Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

4 November 2025

10:30 GMT Europe/London

Boardroom. Montagu Hospital Adwick Rd, Mexborough S64 0AZ

AGENDA

2511 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

Board of Directors Public Agenda - 4 November 2025 v5.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 4 November at 10:30am
in the Boardroom at Montagu Hospital

		Purpose	Page	Time
A	**OPENING ITEMS**			**10:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair of the Board* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known*			5
A2	Actions from previous meeting *Suzy Brain England OBE, Chair of the Board*	*Review*		
A3	Chair's Report including Partnership Update *Suzy Brain England OBE, Chair of the Board*	*Information*		10
A4	Chief Executive's Report including Partnership Update *Richard Parker OBE, Chief Executive*	*Information*		10
	BOARD LEARNING & REFLECTION			**10:55**
A5	Little Voices – Little Steps *Zara Jones, Deputy Chief Executive* *Katie Simpson, Paediatric Planned Care Matron*	*Note*		15
B	**PATIENTS**			**11:10**
B1	Audiology Service Update *Nick Mallaband, Acting Executive Medical Director*	*Review*		10
B2	Audiology Lessons Learned Report *Zara Jones, Deputy Chief Executive*	*Discuss*		10
B3	Maternity & Neonatal Safety Report (Interim) *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Assurance*		10
B4	Digital Enabling Plan *Sam Wilde, Chief Finance Officer* *Dan Howard, Chief Information Officer*	*Approve*		10

B5	Medium Term Planning Framework *Zara Jones, Deputy Chief Executive*	*Note*		5
C	**PEOPLE**			**11:55**
C1	Guardian of Safe Working Report *Zoe Lintin, Chief People Officer* *Mohammad Khan, Guardian of Safe Working*	*Assurance*		10
C2	Freedom to Speak Up Bi-annual Report *Zoe Lintin, Chief People Officer* *Paula Hill, Freedom to Speak Up Guardian*	*Assurance*		10
BREAK 12:15 – 12:45				
D	**PARTNERSHIP**			**12:45**
D1	Doncaster & Bassetlaw Healthcare Services Update *Sam Wilde, Chief Finance Officer*	*Assurance*		5
E	**ASSURANCE & GOVERNANCE**			**12:50**
E1	Integrated Quality & Performance Report *Executive Directors*	*Assurance*		20
E2	Finance & Activity Report – Month 6 *Sam Wilde, Chief Finance Officer* *Denise Smith, Chief Operating Officer*	*Note*		10
E3	Delivery of 2025/26 Strategic Success Measures *Zara Jones, Deputy Chief Executive*	*Assurance*		10
E4	Board Assurance Framework including Trust Risk Register *Zara Jones, Deputy Chief Executive* *Executive Directors*	*Approve*		10
E5	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2025/26 *Denise Smith, Chief Operating Officer*	*Assurance*		5
E6	NHSE Provider Capability Self-assessment Framework *Zara Jones, Deputy Chief Executive*	*Note*		5
E7	Use of Trust Seal *Zara Jones, Deputy Chief Executive*	*Note*		5
E8	Chair's Assurance Log – Finance & Performance Committee *Mark Bailey, Non-executive Director*	*Assurance*		5
E9	Chair's Assurance Log – Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5

E10	Chair's Assurance Log – People Committee *Lucy Nickson, Non-executive Director*	*Assurance*		5
E11	Chair's Assurance Log – Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5
F	**INFORMATION**			**14:15**
F1	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		-
G	**CLOSING ITEMS**			**14:15**
G1	Minutes of the meeting held on 2 September 2025 *Suzy Brain England OBE, Chair of the Board*	*Approve*		5
G2	Pre-submitted Governor questions regarding the business of the meeting (10 minutes) * *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
G3	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair of the Board*	*Discussion*		10
G4	**Date and time of next meeting:** **Date:** Tuesday 6 January 2026 **Time:** 9:30am **Venue:** MS Teams	*Information*		
G5	**Withdrawal of Press and Public** Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. *Suzy Brain England OBE, Chair of the Board*	*Note*		
H	**MEETING CLOSE**			**14:40**
Governor Questions				

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

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

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

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

Suzy Brain England OBE
Chair of the Board

2511 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Standing item | Suzy Brain England OBE, Chair of the Board | 10:30

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

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

REFERENCES

Only PDFs are attached

A1 - Register of Interests & FPP (01.10.2025).pdf

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

Register of Interests

Suzy Brain England OBE, Chair of the Board
Chair at Keep Britain Tidy
Lead Examiner for Chartered Director by the Institute of Directors
Founder and Director of Cloud Talking, Aspirational Mentoring
Co-opted Board member Doncaster Chamber of Commerce
Advisory Committee on Clinical Impact Awards (ACCIA)
Non-executive Director West Yorkshire Combined Authority

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

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

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

Stephen Radford, Non-Executive Director
Non-executive Director, Barnsley Hospital NHS Foundation Trust
Associate, Proservartner
Resident Director, Hartcliffe Meadows (Penistone) Management Company Limited

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

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

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

(as at 1 October 2025)

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

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

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

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

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

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

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

The following have no relevant interests to declare:

Emyr Jones	Non-Executive Director
Zara Jones	Deputy Chief Executive

(as at 1 October 2025)

Fit and Proper Person Declarations

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

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

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

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

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

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

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

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

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

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

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

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

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

(as at 1 October 2025)

2511 - A2 ACTIONS FROM PREVIOUS MEETING

Standing item | Suzy Brain England OBE, Chair of the Board | 10:30

5 minutes

REFERENCES

Only PDFs are attached

A2 - BoD Action Log - 2 September 2025.pdf

Action notes prepared by: Angela O'Mara
Updated: 28 October 2025

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	2 September 2025

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P25/07/B1**	**<u>Audiology Reporting</u>** Performance against agreed trajectories, including clinical priorities, to be incorporated into future Audiology Service updates.	**ZJ**	**September 2025**	**Update 21/8/2025** – capacity and demand work in progress with the Elective Care Improvement Support Team to support/inform trajectories. **Update 02/09/2025 -** The Acting Executive Medical Director confirmed a detailed plan and had been worked through with NHSE Intensive Support Team. The Deputy Chief Executive confirmed that the detailed plan and performance data would be shared with the Finance and Performance Committee. **Action to be closed**.
2.	**P25/07/D1**	**<u>Doncaster & Bassetlaw Healthcare Services</u>** To establish a set of metrics against which performance could be reported.	**SW**	**November 2025**	Included in the paper @ agenda item D1

2511 - A3 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Suzy Brain England OBE, Chair of the Board | 10:35

10 minutes

REFERENCES

Only PDFs are attached

A3 - Chair's Report including Partnership Update.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Chair's Report including Partnership Update**			
Executive Sponsor:	Suzy Brain England OBE, Chair of the Board			
Authors:	Angela O'Mara, Deputy Company Secretary			
Appendices:	None			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	-			

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

Recommendations
The Board is asked to note the report.

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

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **N/A**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Chair's Report

Suzy Brain England
Chair of the Board

Clinical Research Hub

I had the pleasure of officially opening the Clinical Research Hub at Doncaster Royal Infirmary in September. This space provides a welcoming, purpose-built environment for research participants, enhancing their comfort and experience, whilst giving clinicians the space and facilities they need to deliver high-quality studies.

The Trust has a broad and diverse research portfolio, including maternity, paediatrics, surgical and medical specialities and is committed to embedding a culture of research and innovation.

This dedicated research space is essential in supporting the Trust's strategic ambition to become a leading centre for education and research, ensuring that the benefits of research are felt not only by our patients and colleagues, but also by our wider communities across South Yorkshire.

Annual Members Meeting

The Trust held its Annual Members Meeting in the Education Centre at Doncaster Royal Infirmary on 30 September. Board members welcomed members of the public, governors, colleagues and the City of Doncaster Council's Civic Mayor, Councillor Tim Needham. Ahead of the formal meeting, colleagues from across the Trust, showcased their work and local initiatives including virtual wards, stroke services, digital, health and well-being and Freedom to Speak Up. During the meeting, we presented the Trust's 2024/25 Annual Report and Accounts, reflected on achievements, and shared plans for the future; speakers included the Chief Executive, Chief Finance Officer and Lead Governor. In addition to the routine meeting business, revisions to the Trust's Constitution were agreed following consultation with the Board of Directors and Council of Governors. As this was my final Annual Members Meeting, I shared some personal reflections, acknowledging the significant journey and achievements of the Trust and its colleagues during my nine years as Chair of the Board. I also announced that the Council of Governors had approved the appointment of Non-executive Director, Mark Bailey, as Interim Chair, with effect from 1 January 2026. I will work closely with Mark over the next couple of months to ensure a smooth transition and wish him every success. The Annual Report and Accounts, presentations and questions and answers can be found here.

Provider Capability Assessment

In response to recently published NHS England guidance, the Board has recently undertaken a review to assess the organisation's capability against six domains: strategy, leadership and planning, quality of care, people and culture, access and delivery of services, productivity and value for money and financial performance and oversight. The framework will ensure a transparent view of performance, enabling consistent and fair assessment across the NHS. Statements of evidence, supported by wider performance data and external evidence will be considered by regional teams to ensure Trusts have the necessary support to deliver national priorities for patients.

Our People

The Board welcomes Stephen Radford, Non-executive Director to his first Board of Directors meeting, since joining on 1 October 2025. A qualified accountant with over 30 years of private and public sector experience, Stephen brings with him a wealth of knowledge and experience, including the delivery of large-scale transformational change. Stephen is a non-executive board member at Barnsley Hospital NHS Foundation Trust and his insight, and experience will be invaluable as we continue to strengthen our leadership and deliver on our strategic ambitions for patients and colleagues across Doncaster, Bassetlaw and beyond.

Doncaster & Bassetlaw Teaching Hospitals Charity has recently appointed Adrian Petts as the Head of Charity, and I was delighted to meet with him as part of his induction programme. Charitable fundraising activities support a wide range of initiatives across the Trust to support patients and colleagues over and above what is funded by the NHS.

The Chief Executive highlights in his report the good progress made in vaccinating colleagues against influenza, since the seasonal campaign started on 1 October 2025.

The Trust is also encouraging expectant mums to take up their free flu vaccination, which is available in antenatal clinics, GPs or local pharmacies. The vaccine is safe at any stage of pregnancy and helps protect both mother and baby. For everyone else, flu jabs are now available across Doncaster and Bassetlaw in most GP practices and community pharmacies, so please come forward as soon as you're invited. Every vaccination helps protect you, your loved ones and our local NHS this winter.

Partnerships

There has been significant charitable investment at the Trust over many years, with the support of the Fred and Ann Green Legacy, Doncaster Cancer Detection Trust (DCDT) and the Trust's Charity. As DCDT's work as a registered charity comes to a close, it is fitting for me to recognise the incredible support offered over the last 60 years and place on record our thanks. The charity, with the support of local fundraisers, secured the original scanner unit at Doncaster Royal Infirmary in the 1970s, the Jeanette Fish CT Suite, and more recently three ultrasound machines, vital in the diagnosis and monitoring of cancer. The Trust will now continue their mission, through a dedicated ring-fenced fund to raise money specifically for

cancer detection, treatment and innovation, ensuring that DCDT's vision and impact carry on long into the future.

The Trust continues to take all opportunities to work collaboratively with its partners, exploring opportunities to provide healthcare across the communities we serve. South Yorkshire & Bassetlaw Acute Federation is considering the future of fragile services across the system in order to explore more sustainable service models. The Trust recently welcomed the Chair of Sherwood Forest Hospitals to Bassetlaw Hospital where colleagues showcased the development, previously known as Bassetlaw Emergency Village, which houses the Emergency Department, Children's Assessment Unit and Acute Treatment Unit. One of a number of capital projects completed in recent years this along with other developments, including the Mexborough Elective Orthopaedic Centre of Excellence and Community Diagnostic Centre, demonstrate the Trust's strategic ambition to provide the best care environments.

I continue to meet with the South Yorkshire Chairs, our own Chief Executive and the NHS England Regional Director. Recently, I, Richard Parker and Mark Bailey have met with the Regional Director to consider the Trust's mid-year performance, focusing on key priorities, mitigating actions and opportunities across quality, performance and finances.

