Fund balances at 1 April	3,335	7,500
Fund balances at 31 March	<u>2,987</u>	<u>3,335</u>

	Total Funds	
	2024/25	2023/24
Investment assets	8,095	8,218
Cash and receivables	1,142	721
Current liabilities	(6,250)	(5,604)
Total net assets	<u>2,987</u>	<u>3,335</u>
	2025	2024
	£000	£000
Unrestricted income funds	1,100	1,198
Other restricted income funds	1,887	2,137
	<u>2,987</u>	<u>3,335</u>

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 46 Doncaster & Bassetlaw Healthcare Services Ltd

The Trust has a wholly owned subsidiary, Doncaster & Bassetlaw Healthcare Services Ltd ("DBHS Ltd"). DBHS Ltd currently provides Out-patient pharmacy dispensary services at the Doncaster Royal Infirmary site. The summarised financial statements can be seen below:

Summary statement of financial activities

	2024/25 £000	2023/24 £000
Incoming resources	11,732	9,235
Resources expended	(11,317)	(9,077)
Net incoming resources	415	158
Dividends paid	(200)	(250)
Net movement in assets	215	(92)

	2024/25 £000	2023/24 £000
Current assets	2,757	2,853
Cash	255	299
Current liabilities	(2,247)	(2,402)
Total net assets	765	750
Share Capital	550	550
Income & Expenditure reserve	415	200
Total net assets	965	750



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



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Teaching Hospitals**
NHS Foundation Trust

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

CONSTITUTION

Name and title of author/reviewer:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance
Approved by The Board of Directors (subject to CoG and AMM approval):	2 September 2025
Approved by The Council of Governors and Annual members Meeting:	30 September 2025
Date Issued:	1 October 2025
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Table of Contents

Paragraph	Page No.
1. Interpretation and Definitions	4
2. Name	7
3. Principal Purpose.....	7
4. Powers.....	7
5. Membership and Constituencies	7
6. Public Constituency	8
7. Staff Constituency	8
8. Automatic Membership by Default and by Application – Staff	9
9. Restriction on Membership.....	9
10. Annual Members’ Meeting	10
11. Council of Governors - Composition	10
12. Council of Governors - Election of Governors.....	10
13. Council of Governors - Tenure	11
14. Council of Governors – Disqualification and Removal	11
15. Council of Governors – Duties of Governors.....	11
16. Council of Governors – Meetings of Governors.....	12
17. Council of Governors – Standing Orders	12
18. Council of Governors - Conflicts Of Interest of Governors	13
19. Council of Governors – Travel Expenses	13
20. Council of Governors – Further Provisions	13
21. Board of Directors – Composition	13
22. Board of Directors – General Duty	14
23. Board of Directors – Qualification for Appointment as a Non-Executive Director	14
24. Board of Directors – Appointment and Removal of Chair and Other Non-Executive Directors	14
25. Board of Directors – Appointment of Deputy Chair.....	16
26. Board of Directors - Appointment and Removal of the Chief Executive and Other Executive Directors.....	16
27. Board of Directors – Disqualification	17
28. Board of Directors – Meetings	17
29. Board of Directors – Standing Orders	17
30. Board of Directors - Conflicts of Interest of Directors.....	18
32. Registers	19
33. Registers – Inspection and Copies.....	19
34. Documents Available for Public Inspection.....	20
35. Auditor.....	21
36. Audit Committee	21
37. Accounts	21
38. Annual Report, Forward Plans and Non-NHS Work	21
39. Presentation of the Annual Accounts and Reports to the Governors and Members	22
40. Instruments	22
41. Amendment of The Constitution	22
42. Mergers etc. and Significant Transactions	23

Annex 1 - The Public Constituency24

Annex 2 - The Staff Constituency25

Annex 3 - Composition of Council of Governors27

Annex 4 - The Model Election Rules.....29

Annex 5 - Additional Provisions – Council of Governors.....62

Annex 6 - Further Provisions69

Annex 7 - Standing Orders for the Practice and Procedure of the Council of Governors.....78

Annex 8 - Standing Orders for the Practice and Procedure of the Board of Directors..... 93

Annex 9 - Annual Members Meeting111

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 28 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 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 1 st April in a calendar year and ending on 31 st 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

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 undertake activities other than those mentioned in section 3 for the purpose of making additional income available in order better to carry on 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, any of these powers may be delegated to a committee of directors or to an executive director.

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

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

7. PUBLIC CONSTITUENCY

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.

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:

7.2.1 they have made an application for Membership to the Trust; and

7.2.2 they are not eligible to become a Member of the Staff Constituency; and

7.2.3 they are not otherwise disqualified from Membership under paragraph 4 or paragraph 2 of Annex 6.

7.3 Those individuals who live in an area specified for a Public Constituency are referred to collectively as the Public Constituency.

7.4 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

8. STAFF CONSTITUENCY

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:

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

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

8.2 Those individuals who are eligible for Membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

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.

8.4 The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

9. AUTOMATIC MEMBERSHIP BY DEFAULT AND BY APPLICATION – STAFF

9.1 An individual who is:

9.1.1 eligible to become a Member of the Staff Constituency, and

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 they inform the Trust they do not wish to do so.

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.

10. SECTION 10 PATIENTS CONSTITUENCY

Not Used

11. SECTION 11 AUTOMATIC MEMBERSHIP BY DEFAULT -PATIENTS

Not Used

12. RESTRICTION ON MEMBERSHIP

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.

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.

12.3 An individual shall not be eligible for membership of the trust if they:

12.3.1 are under sixteen (16) years old at the date of their application or invitation to become a Member (as the case may be)

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

12.3.7 is deemed to have acted in a manner contrary to the interests of the Trust.

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.

13. ANNUAL MEMBERS' MEETING

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.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 9 – Annual Members' Meeting.

14. COUNCIL OF GOVERNORS - COMPOSITION

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.

14.2 The composition of the Council of Governors is specified in Annex 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.

15. COUNCIL OF GOVERNORS - ELECTION OF GOVERNORS

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules 2014.

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.

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 48 of the Constitution (amendment of the Constitution).

15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

- 16.1 An Elected Governor may hold office for a period of up to three (3) years.
- 16.2 An Elected Governor shall cease to hold office if they cease to be a Member of the Constituency or class by which they were elected.
- 16.3 An Elected Governor shall be eligible for re-election at the end of their term but no Elected Governor may hold office for more than nine (9) years. An Elected Governor may not stand for election again on completion of the maximum nine years. An Elected Governor who does not complete the maximum nine-year term may stand for re-election but only for the remaining years to achieve nine (9) years in total.
- 16.4 An Appointed Governor may hold office for a period of three (3) years.
- 16.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.
- 16.6 An Appointed Governor shall be eligible for re-appointment at the end of their term but no Appointed Governor may hold office for more than nine (9) years.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

- 17.1 The following may not become or continue as a member of the Council of Governors:
- 17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
 - 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;
 - 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 them;
 - 17.1.4 a governor, whose term of office is terminated in line with Annex 5 section 3.
- 17.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.
- 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.
- 17.4 Provisions for the removal of governors are set out in Annex 5.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

- 18.1 The general duties of the Council of Governors are:

- 18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and
- 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 (i.e. the Trust and local community which elects them) with a wider (regional) public interest across the Integrated Care Systems the Trust is linked with.

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.

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.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 28 below) or, in their absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 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.

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

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.

19.4 Details on the standing orders for the procedure and practice of the Council of Governors is given in Annex 7

20. COUNCIL OF GOVERNORS – STANDING ORDERS

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

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.

22. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

22.1 Governors are required to declare any pecuniary, personal or family interest on nomination 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

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.

23. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

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.

24. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. BOARD OF DIRECTORS – COMPOSITION

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

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.

25.3 The Board of Directors is to comprise:

25.3.1 a non-executive Chair (who shall have a casting vote)

25.3.2 other Non-Executive Directors (i.e. not including the Chair)

25.3.3 Executive Directors (but not exceeding the combined number of Non-Executive Directors and the Non-Executive Chair)

25.4 One of the Executive Directors shall be the Chief Executive.

25.5 The Chief Executive shall be the Accounting Officer.

25.6 One of the Executive Directors shall be the Chief Finance Officer.

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).

25.8 One of the Executive Directors is to be a registered nurse or a registered midwife.

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.

26. BOARD OF DIRECTORS – GENERAL DUTY

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.

27. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

27.1 A person may be appointed as a Non-Executive Director only if:

27.1.1 they are a Member of the Public Constituency; and

27.1.2 they are not disqualified by virtue of paragraph 33 below.

28. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

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.

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.

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.

28.4 The provisions of paragraph 5 of Annex 5 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

30. BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR

30.1 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.

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.

31. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

- 31.1 The Non-Executive Directors shall appoint or remove the Chief Executive.
- 31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.
- 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.

32. SECTION 32 (INITIAL FOUNDATION TRUSTS'S)

Not used

33. BOARD OF DIRECTORS – DISQUALIFICATION

- 33.1 The following may not become or continue as a member of the Board of Directors:
- 33.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
 - 33.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and who has not been discharged in respect of it;
 - 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 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;
 - 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
 - 33.1.6 a person who falls within the further grounds for disqualification set out in Annex 6.

34. BOARD OF DIRECTORS – MEETINGS

- 34.1 Meetings of the Board of Directors shall 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.
- 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.

35. BOARD OF DIRECTORS – STANDING ORDERS

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, and are given in Annex 8.

36. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

36.1 The duties that a director of the Trust has by virtue of being a director include in particular:

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.

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.

36.2 The duty referred to in sub-paragraph 36.1.1 is not infringed if:

36.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 The matter has been authorised in accordance with the constitution.

36.3 The duty referred to in sub-paragraph 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.

36.4 In sub-paragraph 36.1.2, “third party” means a person other than –

36.4.1 The Trust, or

36.4.2 A person acting on its behalf.

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.

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

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.

36.9 A director need not declare an interest –

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

36.9.2 if, or to the extent that, the directors are already aware of it;

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.

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.

37. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

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.

38. REGISTERS

38.1 The Trust shall have:

38.1.1 a register of Members showing, in respect of each Member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

38.1.2 a register of members of the Council of Governors;

38.1.3 a register of interests of Governors;

38.1.4 a register of Directors; and

38.1.5 a register of interests of the Directors.

39. ADMISSION TO AND REMOVAL FROM THE REGISTERS

39.1 The process of admission to and removal from the registers shall be as set out in Annex 6.

40. REGISTERS – INSPECTION AND COPIES

40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

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.

40.3 So far as the registers are required to be made available:

40.3.1 they are to be available for inspection free of charge at all reasonable times; and

40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

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.

41. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

- 41.1.1 a copy of the current Constitution;
- 41.1.2 a copy of the latest Annual Accounts and of any report of the auditor on them;
- 41.1.3 a copy of the latest Annual Report;
- 41.1.4 a copy of the latest Annual Quality Report.

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 at all reasonable times:

- 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.
- 41.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
- 41.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.
- 41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- 41.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
- 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.
- 41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- 41.2.8 a copy of any final report published under section 65I (administrator's final report),
- 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.
- 41.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with access to a copy.

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.

42. AUDITOR

42.1 The Trust shall have an External auditor.

42.2 The Council of Governors shall appoint or remove the External auditor at a general meeting of the Council of Governors.

43. AUDIT AND RISK COMMITTEE

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.

44. ACCOUNTS

44.1 The Trust must keep proper accounts and proper records in relation to the accounts.

44.2 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.

44.3 The accounts are to be audited by the Trust's external auditor.

44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as the Regulator may with the approval of the Secretary of State direct.

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.

45. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

45.1 The Trust shall prepare an Annual Report and send it to the Regulator.

45.2 The Trust shall give information as to its forward planning in respect of each financial year to the Regulator.

45.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

45.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

45.5 Each forward plan must include information about:

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

45.5.2 the income it expects to receive from doing so.

45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

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

45.6.2 notify the directors of the Trust and its determination.

45.7 Where the trust 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.

46. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors.

46.1.1 the annual accounts;

46.1.2 any report of the external auditor on them; and

46.1.3 the annual report.

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.

46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. INSTRUMENTS

47.1 The Trust shall have a seal.

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. AMENDMENT OF THE CONSTITUTION

48.1 The Trust may make amendments to its Constitution only if:

48.1.1 more than half of the members of the Council of Governors voting at a meeting approve the amendments; and

48.1.2 more than half of the members of the Board of Directors voting at a meeting approve the amendments.

48.2 Amendments made under paragraph 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.

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):

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

48.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

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.

49. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

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.

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 approve entering into the transaction..