Sitting across two Integrated Care Systems, the Trust continues to engage at a Place and System level with our partners in South Yorkshire and Nottingham and Nottinghamshire to bring organisations and services together at a local level, in order to better focus on improving care, make the best use of available resources and address health inequalities. In April 2026 Nottingham & Nottinghamshire Integrated Care Board will form a cluster arrangement with Derby and Derbyshire and Lincolnshire Integrated Care Boards as part of wide-ranging Government reform of the NHS and healthcare landscape. The ICBs' cluster arrangements will mean that the three current ICBs will work together whilst remaining separate legal entities and will have responsibility for healthcare planning and provision across Derby City, Derbyshire, Lincolnshire, Nottingham City and Nottinghamshire. The aim is to streamline operations, adjust the existing ICB role to have greater focus on health need and outcomes, and to reduce the overall taxpayer cost of NHS commissioning organisations. The clustered ICBs will oversee the local delivery of ambitious plans for NHS healthcare. Having worked closely with the Chair and Chief Executive of Nottingham and Nottinghamshire ICB, Dr Kathy McLean OBE and Amanda Sullivan, I am delighted to hear they have been appointed as the Chair and Chief Executive Designates for the Integrated Care Board Cluster.

To close, as this is my last Board of Directors meeting, I would like to take a moment to reflect on the last nine years as Chair of the Board. I've seen this organisation change, grow and achieve so much, often in the face of real challenges. The colleagues who give so much of themselves every single day, always with dedication, kindness and professionalism. The patients who place their trust in us at their most vulnerable moments, who remind us why our work matters. And the families who turn to us in times of greatest need, who put their faith in our care, and who walk alongside us through joy and through heartbreak. It is those faces, those stories, and those small, human moments of compassion and connection that I will remember the most. They are what make DBTH not just an organisation, but a community and one that I am immensely proud to have been part of. I leave knowing this organisation is in very safe hands, with a strong and capable Board of Directors, and with a Chief Executive in Richard Parker who has been a constant source of support throughout my time here.

2511 - A4 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Richard Parker OBE, Chief Executive | 10:45

10 minutes

REFERENCES

Only PDFs are attached

A4 - Chief Executive's Report including Parnership Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4November 2025
Report Title/ Ref:	**Chief Executive's Report including Partnership Update**			
Executive Sponsor:	Richard Parker OBE, Chief Executive			
Authors:	Emma Shaheen, Director of Communication & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1 - 7			

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

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

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

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

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Chief Executive's Report

Richard Parker OBE
Chief Executive

November 2025

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

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

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

Patients

We deliver safe, exceptional, person-centred care.

Veteran Aware Trust – One Year Approved

Following the trust's initial accreditation awarded in 2018, and re-accreditation in March 2024, we have successfully had our Veteran Aware review approved. As a Veteran Aware accredited organisation, we strive to treat these individuals with the respect and dignity that they deserve, whilst also endeavouring to improve the care we offer to them.

Veteran Aware information for colleagues is available on the HIVE and for patients on the DBTH website.

Cancer patients praise care in national survey

The latest National Cancer Patient Experience Survey shows high levels of satisfaction across a range of measures.

Feedback highlighted that patients felt supported and well-informed throughout their treatment. Almost all respondents said the advice from their main contact person was helpful, while the majority reported that their care plans were kept up to date.

Many also spoke positively about the information they were given on available support, and about how well the care team worked together. Privacy was rated particularly highly, especially when patients were receiving important test results.

Overall, respondents gave DBTH an average score of nine out of ten for the care they received, and our teams will be working hard to continue to improve our patients experience.

Feedback informs improvements to paediatric care

Families on the children's wards at Doncaster Royal Infirmary and Bassetlaw Hospital will notice a number of new changes designed to improve patient experience.

A series of practical improvements – including welcome booklets, bedside communication boards, daily 4pm huddles, child-friendly procedure guides, and clearer discharge information – are now in place to strengthen communication, provide reassurance, and make time in hospital less daunting for children and their carers.

These developments follow detailed feedback from patients, families, and colleagues, gathered through the NHS Staff Survey, the CQC Children and Young Person's Survey, local patient experience reports, and day-to-day conversations on the wards.

Phoenix Therapy Suite opens at Montagu Hospital

The pioneering new stroke rehabilitation facility was officially opened by the Minister of State for Care, Stephen Kinnock MP, giving patients access to cutting-edge therapies previously unavailable on the NHS.

The Phoenix Therapy Suite, based at Montagu Hospital within the Fred and Ann Green Rehabilitation Centre, offers state-of-the-art equipment designed to help stroke survivors regain independence and improve recovery.

The suite includes advanced robotic and interactive devices which support walking, arm and hand movement, and cognitive function. Such technology, previously only available privately, allows

patients to take part in personalised rehabilitation, while still working closely with specialist therapists.

The new service was made possible thanks to the generosity of the late Fred and Ann Green, with the remainder of their legacy funds and support from DBTH Charity, enabling the purchase of the equipment.

People
We are supportive, positive, and welcoming.

Mark Bailey appointed Interim Chair

As the Chair reflects in her report, Mark Bailey was announced at the Annual Members' Meeting as the Interim Chair of the Board, following confirmation by the Trust's Council of Governors.

Mark will take up the position in January 2026, when our current Chair Suzy Brain England OBE completes her final term of office at the end of 2025.

Flu vaccination campaign well underway

More than 13.45% of staff (at time of writing) have taken up the opportunity to have the flu vaccination since the campaign started on 1 October. The campaign aims to protect as many colleagues as possible ahead of winter, helping to keep themselves, their families, and those in their care – including patients and visitors – safe from flu.

The flu vaccine offers the best protection against the virus, reducing the risk of serious illness and helping to prevent outbreaks within healthcare settings. Vaccination also helps to protect the most vulnerable members of the community and supports the NHS by reducing pressures on services through the winter months.

As the Chair reflects in her report, we are also making sure we role model and share key messages with communities about who is eligible for the vaccine and where/how they can get it.

Action on racism, including antisemitism

DBTH continues to be committed to being an anti-racist organisation – not as a slogan, but as a commitment to ensuring every colleague, patient and visitor feels safe, welcome, and treated with mutual respect.

We will not tolerate any form of hatred, antisemitism, Islamophobia, racism, or any discriminatory behaviour.

Aligned with NHS England, we are formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism. The definition can be found here: https://holocaustremembrance.com/wp-content/uploads/2024/01/IHRA-non-legally-binding-working-definition-of-antisemitism-1.pdf

Staff Survey campaign

We are now over the halfway point for this year's NHS Staff Survey, and at time of writing, over 40% of all colleagues have already shared their views.

It only takes around 10 minutes to complete, and colleagues receive their survey in their @NHS.net inbox as an email from IQVIA. Our colleagues in estates and facilities receive a paper copy.

Be Diversified event to celebrate international colleagues

On Friday 26 September, Doncaster and Bassetlaw Teaching Hospitals (DBTH) hosted *Be Diversified! Celebrate, Connect, Be Inspired* – a vibrant cultural celebration honouring its international colleagues – at Armthorpe Community Centre.

Funded by the South Yorkshire Integrated Care Board (SYICB) People Experience Team, the event brought to life key pillars of the Trust's People Plan, particularly the 'Growing for the Future' commitment to supporting and welcoming internationally educated colleagues. It also reflected the People Plan's supporting pillar of 'Belonging in Team DBTH,' which champions a workplace culture where every colleague feels valued, included, and proud to be part of the Trust community.

DBTH Way into Action

Earlier this year, in partnership with independent consultants '*thevaluecircle'* we took part in the "DBTH Way into Action." Colleagues took part in the anonymous workplace experience survey, providing invaluable feedback.

We will be receiving the results in the near future and will look to use these to help to shape plans to strengthen our culture and working environment. The results and any actions will be presented to a future Board of Directors and shared with colleagues.

Partnerships

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

Doncaster Cancer Detection Trust leaves lasting legacy

It is with both heartfelt gratitude and sadness that we mark the closure of Doncaster Cancer Detection Trust (DCDT), a charity that has stood side by side with the Trust and the wider community for over 60 years in the fight against cancer.

Doncaster Cancer Detection Trust has been an incredible force for good in our community. Their legacy lives on, not just in the equipment and buildings they have helped fund, but in the lives they have touched and the hope they have brought to so many families.

We are honoured to continue their mission through a dedicated fund established as part of our hospitals' charity, and we thank every supporter who has contributed over the years and will continue to do so in the future.

As DCDT formally ceases operations, DBTH Charity is committed to upholding its legacy, continuing to fundraise for life-saving equipment and services that support cancer patients across Doncaster, Bassetlaw, and beyond.

Appointment of Chief Executive Designate for new Integrated Care Board Cluster

NHS England have confirmed that Amanda Sullivan has been appointed as the Chief Executive Designate for Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire Integrated Care Boards (ICBs). The three ICBs have clustered together as part of a national requirement to reform NHS commissioning.

New Interim Chief Executive Appointment at South Yorkshire ICB

NHS South Yorkshire has appointed Chris Edwards as interim Chief Executive until 31 March 2026, following the recent retirement of Gavin Boyle. Chris began in post on 20th October.

Acute Federation updates

All the latest updates from the South Yorkshire and Bassetlaw Acute Federation are available in the latest newsletter here:

https://syics.co.uk/application/files/3917/5646/9064/AF_Newsletter_Summer_2025.pdftter_Summer_2025.pdf

Pounds

We are efficient and spend public money wisely.

Financial position update

We remain on plan for our financial performance. The Finance & Activity Report highlights that there is still more work to do to achieve our £31.4 million Cost Improvement Plan (CIP) target, but good progress has been made to date.

Thanks to teams across the organisation for their continued commitment and effort.

National Sustainability success for cutting carbon and waste

DBTH has gained national recognition after being awarded 'Best Reduction of Clinical Waste' at the prestigious Waste Management Awards 2025. The honour highlights the Trust's progress in reducing clinical waste, cutting carbon emissions, and championing environmental sustainability across.

Within theatre departments alone, improvements in waste segregation have delivered an impressive 24% reduction in clinical waste – saving the equivalent of 13.95 tonnes of CO_2 compared to the same period in 2024. This success reflects the Trust's commitment to protecting the environment while maintaining the highest standards of clinical safety.

By introducing a new waste segregation model, DBTH has significantly reduced its environmental footprint and achieved a £6,000 cost saving in just five months.

Green plan refreshed

DBTH has achieved a number of sustainability milestones since launching the first Green Plan in 2022. We have phased out desflurane and removed piped nitrous oxide across all hospital sites, eliminating two anaesthetic gases with a high carbon footprint and saving thousands of pounds which have been directed back into patient care.

We have also transitioned to 100% renewable electricity, significantly cutting emissions across our estate, and introduced recycling for colleagues and patients, beginning at Montagu Hospital before rolling out across all sites.

As a result of these initiatives, total carbon emissions have been reduced by 6,550 tonnes – the equivalent of taking around 1,400 cars off the road each year.

The refreshed green plan can be found here: www.dbth.nhs.uk/green-plan/

BOARD LEARNING & REFLECTION

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

Katie Simpson, Paediatric Planned Care Matron
15 minutes
Presentation to follow

2511 - B PATIENTS

11:10

2511 - B1 AUDIOLOGY SERVICE UPDATE

Discussion Item | Nick Mallaband, Acting Executive Medical Director | 11:10

10 minutes

REFERENCES

Only PDFs are attached

B1 - Audiology Service Update.pdf

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

Executive Summary – Key messages and Issues

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

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

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

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

The outstanding improvement actions are key to being able to run a safe and effective service in the future. To seek assurance on the improvements and mitigations that have been made since the external review in January 2024, there was an NHSE and ICB assurance visit to Audiology Services at DBTH on the 30th September 2025. The scope of the visit included a review of the recovery improvement areas covered in this report [Estates and facilities, equipment, digital systems and staffing].

The paediatric harm review process has almost reached its conclusion with only 4 remaining children to be seen. Since the last update to the board of directors in September 2025, 3 cases of low harm and 1 case of moderate harm have been identified.

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

Updates will continue to be provided to the Board of Directors as our recovery works towards its conclusion.

Recommendations

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

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<tr><td>Previously considered by - including date:</td><td>Executive Team, Trust Leadership Team, Quality Committee & Finance and Performance Committee. Various dates in 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>• Deliver the improvement plan
• Ongoing communications with patients and stakeholders
• Prioritising urgent patients for mutual aid
• Stand service back up when safe to do so</td></tr>
<tr><td>Is this in line with Current risk appetite

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

As previously reported to the board of directors in September 2025, the audiology service across DBTH has offered a limited provision to our patients since September 2024, as we have been undertaking a process of improvement. Since the last update to the board of directors, it is positive to report that the majority of the elements of the audiology service recovery plan have now delivered and we can report an improvement in the number of patients that we are seeing across many parts of the audiology pathway. Whilst we are currently unable to offer the complete end to end paediatric audiology pathway, it is felt that the service we are now offering shows a marked improvement for our community and stakeholders.