49.3 For the purpose of paragraph 49.2, "significant transaction" means a transaction which meets any one of the following criteria:

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;

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;

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)	20	3
Doncaster	City of Doncaster (or any successor organisation)	20	8
Rest of England & Wales	Any other electoral area in England and Wales with the exception of the above	20	1
Total	Public Governors		12

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	20	1
Nurses and Midwives Staff Class	20	2
Other Healthcare Professionals Staff Class	20	1
Non-Clinical Staff Class	20	2
TOTAL	120	6

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 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, Midwives 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 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 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 appoint 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.

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) University of Sheffield;
- (b) Sheffield Hallam University;

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).

2.3.3 Each of the partnering organisations shall be entitled to appoint a Governor in accordance with a process of appointment agreed by it with the Trust.

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

	Electing / Appointing Body	Number of Governors	Total
1.	Public Constituencies		12
	1.1 Bassetlaw District	3	
	1.2 City of Doncaster	8	
	1.3 Rest of England and Wales	1	
2.	Staff Constituency		6
	2.1 Medical and Dental Practitioners Staff Class	1	
	2.2 Nurses and Midwives Staff Class	2	
	2.3 Other Healthcare Professionals Staff Class	1	
	2.4 Non-Clinical Staff Class	2	
3.	Appointed Governors		up to 6
	3.1 City of Doncaster Council	1	
	3.2 Bassetlaw District Council (or its successor organisation)	1	
	3.3	1	
	3.4 University of Sheffield	1	
	3.5 Sheffield Hallam University	2	
	Provision available for further two (2) appointed governors from partnership organisations appointed by the Trust		
	Total Elected Governors		15
	Total Maximum Appointed Governors		6
	Total Number of Governors including appointed		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

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public constituency)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public constituency)
33. Procedure for remote voting by internet
34. Procedure for remote voting by telephone

35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
 37. Validity of votes
 38. Declaration of identity but no ballot (public constituency)
 39. De-duplication of votes
 40. Sealing of packets

PART 6: COUNTING THE VOTES

- STV41. Interpretation of Part 6
 42. Arrangements for counting of the votes
 43. The count
 STV44. Rejected ballot papers and rejected text voting records
 STV45. First stage
 STV46. The quota
 STV47. Transfer of votes
 STV48. Supplementary provisions on transfer
 STV49. Exclusion of candidates
 STV50. Filling of last vacancies
 STV51. Order of election of candidates

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

- STV52. Declaration of result for contested elections
 53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
 55. Delivery of documents
 56. Forwarding of documents received after close of the poll
 57. Retention and public inspection of documents
 58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

- STV59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
 61. Expenses and payments by candidates
 62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
 64. Information about candidates for inclusion with voting information
 65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

- 67. Secrecy
- 68. Prohibition of disclosure of vote
- 69. Disqualification
- 70. Delay in postal service through industrial action or unforeseen event

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 they consider 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 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 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 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.

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 and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

- (a) that 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 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 they have not marked or returned any other voting information in the election, and
- (c) the particulars of 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 their declaration of identity with 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 their 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 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 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 they are 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 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 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 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 their vote;

- (b) prevent a voter from voting for more candidates than 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 they consider 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 they can obtain it.

- 29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

- (a) are satisfied as to the voter’s identity; and
- (b) 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 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 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 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 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 they:
 - (a) are satisfied as to the voter's identity,
 - (b) have no reason to doubt that the voter did not receive the original voting information,
 - (c) 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, 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 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 their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

- 33.5 The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

- 34.1 To cast 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 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 their vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.
- 34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. Voting procedure for remote voting by text message

- 35.1 To cast 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 their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish 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, 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, 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, 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:

¹ It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

- (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 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

STV41.1 In 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 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 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 their vote was given, and
- (ii) that 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 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 their own services voluntarily, in 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 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 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 they think 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 they have 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 they consider appropriate.

ANNEX 5– ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. Council of Governors: Terms of Office (see also Section 14)

a Governor shall:

- 1.1 be elected or appointed for a term of three years;
- 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;
- 1.3 shall cease to hold office if:
 - 1.3.1 in the case of an Elected Governor they cease to be a member of the constituency they represent or where relevant, the class of the constituency they represent and in the case of an Appointed Governor, the sponsoring organisation withdraws its sponsorship of them.
 - 1.3.2 their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or are otherwise ineligible to hold office as a Governor; or
 - 1.3.3 they resign by notice in writing to the Trust.
- 1.4 A Governor shall cease to hold office on death.

2. Council of Governors: Eligibility to be on the Council of Governors

- 2.1 A person shall not be eligible to become or continue in office as a Governor if:
 - 2.1.1 In the case of an elected governor they cease to be eligible to be a Member of the constituency or class within the constituency which they represent
 - 2.1.2 in the case of an Appointed Governor, the appointing organisation withdraws its sponsorship of them;
 - 2.1.3 any of the grounds contained in paragraph 17 of the Constitution apply to them;
 - 2.1.4 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;
 - 2.1.5 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 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;
 - 2.1.6 they 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 ;

- 2.1.7 they have failed to make, or have falsely made, any declaration as required to be made under Section 60 of the 2006 Act or have spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and they are judged to have acted so by a majority 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);
- 2.1.9 They are a person who is the subject of a disqualification order made under the company Directors Disqualification Act 1986;
- 2.1.10 The Regulator has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor 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 DBTH or some other NHS Foundation Trust;
- 2.1.11 they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff in the preceding 10 years;
- 2.1.12 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);
- 2.1.13 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 them;
- 2.1.14 their term of office is terminated pursuant to paragraph 3 below;
- 2.1.15 they are a Member of a Staff Class and any professional registration relevant to 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 they are a person incapable by reason of mental disorder, illness or injury in managing and administering their property and/or affairs;
- 2.1.17 They are 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;
- 2.1.19 They 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
- 2.1.20 the relevant organisation which they represent ceases to exist;

- 2.2 Where a person has been elected or appointed to be a Governor and they become disqualified from that appointment 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 them disqualified or removed.
- 2.3 If it comes to the notice of the Company Secretary that a Governor is disqualified, the Company Secretary shall immediately declare the Governor disqualified and shall give them notice in writing to that effect as soon as practicable.
- 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 their name shall be removed from the Register of Governors.
- 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;
 - 2.5.1

3. Council of Governors: Termination of Tenure

- 3.1 A Governor's term of office shall be terminated:
 - 3.1.1 by the Governor giving notice in writing to the Company Secretary of their resignation from office at any time during that term of office;
 - 3.1.2 by the Trust if it becomes aware of the Governors ineligibility to continue in office for any of the previously stated reasons;
 - 3.1.3 by the Council of Governors if they have 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.
 - 3.1.4 if the Council of Governors resolves to terminate their term of office for reasonable cause on the grounds that in the reasonable opinion of the majority of Governors present and voting at a meeting of the Council of Governors that their continuing as a Governor 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 their continuance in office would not be in the best interests of the Trust; or
 - (g) They have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor by a date six months from the date of their election or appointment; or from a date when they have been asked to undertake additional training or development for any reason;
 - (h) 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) They have committed a material breach of any code of conduct applicable to Governors of the Trust and/or the Governors Standing Orders;
- 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 their name shall be forthwith removed from the Register of Governors.
- 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 their resignation or removal from office. Any re-election would take into account time served as a Governor so that a maximum term would not exceed nine years.
- 3.4 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out above, Elected Governors shall be replaced in accordance with paragraphs 4.1 to 4.4 below.

4. Council of Governors Vacancies

Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the following provisions apply:

- 4.1 In the case of an Elected Governor, where a vacancy arises within 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.
- 4.2 If the vacancy arises during the last 11 months of office, the office will remain vacant until it is filled at the next scheduled election.
- 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.

- 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.

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 the remuneration and 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.

- 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.

- 5.3 Subject to the requirements specified above, each Governor shall exercise their own skill and judgement in their conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring an appropriate perspective of the constituency or organisation by which they were elected or appointed.

- 5.4 The general duties of the Council of Governors are;

- 5.4.1 to hold the Non-Executive Directors to individually and collectively to account for the performance of the Board of Directors;
- 5.4.2 to represent the interests of the Trust as a whole and the interests of the public.

6. Council of Governors: Meetings

- 6.1 The Council of Governors shall hold not less than 3 general meetings each financial year.
- 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.

7. Council of Governors: Declarations

- 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 they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution.

The specified form of declaration shall be set out on the Nomination Form referred to in the Election Scheme.