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

The Audiology Recovery Programme

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

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

Our own audiologists who have successfully completed their competency assessments are continuing to see patients across both the adults and paediatric waiting lists. In September 2025, 1287 patients were seen across both the adults and paediatric service, this compares to 1153 seen in August 2025. The adult insourcing was recommenced in August for three months and the SME paediatric activity continued throughout September; with an additional 271 adult and paediatric patients seen for diagnostics and fittings over the weekends in September.

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

Engagement with our patient stakeholder groups continues. On the 1st October DRI hosted a meeting with the Doncaster Deaf Society, the Doncaster Audiology Action Group and the Doncaster Deaf Trust. The purpose of the meeting was twofold; to provide assurance to our stakeholders in relation to the progress and pace of the improvement work at DBTH and to listen to helpful thoughts and ideas from the stakeholders with regards to some specific improvements that were shared to help improve the patient experience.

Harm reviews update – paediatric audiology

To date ninety cases have been reviewed by NHS England Subject Matter Experts (SMEs) and levels of harm allocated, leaving only 4 cases still to be reviewed. Plans are in place to see three of these children and the fourth child has moved out of the area.

Of the ninety children reviewed for harm the outcomes to date are:

Sixty Five - no harm

Thirteen – low harm

Eleven – moderate harm

One – severe harm

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

The learning from the case of severe harm has been incorporated into the DBTH Patient Safety Incident Response Framework [PSIRF] principles that focus on investigating less and learning more. In addition the ICB has requested that a Patient Safety Incident Investigation [PSII] is undertaken to investigate the case of severe harm to understand if there are any additional areas of learning that can be taken from it, over and

above the causation factors already identified. The investigation is currently underway and an update will be provided to the board of directors in the next audiology board report.

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

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

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

Mutual aid update

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

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

Nottingham University Hospital Trust [NUTH] had agreed to take seventy five P4 Children [these are children who have been assessed as having the lowest level of clinical need but represent the biggest cohort of children on the paediatric waiting list - 870]. It was planned for the children to be seen in cohorts of 25 over the months of September, October and November, however the uptake from parents to take their children to Nottingham has been low, with only 9 children referred in September and 4 in October.

Additionally, Sheffield Children's Hospital (SCH) have offered mutual aid with the P4 cohort, and arrangements are currently being finalised for them to accept circa 500 P4 review children over the coming months. It is anticipated that this cohort of children will all be seen by mid-January 2025. Having worked with SCH earlier in the year to outsource another cohort of our paediatric audiology patients, we encountered minimal issues in asking parents to travel to SCH for their children to attend for appointments.

We are continuing to provide specialist paediatric insourcing at weekends and occasional weekdays, from subject matter experts identified and approved by NHSE to assess and treat the children from the waiting list who are of the highest clinical priority [P1 and P2 patients]. This arrangement started at the beginning of July and to date 115 children have been seen. This is an open ended agreement that is funded via NHSE as part of the national review of paediatric audiology services.

We have just concluded our insourcing from *Your Medical Services* [YMS] for our adult patients at weekends, this ran from the beginning of August 2025 to the 19th October 2025. YMS saw adults who were on the waiting list for diagnostic assessments in the first month, in the second month; adults requiring fittings and in the third month they saw a combination of both. In total during this period they have seen 423 diagnostic patients and 331 fittings patients.

Clinical Workforce update

The competency assessments for the paediatric audiologists will commence on the 27th October2025. They will receive training and assessment of their competencies from a senior audiologist SME from SCH who has been fully endorsed by NHSE to undertake this piece of work.

The timescales for this have slipped by approximately one month due to a combination of annual leave and capacity constraints in SCH. A Service Level Agreement has been negotiated between DBTH and SCH for this piece of work for 12 days in the initial instance.

To train and assess the adult audiologists, NUTH are providing a senior adult audiologist SME, to work alongside our adult audiologists on site in Sandringham Road. This arrangement commenced on the 1st September 2025 and eleven days have been allocated in the initial instance across the team for this piece of work to be delivered. To date, four of our eight adult audiologists have been successfully competency assessed enabling them to be able to deliver the whole adult audiology patient pathway. The assessment process continues for the remaining four.

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

A multi-disciplinary study day was arranged for the 16th October between colleagues from NUTH [National Implant Centre] and DBTH to look at the Bone Anchored Hearing Aid [BAHA] pathway. The day was supported by an ENT consultant from NUTH along with their Head of Service and the service lead for BAHA. An ENT consultant from DBTH along with the head of service and the two clinical leads also attended the session. The current provision of the BAHA pathway has been paused in DBTH since the limiting of the service in September 2024. The purpose of the day was to develop a new DBTH multi-disciplinary team pathway could be delivered utilising the NUTH accredited model.

NUTH have offered to undertake all of the outstanding BAHA assessments currently on our waiting list and work has started in DBTH to set up clinics for BAHA repairs and reviews. Competency assessments of 2 senior DBTH audiologists is in progress assisted by colleagues from NUTH. This will enable them to be able to deliver this complex area of work, utilising protocols and processes that are in use in NUTH and have been shared with the DBTH service.

Data update

The audiology service has been working closely with the Elective Care Improvement Support Team [IST] to undertake demand and capacity modelling for adult and paediatric audiology to understand the capacity required to meet the diagnostic waiting time standard (DM01). This work is now complete and has been shared with the ICB and also endorsed by the IST.

The Elective IST has also supported the service to develop a Patient Tracking List (PTL) for paediatric and adult audiology; PTL meetings commenced in September 2025 and have had a positive impact on the management of our longest waiting audiology patients. The Elective IST shadowed these meetings initially to ensure these were established in line with best practice.

Capacity analysis has been undertaken in the last two weeks to plan the audiology capacity required for the 2026/27. It is pleasing to report that recent work on the data quality has been valuable in enabling the capacity planning work to be undertaken with assurance and confidence. Alongside the capacity planning work, a master rota has also been developed to provide a robust foundation for service delivery.

NHSE and ICB assurance visit to Audiology Services at DBTH

To seek assurance on the improvements and mitigations that have been made since the external review in January 2024, there was an NHSE and ICB assurance visit to Audiology Services at DBTH on the 30th September 2025. The scope of the visit included a review of the recovery improvement areas covered in this report and was aligned to a Terms of Reference agreed between the ICB, NHSE and DBTH.

We received the following feedback on the day of the visit;

- Interviews with staff were open and transparent
- Improved leadership across the audiology team.
- Significant improvements in both the equipment and the environment.
- The new IT system was well embedded within the department.
- Clear sight of patient flow through the department.
- Clear standard operating procedures in place across the service.

We are awaiting the final ratified version of the report following the visit. Once this is received we will review all recommendations carefully and incorporate them in to the overarching audiology action plan to enable effective oversight of delivery.

The final version of the assurance visit report will be shared with the board of directors in the December board report.

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

2511 - B2 AUDIOLOGY LESSON LEARNED REPORT

Information Item | Zara Jones, Deputy Chief Executive | 11:20

10 minutes

REFERENCES

Only PDFs are attached

B2 - Audiology Lessons Learned Report.pdf

B2 - Appendix 1 - Action Plan.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Audiology Lessons Learned Report**			
Executive Sponsor:	Zara Jone, Deputy Chief Executive			
Authors:	Claire Jones, Audiology Recovery Program Lead			
Appendices:	Appendix 1 – Action plan			
Purpose of the report	Assurance	Decision required	Information	Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF 1-4 & 6, 7			

Executive Summary – Key messages and Issues

This report presents the findings of a comprehensive review of the Audiology Service at Doncaster and Bassetlaw Teaching Hospitals (DBTH), which led to a temporary pause in elements of service delivery in September 2024.

Following a self-assessment exercise, a number of deficiencies were identified relating to service delivery, infrastructure, digital systems and staff competency. While these issues had been recognised individually, they had not previously been considered collectively, highlighting weaknesses in internal processes and governance.

This lessons learned report explores those issues and sets out a series of strategic recommendations designed to prevent recurrence, strengthen leadership and governance and enhance oversight across all services in the Trust.

A key commitment of the recovery work was to share an open lessons learned report and this document fulfils that commitment.

Significant progress has already been made across the organisation in addressing the areas identified through this review. The report reflects systems and practices that existed at an earlier point in time. Many of the actions described are already in progress and are being embedded into business-as-usual arrangements.

To provide clear accountability and delivery assurance, existing detailed action plans will be mapped against the overarching summary of recommendations. This will confirm ownership, target completion dates and review points for checking that actions have been fully embedded.

Recommendations

B The Board is asked to:

1. Note the findings of the Audiology Service Lessons Learned Report and the progress already achieved through the ongoing recovery and improvement programme.
2. Support the mapping of existing action plans against the overarching summary of recommendations to confirm clear ownership, completion dates and review points.
3. Agree that the findings and themes from this review will be tested against the Trust's wider governance processes to ensure alignment and strengthen system-wide assurance.
4. Confirm that continued oversight of progress and assurance will be provided through the Quality Committee, with regular reporting to the Board.

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<tr><td>Previously considered by - including date:</td><td>Reports have been shared and considered by the Executive Team, Trust Leadership Team, Quality Committee and the Board of Directors through 2024 and 2025.</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Board recommendations as set out above</td></tr>
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Audiology Lessons Learned Report

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Prepared by: Claire Jones, Audiology Recovery Programme lead

04 November 2025

1. Executive Summary

This report presents the findings of a comprehensive review of the Audiology Service at Doncaster and Bassetlaw Teaching Hospitals (DBTH) which led to a temporary pause in elements of service delivery in September 2024.

Following a self-assessment exercise a number of deficiencies were identified relating to service delivery, infrastructure, digital systems and staff competency. While these issues had been recognised individually at points in time they had not previously been connected as part of a collective organisational understanding, highlighting weaknesses in internal oversight and governance.

This lessons learned report provides a summary of those findings and sets out strategic recommendations designed to prevent recurrence, strengthen leadership and governance and enhance assurance across all clinical services.

Significant progress has already been made. The issues described within this report reflect historical systems and practices. Since the review the organisation has taken extensive action to stabilise, recover and improve the service. Many of the actions identified are already underway and continue to be embedded across the Trust as part of a structured recovery and improvement programme.

2. Background and Context

In 2023 the Scottish Government's *Lothian Report* identified serious failings in paediatric audiology services. Following this NHS England (NHSE) required all paediatric audiology services in England to undertake self-assessments covering quality assurance, training, governance and patient-centred care.

The DBTH self-assessment completed in late 2023 was submitted without divisional or executive review and triggered concerns that led to an external visit by NHSE and the South Yorkshire Integrated Care Board (ICB) in January 2024. The visit identified safety concerns across both paediatric and adult audiology resulting in immediate mitigations being introduced including double-reporting of diagnostic tests by Leeds Teaching Hospitals.

A comprehensive recovery plan was established in February 2024 to address estates, infrastructure, digital systems, service performance and staff competencies. During this period the implementation of a new clinical system (RioMed) presented additional challenges leading to instability within the service.

In September 2024 the DBTH Executive Team took the decision to temporarily limit activity across the audiology service to ensure patient safety while improvements were implemented. A refreshed recovery plan was developed supported by regular reporting to the Board, patients and external stakeholders.

Since then, significant improvements have been achieved including new testing equipment, strengthened data quality assurance and completion of estates upgrades. Remaining actions relating to paediatric competencies are expected to conclude by March 2026.

During the pause urgent and essential patient needs continued to be met through insourcing, outsourcing and mutual aid with other NHS providers via the South Yorkshire Acute Federation. The service has now safely resumed the full adult pathway and the assessment stage of the paediatric pathway.

3. Methodology

The lessons learned review was undertaken through:

- Analysis of feedback and documentation spanning July 2023 to October 2024
- Review of papers presented to sub-committees of the Board
- Examination of operational, clinical and governance processes
- Targeted interviews with staff and stakeholders

The purpose was to identify lessons learned, understand contributing factors and develop early warning red flags to support proactive oversight of all Trust services.