8. Council of Governors: Lead Governor

- 8.1 No person may serve as the Lead Governor for more than a total of nine years.
- 8.2 A person elected as the Lead Governor shall cease to be eligible to continue serving as the Lead Governor if they cease 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.

9. Council of Governors: Appointment of Senior Independent Director

- 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.
- 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 Chief Finance Officer has failed to resolve or for which such contact is inappropriate.
- 9.3 A person appointed as the Senior Independent Director shall cease to be eligible to continue serving as the Senior Independent Director if they cease 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 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 they cease to live in the area of the Public Constituency of which 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 they are a Member they shall forthwith advise the Trust that they are no longer eligible to continue as a Member and the Trust shall forthwith remove 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 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 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 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.
 - 4.1.7 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.

5. Board of Directors: Disqualification

- 5.1 In addition to the grounds of disqualification set out in Sections 28 -31 of the Constitution, a person may also not be or continue as a Director of the Trust if:
- 5.1.1 in the case of a Non-Executive Director, s/he no longer satisfies the relevant requirements for appointment;
 - 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;
 - 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;
 - 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;
 - 5.1.5 in the case of an Executive Director, s/he is no longer employed by the Trust;
 - 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;
 - 5.1.7 s/he is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;
 - 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;
 - 5.1.9 s/he has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake.

5.1.10 s/he is a partner or spouse of an existing Director.

6. Governors and Directors: Communication and Conflict

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.

6.2 Informal Communications

- 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.
- 6.2.2 The Chair shall use 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 Chief Executive or their nominated officer; and
 - (d) involvement in Membership recruitment and briefing at public events organised by the Trust.

6.3 Formal Communication

- 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.
- 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.

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.

6.3.4 Communications initiated by the Board of Directors and intended for the Council of Governors will be conducted as follows:

- (a) the Board of Directors' proposals for the strategic direction and the Annual Report and Forward Plan;
- (b) the Board of Directors' proposals for developments;
- (c) Trust Performance;
- (d) involvement in service reviews and evaluation relating to the Trusts services ; and proposed changes, plans and developments for the Trust other than those covered above.

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.

6.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:

- (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, the Deputy Chair or the Senior Independent Director;

6.4 Resolving Conflict between the Council of Governor and the Board of Directors

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.

6.4.2 If the Chair cannot achieve resolution of a disagreement or dispute between the Council of Governors and the Board of Directors through informal efforts the Chair will follow the dispute resolution process described 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.

- (a) the Chair will call a joint meeting (Resolution Meeting) of equal numbers 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 resolution meeting will be held in private. 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 the Resolution Meeting fails to resolve the conflict, the dispute will be deferred back to the Board of Directors who shall make the final decision;
- (c)

7. Resolving Disputes about the Entitlement to Membership of the Trust and Eligibility for Membership of the Council of Governors

- 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.
- 7.2 The Chief Executive (or their nominated representative) shall:
 - 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;
 - 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
 - 7.2.3 communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.
 - 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.

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.
- 8.3 The Trust 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 Charity or Director of a wholly owned subsidiary.

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.

10. Registers

- 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.
- 10.2 Register of Members
 - 10.2.1 Members must complete and sign an application in the form prescribed by the Company Secretary; and
 - 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.
- 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.
- 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.
- 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.

11. Auditor

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:

11.1.1 the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998; or

11.1.2 any other body of accountants established in the United Kingdom and approved by The Regulator.

12. Accounts

12.1 The following documents will be made available to the Comptroller and Auditor General for examination at their request:

12.1.1 the accounts;

12.1.2 any records relating to them; and

12.1.3 any report of the auditor on them.

12.2 In preparing its annual accounts, the Trust is to comply with any directions given by the Regulator with the approval of the Treasury as to:

12.2.1 the methods and principles according to which the accounts are to be prepared; and

12.2.2 the information to be given in the accounts.

12.3 The Trust must:

12.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

12.3.2 once it has done so, send copies of those documents to the Regulator

12.4 Annual reports and forward plans

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.

12.4.2 The Trust is to comply with any decision NHS Improvement/England makes as to:

12.4.3 the form of the reports;

12.4.4 when the reports are to be sent to it; and

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

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 2.17 (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 advisers 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 themselves 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

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 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.