4. Detailed Findings

4.1 Leadership

Leadership within the service lacked consistency and visibility. The Head of Service post remained vacant between 2017 and 2024 with the clinical lead assuming de facto responsibility without sufficient support or oversight. Divisional engagement was inconsistent and executive visibility limited.
Issues Identified:

- Leadership defaulted to tenure rather than capability
- Absence of senior oversight and divisional engagement
- High turnover at business management level created instability
- Lack of executive and non-executive visibility
- Concerns were not escalated

4.2 Governance

The service operated with minimal connection to divisional governance. Reporting lines were unclear and escalation routes ineffective resulting in poor organisational visibility of risks.
Issues Identified:

- No dedicated governance structure linking to the division
- Incidents and complaints managed locally with no Trust-wide learning
- Service not represented in divisional or corporate decision-making forums

4.3 Team and Workforce

The team operated largely autonomously and outside Trust policies. Training, appraisals and peer support were inconsistent and staff feedback was not acted upon.

Issues Identified:

- No training or competency renewal framework
- Lack of line management and appraisals
- Self-managed leave and unmanaged sickness
- Staff survey results not analysed or acted upon

4.4 Systems and Digital Infrastructure

The procurement and implementation of the RioMed system lacked appropriate governance and did not align with the Trust's wider digital strategy. Data access was restricted to a single individual creating operational risk.

Issues Identified:

- Limited market curiosity during procurement
- Procurement undertaken without adequate clinical leadership involvement
- Lack of board-level approval and digital oversight
- Single-user access and data constraints

4.5 Performance and Operational Delivery

Audiology performance data was not routinely reviewed within divisional meetings. Reports were produced but not discussed or acted upon.

Issues Identified:

- No structured operational performance oversight
- Reports submitted but not reviewed or escalated

4.6 Data and Reporting

DM01 data was historically inaccurate due to lack of understanding of reporting requirements and weak validation. Performance data was not reviewed with parity alongside other diagnostic services.

Issues Identified:

- Inconsistent data reporting and review
- Limited access to systems and poor data literacy
- Lack of DM01 training

5. Committee Review Timeline and Escalation History

A review of Board and sub-committee papers between February 2023 and October 2024 found intermittent references to concerns about audiology but no sustained follow-through. Routine Board reporting began only after the external review in January 2024 with executive oversight strengthened thereafter with an executive sponsored paper presented to the DBTH Board bi-monthly.

A review of committee discussions summarises the following:

Date	Committee	Key Audiology Issues Raised
07.02.23	Quality & Effectiveness	Staff survey concerns, bank staff usage highlighted.
02.05.23	People Committee	AHP workforce look back scheduled (Audiologists misclassified as they are clinical scientists)
07.06.23	Patient Experience & Involvement	Complaints from Deaf Society about poor patient experience.
11.08.23	Workforce & Education	Audiology workshop on workforce planning proposed, later postponed due to potential Audiology staffing changes in the service.
09.02.24	Workforce & Education	Banding and structure review suggested along with dental nurses and orthoptists.
28.02.24	Patient Experience & Involvement	Service described as "broken"; QI project proposed
04.06.24	Quality & Effectiveness	Full report requested re the audiology service
20.06.25	People Committee	Recruitment success noted for hearing screeners and audiologists.
Sep 2024	Trust Risk Report	Extreme risk [20] recorded on Trust risk register due to lack of soundproofed rooms
22.10.24	People Committee	Audiology identified as one of 6 SY Acute Federation clinical sustainability services

6. Stakeholder Feedback

Interviews and engagement feedback consistently highlighted gaps in leadership visibility, governance and operational support. Many stakeholders perceived that someone else was accountable which diluted responsibility and contributed to the lack of earlier intervention.

7. Lessons Learned and Red Flags

The review identifies the following 'red flags' for early identification of emerging issues across any service:

- Limited visibility in governance and reporting structures
- Absence of leadership development and succession planning
- Weak engagement with staff feedback and performance data

- Single points of failure in systems and data access
- Inconsistent application of Trust policies

8. Conclusion and Next Steps

This review concludes that the challenges within the audiology service arose from cumulative system weaknesses in leadership, governance and oversight. These issues persisted undetected for an extended period due to insufficient curiosity, escalation and accountability within divisional and executive governance.

Since the service pause in September 2024 a comprehensive recovery programme has been implemented and substantial progress achieved. Improvements are evident across all domains: leadership, governance, workforce, systems and data with continuing oversight from divisional and executive teams.

Mapping of existing detailed action plans against the overarching summary (Appendix 1) will now be undertaken to confirm delivery ownership, target completion dates and timescales for checking that ongoing actions are embedded into business-as-usual arrangements.

Oversight of progress will be maintained through the Quality Committee which will provide regular assurance to the Board on delivery against the agreed actions and the sustainability of improvements.

Appendix 1 - The table below consolidates the key findings and themes from the Audiology Service Lessons Learned Review and sets out the associated actions at service, divisional and Trust level. It reflects progress already made and areas of ongoing improvement. In addition, the findings and themes from this review will be tested against the Trust's wider governance processes to confirm alignment, identify any gaps and strengthen system-wide assurance.

Appendix 1: Summary of Ongoing Actions and Improvements Following the Audiology Review

Theme	Key Issue	Audiology Service Actions (Progress and Ongoing Improvement)	Divisional Actions (Progress and Ongoing Improvement)	Wider Trust Actions (Progress and Ongoing Improvement)
Leadership	Issues within the audiology service reflected a lack of accountability and engagement with the wider Trust. Executive and divisional oversight and leadership development investment were limited.	Building leadership capability through succession planning and the Scope for Growth framework, with opportunities for individual development via Trust programmes and 360 feedback. Recruitment undertaken with integrity and aligned to Trust values and behaviours. Continued engagement with the FTSU Guardian to sustain a just and learning culture.	Strengthening consistent, accountable divisional management arrangements, with regular service reviews and leadership oversight embedded.	Leadership development now routinely highlighted through the appraisal process, with key individuals aligned to Trust leadership programmes. Extending executive and non-executive visibility across all services through walkarounds and governance engagement.
Governance	Audiology governance pathways had limited visibility at divisional level and training for service leads required strengthening.	Governance pathways now firmly established, with bi-weekly meetings linking into the divisional structure and broad team attendance. Governance training underway for service leads. Improved escalation mechanisms ensure visibility at all organisational levels. Enhanced two-way communication across the team.	Embedding effective divisional governance arrangements to act on service-level information and strengthening local oversight.	Ensuring all specialties have equitable representation in divisional governance, regardless of size, to support transparency and consistency. Testing the findings and themes from this review against the Trust's wider governance processes to confirm alignment, identify any gaps and strengthen system-wide assurance.

Appendix 1: Summary of Ongoing Actions and Improvements Following the Audiology Review

Theme	Key Issue	Audiology Service Actions (Progress and Ongoing Improvement)	Divisional Actions (Progress and Ongoing Improvement)	Wider Trust Actions (Progress and Ongoing Improvement)
Team and Workforce	Engagement, appraisals and access to development had been inconsistent, with variable application of Trust workforce policies.	Appraisals completed for all staff in 2025 within the allocated period. Learning Needs Analysis undertaken, with resources allocated to support development. Staff survey results shared with teams, with improvement actions in progress. Consistent application of Trust policies on leave and sickness.	Continuing divisional oversight of workforce planning and education strategy, ensuring audiology is fully integrated within divisional workforce planning.	Ensuring consistent access to development resources across all services through Trust-wide workforce and education strategies. Triangulation of staff survey results at service/specialty level with other key metrics to inform hotspots and escalations in a timely manner.
Systems and Digital Infrastructure	Operational performance reporting and divisional oversight required strengthening. The procurement of the RioMed system highlighted a need for greater alignment with the Trust's digital strategy.	Regular monthly data now produced across all elements of the service to support data-driven decision-making. All staff have access to the AuditBase clinical system and have completed training. Performance reporting continues to be refined, with divisional oversight to be fully re-established as BAU.	Increasing divisional curiosity and proactive engagement with service performance through strengthened oversight of dashboards and data reports.	Progressing the development of a Trust-wide performance reporting framework. Centralising procurement governance and ensuring board-level oversight for non-standard systems. Aligning specialty systems with the Trust-wide digital strategy and ensuring risk assessments precede implementation.
Data and Reporting	Oversight of DM01 performance and training in reporting expectations required improvement.	Internal analytics capacity developed within the service, with coherent, timely data presentation now supporting local decision-making.	Continuing to strengthen divisional oversight of DM01 data and reporting standards across all services.	Ensuring DM01 services receive equal scrutiny and importance. Improving shared access to performance and activity data across leadership teams. Standardising data reporting formats and expectations across specialties.

2511 - B3 MATERNITY & NEONATAL SAFETY REPORT (INTERIM)

Discussion Item | Karen Jessop, Chief Nurse | 11:30

Lois Mellor, Director of Midwifery
10 minutes

REFERENCES

Only PDFs are attached

- B3 - Maternity & Neonatal Safety Report.pdf
- B3 - Appendix 1 - PMRT Q1 2025-2026.pdf
- B3 - Appendix 2 - Transitional Care Progress Update.pdf
- B3 - Appendix 3 - Trust Quality Metrics.pdf
- B3 - Glossary of Terms - Maternity.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Maternity & Neonatal Safety Report (interim)**			
Executive Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Lois Mellor, Director of Midwifery			
Appendices:	Appendix 1 - PMRT Q1 Appendix 2 - Transitional Care progress update Appendix 3 - Trust Quality Metrics			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7			

Executive Summary – Key messages and Issues

The following report covers the work related to the improvement of maternity and neonatal services which includes;

- PMRT reviews
- Training compliance for anaesthetic, maternity and neonatal staff
- Board safety champion meeting with the perinatal leadership team
- Transitional care progress update
- Perinatal metrics

It is in addition to the items previously reviewed and approved by the Quality Committee in October and which are documented in the Quality Committee chair's highlight report on the agenda.

To note: patient level detail of the PMRT reviews has been removed from this report.

Recommendations

For the Trust Board of Directors to take assurance from the detail provided within this maternity and neonatal safety report and to record in the Trust Board minutes to provide evidence for the maternity incentive scheme the following;

- Reviewed and approved the Q1 Perinatal Mortality Report
- Noted training concerns
- Noted that Board Safety Champions are meeting with the perinatal leadership team bi-monthly and any support required of the Trust Board has been identified and is being implemented
- Reviewed and approved the transitional care progress update
- Reviewed the Trust's Quality Metrics

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

<table>
<tr><td>Legal/ Regulation:</td><td></td></tr>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>The Maternity and Neonatal Safety Quality Group
Divisional Governance Meetings
Quality Committee</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Support to continue improvements in maternity & neonatal service, and achieve year 7 CNST standards</td></tr>
<tr><td>Is this in line with Current risk appetite

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

1. Report Overview

This report is an interim report and supports the items previously reviewed and approved by the Quality Committee on behalf of the Trust Board in October 2025 and which are documented in the Quality Committees chair's highlight report on the agenda.

It also presents to the Trust Board the Q1 PMRT report which the Trust Board is required to receive as per CNST requirements, together with:

- Training updates
- Transitional care progress update
- Confirmation that the Board Safety Champions are meeting with the perinatal leadership team bi-monthly
- Any support required of the Trust Board has been identified and is being implemented
- The Trust's Quality Metrics.

2. Perinatal Mortality Rate

Below is a short update on the last five months data and included for review by the trust board in the Q1 Perinatal Mortality Report (Appendix 1).

2.1 Stillbirths and late fetal loss > 22 weeks

In April 2025 we have had 0 stillbirth and 0 late fetal loss reportable to MBRRACE
In May 2025 we have had 1 stillbirth, 0 late fetal loss reportable to MBRRACE
In June 2025 we have had 1 stillbirth, 0 late fetal loss reportable to MBRRACE
In July 2025 we have had 2 stillbirths, and 0 late fetal loss reportable to MBRRACE
In August 2025 we have had 0, and 0 late fetal loss reportable to MBRRACE

2.2 Neonatal Deaths

In April 2025 we have had 1 late neonatal death reportable to MBRRACE
In May 2025 we have had 0 neonatal deaths
In June 2025 we have had 1 late neonatal death reportable to MBRRACE
In July 2025 we have had 1 early neonatal death reportable to MBRRACE
In August 2025 we have had 1 early neonatal death reportable to MBRRACE

2.3 Learning from the PMRT reviews April - August 2025

Issues

Discussions about timing of birth for diabetic women are being actioned by the LMNS and taking to maternal medicine and diabetic networks for further discussion.
Urinary catheter management/insertion
Timely escalation of observations scoring a red on MEOWS

Learning

Q1 PMRT report is attached in Appendix 1.

3. Training Update

Training continues to be delivered monthly and monitored, staff are booked onto training and this is allocated in the roster to maintain > 90% in all staff groups. Non-attendance is flagged after every session, and is followed up by the relevant line manager. This can affect the training figures and is managed proactively by reallocating dates to attend.

Safety Action 8 for CNST (training) remains at risk and is being monitored after each training session delivered.

4. Safety Champion meetings

The board safety champion and non-executive directors have met with the perinatal quadrumvirate leadership team on the following occasions 22nd May 2025, 10th July 2025 and 11th September 2025.

4.1 Any support required of Trust Board following Safety Champion meetings and progress to show implementation

Nothing identified for the Trust Board at present.

5. DBTH transitional care

For CNST year 6 an action plan was developed which was approved by the board in July 2024. This has been reviewed and updated in light of year 7 requirements and progress made from year 6.

The new action plan to support a transitional care pathway based on the BAPM framework for babies from 34+0 was approved at the Quality Committee (subcommittee of the Trust Board) on 7th August 2025 and reported to Trust Board in the Quality Committee highlight report on 2nd September 2025.

The neonatal and maternity services are working together to progress the project and scope the resources required to commence the service by Q4 of 2025/26. A further progress update is attached for review and approval by the trust board (Appendix 2).

6. Perinatal Metrics

The Trust maternity dashboard has been included in Appendix 3.

Metrics with no significant change are;

- Number of births
- Stillbirth average days between
- Hypoxic-Ischaemic encephalopathy (HIE) average days between
- Neonatal deaths average days between
- Unexpected admission to the neonatal unit
- 3rd and 4th degree tear

Metrics with significant deterioration;

- Booking within 10 weeks gestation

Decreasing trajectories in ability to offer women an appointment with maternity services before 10 weeks gestation. A task and finish group has been commenced to identify actions that will improve the trust position.

Metrics with a significant improvement;

- HIE
- Stillbirth rate

This data is reviewed at all governance meetings in the division, and there are a number of streams of work ongoing.

7. Recommendation

The Board of Directors is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme that the following have been reviewed and approved;

- Q1 Perinatal Mortality Report (Appendix 1)
- Transitional care progress update (Appendix 2)
- Trusts Quality Metrics (Appendix 3)

And formally record that;

- Training concerns noted
- Board Safety Champions are meeting with the perinatal leadership team bimonthly and any support required of the Trust Board will be highlighted when identified

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

Quarter 1 period: 01/04/2025 to 30/06/2025

1. Introduction

This is a quarterly report produced by the Children and Families Division and will be reported to the Perinatal Mortality and Morbidity Divisional Meeting, the Trust Mortality Governance Committee and the Trust Board. The report details the use of the National Perinatal Mortality Review Tool (PMRT) in the review of all;

- Late Fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths from 24+0 onwards
- All neonatal deaths from 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

(Termination of pregnancies (TOP) for abnormality and babies with a birth weight under 500gms if gestation is not known at birth, are excluded).

In accordance with the requirements of the Clinical Negligence Scheme for Trusts (CNST) – NHS Resolution, all stillbirths and Neonatal deaths eligible for review using the PMRT on a rolling basis from 1st December 2024 will be a part of the Quarterly Reports submitted to the Trust Board and will include details of all deaths reviewed and consequent action plans.

This report also documents whether the required standards within Safety Action standard 1 have been met.

The Maternity & Newborn Safety Investigations (MNSI) will also review cases where a specific criteria has been met following consent from the family. Where the review has been accepted by MNSI this will be highlighted within the quarterly report.

Babies who meet MNSI criteria include all babies born at least 37 completed weeks of gestation, who have one of the following outcomes;

- **Intrapartum stillbirth**: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- **Early neonatal death**: when the baby died within the first week of life (0-6) days of any cause.

The definition of labour used by MNSI is;

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).

This report focuses on births from 24+0 weeks' gestational age, with the exception of the chapter on mortality rates by gestational age, which includes information on births at 22+0 to 23+6 weeks' gestational age. This avoids the influence of the wide disparity in the classification of babies born before 24+0 weeks' gestational age as a neonatal death or a fetal loss. **All terminations of pregnancy have been excluded from the mortality rates reported.**

2. Trust Stillbirths And Late Fetal Losses From 22 Weeks Gestation

The latest MBRRACE Report for births 2023 gives a national stillbirth rate of 3.22 per 1000, a minimal decrease from the 3.35 figure for the year prior. This figure is calculated from births at 24 weeks or over, and excluding terminations of pregnancy.

The Trust annual stillbirth rate for 2024 **from 24+0 weeks** of pregnancy and above across both sites is to 3.12 stillbirths per 1,000 births. In numerical values this was 11 stillbirths. During this same period from **22 weeks of pregnancy to full term** in addition to the 11 stillbirths there were 3 late fetal losses.

The annual statistic is recorded in each quarterly report to identify any rising trends in a timely manner, however this is the crude, and not adjusted and stabilised figure.

During the first quarter of 2025-2026, from 1st April 2025 to 30th June 2025 there have been **2** stillbirths (both antenatal stillbirths and both at DRI) and **1** medical termination of pregnancy (MTOP) for fetal abnormality above 24 weeks gestation (also at DRI). Of this time period, there were a total of 1,075 births, of which 729 births at DRI and 346 Births at BDGH.

There have been **0** late fetal losses between 22+0-23+6 weeks gestation during this quarter (at DRI). During the same timescale, there has been **1** MTOP's of this same gestation.

This provides a trust adjusted stillbirth rate of **1.86 per 1000 births for quarter 1**, from 24 weeks gestation; which is a decrease from last quarter (quarter 4 of 2024-2025 adjusted stillbirth rate of 4.81 per 1000 births).

Combining the figures from quarters 1 of 2025-2026 and quarters 2, 3 and 4 of 2024-2025 the rolling adjusted stillbirth rate is **2.82** per 1000 births. This equates to 12 stillbirths from 24 weeks of gestation (total births for this period is 4,248 births for both sites).

3. NEONATAL DEATHS

The latest MBRRACE Report for births 2023 gives a national neonatal death rate of 1.62 deaths per 1,000, a decrease from 1.7 deaths per 1,000 when compared to the 2022. The rate is calculated for births over 24 weeks and includes deaths to 28 days.

Deaths that are included in the Trust rates are those of babies that were born and died within the trust. The Trust annual 2024 stabilised and adjusted rate was 0.2 per 1000. In numerical values this was 1 early neonatal death.

During the first quarter of 2025-2026, from 1st April 2025 to 30th June 2025 there have been **2** Neonatal and post-Neonatal deaths, and **1** neonatal death following a medical termination of pregnancy (MTOP) for fetal abnormality above 22 weeks gestation (at DRI) of the 1,075 births across both sites. 729 births being at DRI and 346 Births being at BDGH.

This provides the Trust with a stabilised and adjusted rate for this quarter 1 of 2025-2026 of 1.86 per 1,000.

Combining the figures from quarters 1 of 2025-2026 and quarters 2, 3 and 4 of 2024-2025 (excluding the deaths under 22+0 and MTOP resulting in NND) the rolling adjusted neonatal and post-neonatal deaths rates of **4** equates to a rate of 0.94 per 1,000 births from 22 weeks of gestation (total births for this period is 4,248 for both sites).

MBRRACE is informed of all neonatal deaths from 20 weeks gestation, only those above 22+0 weeks and weighing more than 500g meet the criteria for PMRT review.

CNST Year 7 – Safety action 1

Requirements	CNST requirement compliance	CNST Trust Compliance to date
a) All eligible perinatal deaths from 1 December 2024 should be notified to MBRRACE-UK within seven working days.	**100%**	**100%**
b) For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	**95%**	**100%**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months.	**95%**	**100%**
	75%	**100%**
For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT (from 2nd April 2025).	**50%**	**50%**
d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.		**Q3 presented to Trust Board in March 2025 Q4 presented to Trust Board in July 2025 Q1 detailed within this report will be reported at QC (delegated subcommittee of the Trust Board) October and summary of number of deaths / action(s) to Trust Board November**

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *4*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
3	1	1	1	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal death reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	1	1	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACEUK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Social, economic and deprivation data (SB)		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25				2			2
	26-35							
	36-45							
	46+							
Smoking status	Never smoked				1			1
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker				1			1
	Unspecified							
Ethnicity	White				1			1
	Black							
	Asian				1			1
	Chinese/other							
	Mixed							
IMDD	1-4							
	5-7				2			2
	8-10							
	Not available							
Employment	Employed							
	Not employed				2			2
	Student							
	Homemaker							
	Sick/Disabled							
	Unknown							
Marital status	Married / Civil Partner							
	Single				1			1
	Cohabiting				1			1
Learning or communication difficulties	Yes				2			2
	No							

Social, economic and deprivation data **(NND)**		Gestational age at birth						
		Unknown	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Age	<18							
	19-25				1			1
	26-35						1	1
	36-45							
	46+							
Smoking status	Never smoked				1		1	2
	Non-smoker stopped before conception							
	Non-smoker stopped after conception							
	Smoker							
Ethnicity	White				1		1	2
	Black							
	Asian							
	Chinese/other							
	Mixed							
IMDD	1-4				1			1
	5-8						1	1
	8-10							
Employment	Employed				1		1	2
	Not employed							
	Homemaker							
	Sick							
	Not stated							
Marital status	Married							
	Single							
	Cohabiting				1		1	2
Learning or communication difficulties	Yes							
	No				1		1	2

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	1	0	0	1
Antepartum stillbirths	*0*	*0*	*0*	*1*	*0*	*0*	*1*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	1	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	1	0	1	2
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	0	0	1
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	0	0	0	0	1	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	1	0	1	2
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	1	0	1	2
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	1	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	1	0	0	1
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	1	0	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	1	100% (1)
Admin/Clerical	2	100% (1)
Ambulance Team	0	0%
Bereavement Team	1	100% (1)
Community Midwife	1	100% (1)
External	3	100% (1)
Management Team	2	100% (1)
Midwife	16	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	1	100% (1)
Neonatologist	7	100% (1)
Obstetrician	6	100% (1)
Other	1	100% (1)
Risk Manager or Governance Team	2	100% (1)
Safety Champion	1	100% (1)
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	1	100% (1)
Ambulance Team	0	0%
Bereavement Team	2	100% (1)
Community Midwife	0	0%
External	4	100% (1)
Management Team	3	100% (1)
Midwife	10	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	2	100% (1)
Neonatologist	8	100% (1)
Obstetrician	10	100% (1)
Other	2	100% (1)
Risk Manager or Governance Team	3	100% (1)
Safety Champion	1	100% (1)
Sonographer or Radiographer	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	1	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	1	1
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**1 causes of death out of 1 reviews**
	Placental malperfusion
Neonatal deaths	**1 causes of death out of 1 reviews**
	duct dependent circulation or systemic blood flow and diagnosis that might be In keeping with that will be critical coarctation of the aorta
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
During resuscitation of the baby appropriate drugs were given but one or more was given at an incorrect dose	1	PSII action to be created following action meeting
		PSII action to be created following action meeting
BP monitoring in postnatal period	1	Admin error this has been escalated to the manager for ward clerk's to review and action the error
During resuscitation of the baby vascular access was secured but this took more than one attempt or took too long to achieve	1	No action entered
During the early bereavement period the baby was not cared for in a cold cot because the cold cot was not offered	1	Difficult to ascertain from the notes / investigations if this was required as baby transferred to mortuary after family left the unit which was soon after the death of Pyper
During the resuscitation of the baby continuing respiratory support was required and not administered appropriately	1	PSII action to be created following action meeting
During the resuscitation of the baby the initial resuscitation was not carried out appropriately	1	PSII action to be created following action meeting
During the resuscitation the baby's temperature was not maintained within an appropriate range	1	PSII action to be created following action meeting
The baby was not able to be resuscitated although in the circumstance it would be reasonableto expect the resusciation to have been successful	1	PSII action to be created following action meeting

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

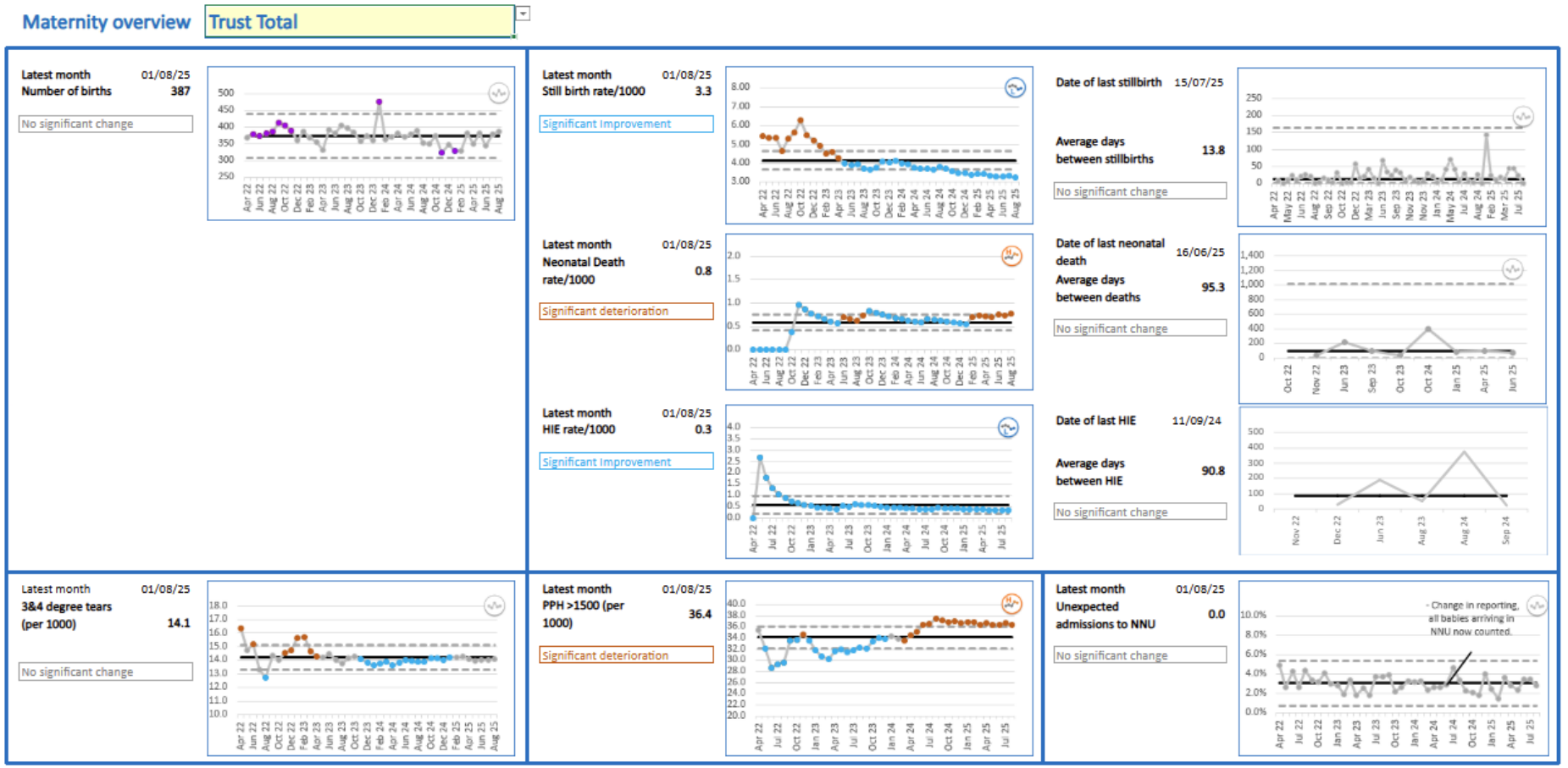
Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	BP monitoring in postnatal period

Year 6/7 CNST Action Plan - Transitional Care Progress Update September 25

Action No	Action	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Completed	Progress Rag Rating	Comments/Evidence
1	Estates to support TC	Identify TC areas at both Doncaster and Bassetlaw Site	LJ/KO'S/ AM	Sep-24	Yes	Green	Areas identifed at both sites
2	Staffing model	Review current staffing model	DB/SF/AM	Sep-24	Yes	Green	To extend TC to full BAPM standards. TC requires additional staffing model at Doncaster and to be merged into SCBU at Basetlaw.Staffing model agreed
3	Band 3/4 training /badgernet	Develop training package for band 3 MSW and TNA. Liaise with ODN	AM	Jan-26	No	Red	ODN have an training package. Need new midwives in post then B3's then can start training Once M2 open plans to identify band 3 MSW for TC and to agree training package. Addtional staff training package completed for midwives on Baby IV Abx. Staff now commencing clinical skill sign off
4	Meet with MNVP	Collaborate with MNVP on TC care/guidelines	LJ/KO'S/ AM	Jan-26	No	Red	Recuiting new MNVP chair.To plan initial engagement meeting when in post Engage with MNVP regional strategic lead
5	TC guidleine to include full BAPM standards including NGT feeding is not being supported on TC reviewed at a later date	Once staffing model agreed and implement to review TC guidleine and include additional BAPM standards	DB /SF	Jan-26	No	Red	To implement full model with training to enable guideline to be fully implememted

Appendix 3: Trust Quality Metrics



Glossary of terms / Definitions for use with maternity papers

A-EQUIP - model used for midwifery advocacy for education and quality improvement

AN - Antenatal (before birth)

ATAIN - Avoiding term admissions to neonatal unit (Term 37-42 weeks)

BAPM - British Association of Perinatal Medicine (neonatal)

BR+® - Birthrate plus (workforce tool to calculate the number of midwives required to look after a cohort of women)

Cephalic - Head down

CNST - Clinical Negligence Scheme for Trusts

CTG - Cardiotocography (fetal monitor)

CQC - Care Quality Commission (Our regulator)

Cooling - baby actively cooled lowering the body temperature

DoM - Director of Midwifery

EFW - Estimated fetal weight

FTSU - Freedom to speak up

G - Gravis (total number of pregnancies including miscarriages)

GIRFT - Getting it right first time (Benchmarking data)

HSIB - Health Service Investigation bureau

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

IUD - intrauterine death (in the uterus)

IRM - Incident review meeting

LMNS - Local maternity and neonatal system (the fours trusts in south Yorkshire)

MIS - maternity Incentive Scheme (CNST)

MNSI - maternity and neonatal services investigations (formerly HSIB)

MNVP - Maternity and neonatal voices partnership (our service users)

MSDS - Maternity dataset

NED - Non-executive director

NICU - neonatal intensive care unit

NLS - Newborn life support (resuscitation)

NMPA - National maternity and perinatal Audit (provide stats & benchmarking)

OCR - Obstetric case review (learning meeting for interesting cases)

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

PFDR - Prevention of future deaths

PMRT - Perinatal Mortality Review Tool (system used assess care given)

PPH - Postpartum haemorrhage (after birth)

PROMPT - Practical Obstetric Multi-professional training (skill based training)

PSII - Patient safety incident Investigations

QI - Quality Improvement

Quadrumvirate - management team including obstetric, midwifery, neonatal & business (Quad)

RDS - respiratory distress syndrome (breathing problems)

Red Flag - Indicator that the system is under pressure (quality indicator)

RIP - rest in peace

SVD - Spontaneous vaginal delivery

SBLCBV2 - Saving babies Lives care bundle (bundle of care to reduce poor outcomes)

MCoC - Midwifery continuity of Care (6-8 midwives working in a team to provide care)

Other information

Term is 37-42 weeks long

Viability is 24 weeks (in law) - gestation a pregnancy is considered to be viable

Resuscitation of an infant can be considered from 22 weeks (parent will be counselled about the possible outcomes)

3rd / 4th degree tear - significant tearing of perineum / muscles during birth requiring repair in theatre

Lois Mellor
Director of Midwifery
Updated 24.6.24

2511 - B4 DIGITAL ENABLING PLAN

Decision Item | Sam Wilde, Chief Finance Officer | 11:40

10 minutes

REFERENCES

Only PDFs are attached

B4 - Digital Enabling Plan.pdf

B4 - Appendix 1 Digital Enabling Plan 2025-2029.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Digital Enabling Plan (2025-2029)**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Dan Howard, Chief Information Officer			
Appendices:	Appendix 1 – Digital Enabling Plan 2025-2029			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF Risk 7: 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.			

Executive Summary – Key messages and Issues

Our new Digital Enabling Plan (2025 – 2029) sets the strategic direction, the foundations and the ambition for the digital transformation we will be delivering at DBTH. It is circulated for review and final approval.

In summary:

- It is an ambitious and aspirational plan, balanced against the opportunities and challenges locally, regionally and nationally
- It recognises the significant and fundamental way in which digital will change healthcare over the coming years, for example the 'analogue to digital' shift within the "Fit for the Future: 10 Year Health Plan for England" and new NHS online hospital announced in October 2025
- It aligns directly and supports delivery of our Trust Strategy (2025-2029)
- It includes an assessment of the progress made during delivery of the previous DBTH Digital Strategy
- It incorporates and takes account of all feedback provided to date from colleagues, partners and patients
- The five ambitions are:
    - Ambition 1: Digital Foundations;
    - Ambition 2: Electronic Patient Record;
    - Ambition 3: Digital Innovation;
    - Ambition 4: Analytics and Data Quality; and
    - Ambition 5: Digital workforce, engagement and culture.
- There is a detailed action plan within each ambition which includes metrics for delivery at the end of each year.

It has been shared with the following groups for feedback.

- Executive Team (1st October)
- Digital Data and Technology Committee (7th October)
- Trust Leadership Team (October)
- Partnership Forum (14th October)
- Workforce and Education Group (17th October)

- Finance and Performance Committee (23rd October)
- Digital Provider Board (28th October)
- Doncaster Place Digital Transformation Group (31st October)

Recommendations

Trust Board is asked to:

- Review the Digital Enabling Plan including its vision, five ambitions and priorities for delivery
- **APPROVE** the Digital Enabling Plan

Healthier together – delivering exceptional care for all

Patients	Excellent and reliable digital systems and services will mean that patients receive better care as the right information will be available at the right time and in the right place.
People	Colleagues will have access to great IT systems and equipment, which is reliable and works for them and makes their job easier.
Partnerships	We continue to work in partnership with other Trusts and NHSE, on shared systems, on information sharing and through other joined up working initiatives. This will lead to reduced cost, more benefits and increased resilience within digital.
Pounds	Our digital work will offer best value through appropriate procurement and good contract management. We will benefit from economies of scale where possible.
Health Inequalities	Our digital work reduces both health inequalities and digital exclusion. Our data is routinely used to make improvements to provide equity of healthcare across different population and demographic groups.
Legal/ Regulation:	Legal and regulatory issues are regularly reviewed. We seek specialist legal support where necessary and meet all relevant regulatory standards.
Partner ICB strategies	Our digital work fully aligns to partner ICB strategies including our digital convergence agenda.

Assurance Route

Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Outcomes, next steps and timelines are set out in the Digital Enabling Plan

Is this in line with Current risk appetite

YES

None	Minimal	Cautious	Open	Seek	Significant
	Quality Regulatory	Finance		People	

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Digital

Enabling plan 2025 to 2029

Doncaster and Bassetlaw Teaching Hospitals

The DBTH Way

Contents

Foreword

Digital technology is all around us and impacts almost every aspect of our lives.

We want Doncaster and Bassetlaw Teaching Hospitals to be the best Trust of its kind in the country, harnessing the power of modern technology.

This plan sets out how we will use digital innovation to improve the lives of our patients and colleagues as well as supporting the delivery of world class healthcare and research. It underpins our Trust strategy, supporting and improving the way our teams work by providing excellent systems and digital tools that give them more time to care. This includes making our services safer, more effective, and easier to access, all enhancing the overall experience of patients and colleagues alike.

Digital has a key role to play in the innovation and research ambitions of the Trust. Through this Enabling Plan, we intend to develop our innovation and research relationships further.

Embedded throughout this enabling plan is our ambition to work collaboratively across organisational boundaries, knowing we can achieve far more when working together.

Our ambition is to transform healthcare, digitise information and build strong foundations. This document sets out our path to get there.

Dan Howard
Chief Information Officer

Our plan to transform healthcare, digitise information and build strong foundations.

Despite advancements over recent years, there is a long way to go to realise the full digital potential of the NHS.

Our previous Digital Strategy (2021-2024) set out an ambition to digitise patient interactions and end-to-end process, improve technology along with the user experience and improve data sharing. We made great progress in several areas, such as extending the use of Nervecentre, implementing new clinical systems (such as Radiology Information System, Digital Paging and Audiology system) improving the use of technology (such as replacement devices and upgrading systems such as our Patient Administration System) and we've made a step change in our sharing of information through our use of the Yorkshire and Humber Care Record (YHCR). Some elements were not delivered however, such as a reduction in clinical systems, more integration with wearable devices, a significant reduction in the use of paper and a single patient portal. This Enabling Plan builds on progress made to date and sets us on a path to be a digital exemplar in the future.

During the lifetime of this enabling plan, we will make step change improvements to healthcare to deliver the strategic ambition of becoming a digitally enabled and mature organisation. This includes introducing digital health literacy programmes, expanding shared care records, rolling out an electronic patient record (EPR) system and implementing artificial intelligence and remote monitoring tools to enhance diagnostic accuracy and reduce the burden on traditional healthcare settings. We will also achieve this by delivering the priorities within each of our Digital Ambition as outlined in this Enabling Plan.

Starting with the essential foundations, we will implement WiFi and network upgrades across our major sites and provide thousands of new devices for colleagues. This will ensure our teams have reliable equipment that works well with minimal downtime. We will also ensure our digital services are resilient, reliable and fit for purpose.

Our Electronic Patient Record (EPR) Full Business Case is set for approval later in 2025 which will unlock funding for the system, for resources and for infrastructure. We are progressing readiness activities in terms of digital literacy, data quality improvements and clinical process redesign. Our new EPR will significantly accelerate our journey towards reducing our reliance on paper and improve our ability to communicate with patients and partners, while supporting system-wide clinical strategies to develop cross organisational pathways. Our new EPR also will significantly improve the user experience and streamline our support and training.

We have made significant progress with digital innovation in recent years, for example using Artificial Intelligence through the use of Co-Pilot and Robotic Process Automation. We will be setting up a digital exemplar ward in early 2026 which will showcase new technology and ways of working to our teams, stakeholders and patients. We will pilot new technologies such as ambient voice (which uses Artificial Intelligence to turn the words spoken by patients and clinicians into written words in real time) and continue to push the boundaries of digital innovation so that our patients receive the best care possible and our Trust is recognised as a leader nationally for research and development.

We are keen that our colleagues have the right information to help make better clinical and operational decisions. Our ambition for analytics and data quality is to enhance information and reporting, aligning digital transformation with workforce resilience, operational efficiency and better patient outcomes.

We hope this document will be a guide for our digital working, innovation and collaboration and we look forward to the exciting realisation of our digital ambition in the years ahead.

About the Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) is one of Yorkshire's leading acute trusts, caring for more than 440,000 people across South Yorkshire, North Nottinghamshire, and the surrounding areas.

We provide a full range of hospital and community-based services across three main sites - Doncaster Royal Infirmary, Bassetlaw Hospital and Montagu Hospital- alongside additional outpatient clinics and health services within Retford Hospital, the Sandringham Road Clinic and Devonshire House.

As a teaching hospital, we work closely with local universities, contributing to the development of future healthcare professionals while advancing research and innovation.

We're proud to train 25% of the region's medical students and 30% of all other healthcare professional students, supporting the future of the NHS.

Our vision:

Healthier Together – Delivering Exceptional Care for All

guides everything we do and reflects our ambition to deliver the very best outcomes for our patients, while ensuring our colleagues feel supported, respected, and empowered.

With over 7,300 colleagues, our teams are united by the **DBTH Way** – our shared approach to delivering outstanding care. It's built on our **We Care Values** of being kind, keeping respectful, and working together to give colleagues what they need to thrive.

Our Trust Vision

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), our Vision is simple but powerful:

Healthier Together – Delivering Exceptional Care for All.

This Vision shapes everything we do, driving our ambition to deliver the best outcomes for patients while creating a supportive, respectful, and empowering environment for colleagues.

To help us achieve this, we're guided by our Values and behaviours, known as '**We Care**', which are brought to life through living the '**DBTH Way**'.

We care

The DBTH Way

Our Strategic Priorities

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

People
We are supportive, positive and welcoming.

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

Pounds
We are efficient and spend public money wisely.

Our Strategic Ambitions

Provide the best care environments
We are improving care spaces by modernising facilities, enhancing community care, and reducing pressure on our hospitals, with a focus on funding, safety, and service integration.

Tackling health inequalities
We prioritise health equity through prevention, partnerships, training and targeted support for underserved communities.

Becoming a leading centre for research and education
We aim to enhance patient care, expand student placements, invest in facilities, and grow clinical trials and funding.

Becoming a digitally enabled and mature organisation
Intergrating technology and innovation to improve care, enhance support for colleagues and improve efficiency through an electronic patient record, AI and shared records.

Our current digital services

The Digital Maturity Assessment helps providers and integrated care systems across England to understand their level of digital maturity by identifying key strengths and gaps in the provision of digital services.

In the most recent NHS Digital Maturity Assessment in July 2025, DBTH scored 2.4 which was slightly below average against our peers within the region and across England. Our ambition is to increase the 'ensure smart foundations' and 'empower people' pillars which will significantly increase our overall score in future assessments.

We currently have over 150 IT systems across the Trust, many of which are not connected. This makes it difficult for clinicians to see a complete picture of a patient's care, slowing down decisions and increasing the risk of missed information.

Our new Electronic Patient Record (EPR) will replace these fragmented systems with a single, robust platform.

Clinicians will have timely access to accurate information at the point of care, supporting safer clinical decisions, reducing duplication, and freeing up more time for direct patient care. Patients will benefit from more joined-up, consistent, and efficient care across the Trust.

We have made significant improvements in recent years, including:

- infrastructure improvements
- embedding our current EPR
- use of the shared electronic record systems across South Yorkshire and Nottinghamshire
- increased use of dashboards for information management
- a new Radiology Information Management system
- a new Audiology system
- a new digital paging system

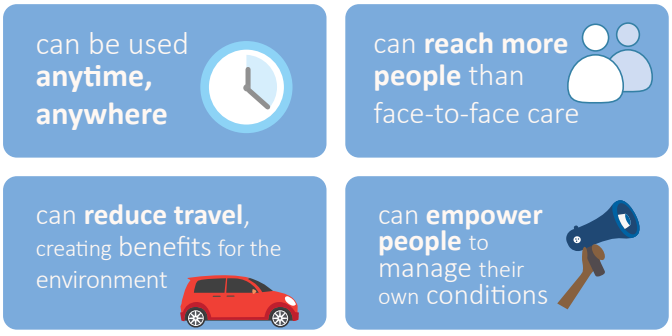
Developing the Digital Enabling Plan

Engagement with colleagues and partners

In developing this Enabling Plan we engaged widely through a variety of means:

- All colleague survey
- Workshop with senior leaders within the Trust
- Discussion with system partners such as other Trusts, Place based groups and ICBs
- Feedback from Trust professional groups such as Nursing, Midwifery, and Allied Health Professionals
- Feedback from a variety of patient groups

Senior leaders and colleagues identified a range of ways digital technology can support them to improve patient care, experience and enhance productivity and team satisfaction:



Our digital vision

We will deliver digitally enabled services that provide exceptional care, quality and safety for our patients, built on a single view of information for our clinicians, with collaboration at the core.

We aspire to be the most improved Digital Trust in England by December 2029.

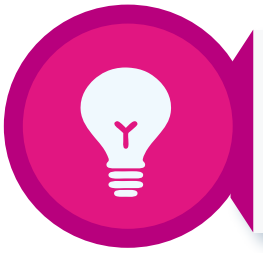
To achieve this vision, we will focus on the following ambitions:

Digital Foundations

We will improve infrastructure such as WiFi, cyber security and provide user technology which supports an amazing user experience.

Implementation of a new Electronic Patient Record

From February 2026, we will begin implementing our new EPR based on the Oracle Health platform introduced at Sheffield Teaching Hospitals - with go-live planned for late 2027. We will also replace other major supporting systems as needed. Collectively these will provide easy to use systems giving access to accurate up to date information at any place and time.



Digital Innovation

We will implement safe, evidence-based digital innovations, including the use of Artificial Intelligence (AI) and machine learning to improve clinical outcomes, patient experience, and operational productivity.

Analytics & Data Quality

We will become a data driven and information rich Trust, using analytics to shape current and future clinical care and to support clinicians to make excellent clinical decisions. We will integrate new technology, using automation, and applying standards and governance to improve data quality.

Digital Workforce, Engagement & Communication

We will introduce a digital-first culture, ensuring our workforce has the skills to make the most of digital, data and technology.

We will know we have achieved this ambition when...

Patients say...

"I can easily access my information from my device."

"I know my information is safe."

"I can make appointments using my device."

"My care can be monitored from home."

All colleagues say...

"The software and device I have helps me work better."

"The systems I use are easy to access."

"I feel confident using Trust IT systems."

"I have access to all of the training I need."

"When I have an IT problem, it is fixed promptly."

Managers say...

"I understand the performance of my team."

"I have access to the information I need to influence decision making."

"I trust the analysis and performance information I have and can answer queries on the data."

Clinicians say...

"I can provide better care because of the systems and IT equipment I have."

"I can easily view patient records, wherever I am."

"I feel supported by digital when using systems and IT equipment."

Digital Foundations

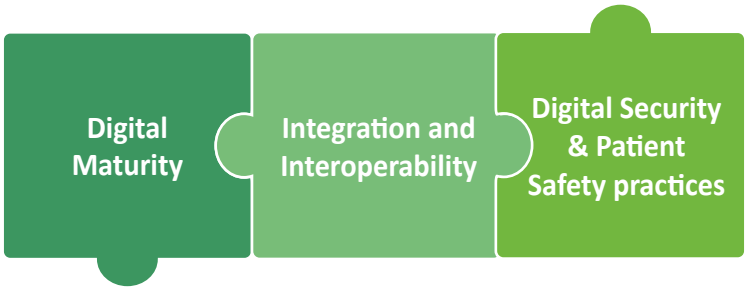
In collaboration with suppliers and regional healthcare partners, we aim to ensure that colleagues and patients can access the information they need, whenever and wherever it's required. By harnessing digital healthcare tools and high-quality, complete data, we will streamline processes, automate routine tasks, support better clinical decision-making, and reduce risk.

In preparation for the upcoming Electronic Patient Record (EPR) and a digital-first approach to care- and in line with the What Good Looks Like framework (Smart Foundations, Improving Care, Empowering Citizens, and Safe Practice)- the Trust's Digital Service is delivering essential technology improvements to support the successful implementation of the new Electronic Patient Record system, alongside integration with existing systems and medical devices, by the end of 2027.

The resulting combination of advanced software and modern hardware will deliver efficient and safe access to a comprehensive patient health information record and associated electronic workflows, replacing and surpassing current systems capabilities and paper-based records and processes.

We will provide and enable a simple, but highly integrated digital ecosystem to facilitate clinician-driven innovation, supported by the rapid and safe flow of health information essential to effective coordination and continuity of care.

To achieve our goal, we will focus on:



Digital Maturity

Building upon the Trust's basic electronic and paper records and timeworn hardware, we will deliver a wholly integrated digital-first environment. The use of modern high-quality, reliable, technology will enable and enhance efficient operations and excellent clinical services. Using HIMSS digital maturity assessments, our ambition is to progress to the highest rating (Level 7) by the end of 2029, having achieved Level 5 following the successful implementation of the new EPR in October 2027.

Integration and Interoperability

Ensure the Trust's systems and medical devices can reliably and securely share information within a single, comprehensive electronic record. This will give colleagues access to up-to-date patient information across all care settings within the Trust and the wider region, enabling seamless, coordinated care.

Digital Security and Patient Safety

We will reinforce and develop the Trust's protection against cyber-attacks and data security or systems-based incidents. We will deploy supporting defensive, fault resilience and high availability technologies within our solution architecture. These measures will protect our essential clinical services and the information entrusted to us by our patients, in line with the NSH 'Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) ' assurance framework and the Department of Health and Social Care's 'Cyber Security Strategy for health and social care: 2023 to 2030'.

To achieve our aims, we will invest in:

Modern, fit for purpose end-user devices	New laptops, desktops, large monitors, computers on wheels and wall-mounted equipment and displays.
Healthcare-specific mobile devices	Designed to support eObs and other clinical workflows.
Fast and reliable networking and Wifi	Enabling rapid access where and when colleagues need it.
High availability and cyber security improvements	Assuring a resilient and safe approach to EPR operations, with a combination of services hosted in the cloud, as hybrid, or locally, as best fits the Trust's needs.
Replacement and fit-for-purpose IT Service Desk and IT Service Management solution	Supporting teams and services aligned with the 'Information Technology Infrastructure Library' (ITIL) framework and pursuing NHS 'Service Desk Institute' (SDI) accreditation for best practice, including effective incident and problem management, systems, network, and asset performance monitoring in real time, secure single sign-on across all the Trust's applications, AI chat functionality for IT issues and service requests, and user self-service for password resets, access provisioning, rapid replacement of faulty hardware, amongst other expected service improvements.
Leveraging national investment in NHS 365	This includes reducing costs for locally procured software, servers, and storage by adopting progressive web app (PWA) versions of Microsoft Office and migrating files and data to 365 via OneDrive and SharePoint. These changes will support more efficient online collaboration while minimising duplicated email attachments and the risks of multiple document versions in circulation.
Participating in the NHSE sponsored national pilot of Copilot	AI software integrated with NHS 365, from which evidence of the potential for AI to improve efficiencies and reduce costs at the Trust is already emerging.

Measuring our improvement

Within 1 year
(by December 2026)

- Maintaining 'Standards Met' assessment for the CA_DSP Toolkit.
- 15% reduction of number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone).
- Full review of Digital Services Service Level Agreement.
- 15% reduction in number of calls to the service desk for poor Wi-Fi and hardware performance and slow connectivity.
- No more than 1% of service desk calls for incident response outstanding without a resolution after 31 days of the call being made.
- Doncaster Royal Infirmary and Bassetlaw Hospital network and Wifi refresh to be completed.

Within 2 years
(by December 2027)

- Centralised device replacement programme introduced.
- 25% reduction of number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone).
- We will extend our service desk support hours to reflect demand.
- 25% reduction in number of calls to the service desk for poor Wi-Fi and hardware performance and slow connectivity.
- Trust-wide WiFi enhancement complete. (July 2027)
- New hardware roll-out to support EPR complete.

Within 3 years
(by December 2028)

- Service Desk accreditation.
- 35% reduction of number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone).
- Customer satisfaction for the digital team increases to 85%.
- 35% reduction in number of calls to the service desk for poor Wi-Fi and hardware performance and slow connectivity.
- Develop a 'cloud-first' policy for data storage/new systems
- Digital Maturity Assessment increase overall score to 3.5/5.

Within 4 years
(by December 2029)

- Achieve enhanced compliance with the objectives and principles of the CAF_DSP Toolkit year on year.
- 50% reduction of number of service desk calls that could have been resolved using self-help (or are first time fixes over the phone).
- Customer satisfaction for the digital team increases to 95%.
- 50% reduction in number of calls to the service desk for poor Wi-Fi and hardware performance and slow connectivity.
- Single sign-on extended to 25% of the workforce.
- Digital Maturity Assessment increase overall score to 4/5.

Electronic Patient Record

We are introducing a new Electronic Patient Record (EPR) system across our Trust by late 2027, replacing many of our existing systems with a single, more efficient way of working.

In the lead-up to implementation, we will focus on improving digital literacy and data quality, helping colleagues feel confident with the new system and ensuring a seamless migration of information. As we go live, every colleague will receive the right training and support, the system will be configured to work in the best possible way, and clinical safety will remain our highest priority.

Together, these steps will make sure the transition is smooth and that everyone feels supported throughout the change.

About the new system

The EPR will be a shared version of the Oracle Health system used by Sheffield Teaching Hospitals and will go live in late 2027.

New ways of working enabled by the new EPR will free up time for care, improve record-keeping, and make accessing patient information faster and more secure. It will also help us work more closely with colleagues across the region, ensuring more joined-up care for patients.

Implementation will begin in February 2026.

What key systems are we replacing?

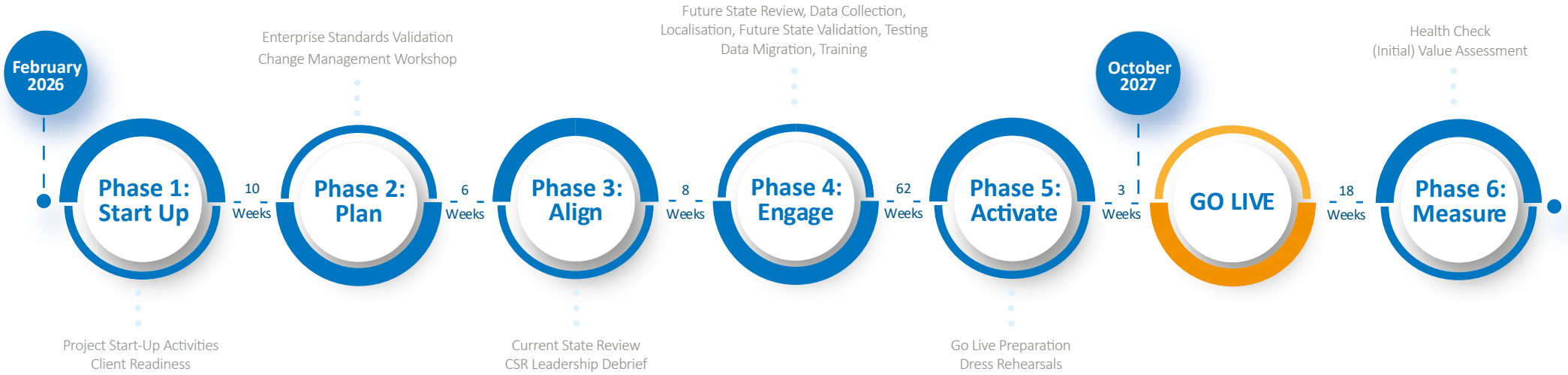
- **Patient Administration System (PAS)**: The core system used for patient registration, appointments, and admissions.
- **Symphony**: The system used within urgent and emergency care.
- **WellSky**: Electronic prescribing and medicines administration system (Pharmacy Stock Control System will be retained).
- **Bluespier**: Theatre management system.
- **Paper records**: Used widely across the Trust.
- **ICE**: Used for requesting tests and viewing results.

About ORBIT

The programme to implement an EPR has been named **ORBIT**- One Record, Better Information & Treatment. Named by colleagues, this programme reflects our ambition to transform care by replacing multiple systems with a single, more efficient and user-friendly platform.

ORBIT will be a clinically led programme, with Acting Chief Medical Officer Nick Mallaband serving as the Senior Responsible Officer. A robust change and readiness strategy will guide the programme, creating a shared endeavour that brings together the knowledge, skills and experience of the ORBIT team, clinical and operational colleagues at all levels, and Oracle Health. This approach will ensure Trust teams are well-prepared and supported to adopt new ways of working.

Programme Timeline



Our ambitions

- **Seamless access to patient records** - with unified records all in one place, enabling patient care and safety.
- **Reduced paper-based practices** - moving paper-based processes to easy-to-use digital platforms.
- **Patient-held and accessible records** - providing patients with the power to monitor their healthcare data.
- **User experience** - developing user-friendly solutions that cater for all, regardless of the level of digital literacy.
- **Improved decision making** - longitudinal record and clinical decision support guides colleagues and standardises workflows.
- **Greater efficiency** - streamlined practice releases time to care, supports clinical audit, SNOMED CT and PRSB standards, improves hospital reputation and professionalises record keeping.

Measuring our improvement

Within 1 year
(by December 2026)

- EPR Full Business Case approved by NHS England.
- Readiness underway (process flow mapping, data migration, data quality, digital literacy).
- Upgraded Maternity system.
- Reduction in 10% of paper in use across the Trust
- 5% reduction in the number of clinical systems in use.
- Pre-EPR Data Cleansing including, use of AI for targeted data validation.
- Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Records (EMR) assessment for benchmarking.

Within 2 years
(by December 2027)

- Fully implemented and optimised EPR system, including integrated Electronic Prescribing and Medicines Administration.
- Shared Cancer System replacement.
- All four Federated Data Platform 'products' in use.
- Reduction in 20% of paper in use across the Trust.
- 10% reduction in the number of clinical systems in use.
- Electronic Document Management system implemented
- Governance for new EPR (design authority) established and effectiveness assessed.

Within 3 years
(by December 2028)

- Picture Archiving and Communication System system replaced.
- Measured increased in colleague satisfaction of the new EPR system. Improved efficiencies and colleague wellbeing.
- ICE review and if appropriate, shared system implemented.
- Reduction in 60% of paper in use across the Trust.
- 15% reduction in the number of clinical systems in use.
- Feedback on EPR (and other major system training) exceeds 4/5.
- New ESR system implemented (subject to national roll-out plan and further approval).

Within 4 years
(by December 2029)

- Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Records (EMR) assessment – Level 7.
- LIMS implementation go-live.
- Second upgrade for maternity system
- Reduction in 80% of paper in use across the Trust.
- 25% reduction in the number of clinical systems in use.
- Feedback on EPR (and other major system training) exceeds 4.5/5.
- Shared Cancer System upgraded.

Digital Innovation

The urgency for innovation has never been greater. Our ambition is to be a testbed for faster adoption of safe, evidence-based digital innovations to improve clinical outcomes, patient experience, and operational productivity.

We will translate national strategy into local delivery, adopting what works quickly, generating real-world evidence for emerging technologies, and scaling only those tools that are safe, value-adding, and equitable. This approach will ensure DBTH remains aligned with NHS England's priorities for innovation while addressing local health needs.

The NHS is transitioning toward a unified, evidence-led approach to digital transformation, driven by the Accelerated Access Collaborative (AAC), National Institute for Health and Care Excellence's (NICE) evidence framework standards for digital health, and NHS England's Digital Technology Assessment Criteria (DTAC). These frameworks provide clear guidance on safety, clinical efficacy, and interoperability, removing unnecessary duplication and enabling Trusts like DBTH to adopt proven technologies at pace. By anchoring all digital decisions to these national standards, DBTH can reduce governance complexity and accelerate the delivery of tangible benefits for patients and colleagues.

Artificial Intelligence

A key to achieving our ambitions is the adoption of a robust Artificial Intelligence (AI) Policy reflecting NHS guidance and regulatory requirements. All AI solutions introduced within DBTH will undergo rigorous governance, ensuring they comply with DTAC and NICE evidence standards.

This includes clinical safety checks, data protection impact assessments, and adherence to DCB0129/0160 clinical risk management protocols.

For any AI tool deployed, explainability, bias monitoring, and transparency will be mandated, ensuring decisions remain safe, fair, and accountable. Generative AI will be introduced cautiously for defined, low-risk tasks-such as summarising documents or drafting patient information- with strict controls to ensure human oversight and auditability.

Our AI policy also establishes post-deployment assurance, requiring continuous monitoring for performance, safety, and equity. Each solution will be added to a benefits and safety register, supported by sunset clauses to decommission tools that fail to deliver value. By embedding fairness reviews and ensuring compliance with accessibility standards, DBTH will mitigate the risk of digital exclusion and inequity in care delivery.

To align with the NHS England strategy on innovation, DBTH will work closely with the NHS Innovation Service, providing a clear entry point for external innovators and colleague-led ideas.

From 2025 to 2028, DBTH will prioritise four key areas:

AI-enabled imaging and diagnostics to reduce backlog and turnaround times

Automation to streamline administrative processes and free up clinical time

Virtual care solutions for long-term condition management

Commitment to equity by design, ensuring all innovations meet usability and accessibility requirements

These initiatives will be underpinned by open standards, interoperable platforms, and strong supplier relationships to avoid fragmentation and support seamless integration across systems.

Digital Academy

People and skills will be central to this plan. DBTH will invest in digital literacy training through a Digital Academy, covering AI fundamentals, prompt safety, and evaluation methods. By leveraging NHS AI resources and national communities of practice, we will build confidence and competence among clinicians and operational colleagues, ensuring successful adoption and cultural readiness for innovation.

DBTH will embed transparency and accountability into its innovation process. Each initiative will have measurable outcomes - covering safety, clinical impact, operational efficiency, and equity- and findings will be shared publicly through short “innovation notes.”

This aligns with NICE’s real-world evidence standards and supports the wider NHS ambition to scale what works across systems.

By combining rigorous governance, proactive adoption, and a culture of learning, DBTH’s Digital Enabling Plan will ensure that innovation translates into meaningful improvements for patients, clinicians, and the health system.

Measuring our improvement

Within 1 year
(by December 2026)

- System in place to capture digital innovation ideas from colleagues.
- Integration of NHS App with local services, enabling appointment booking, prescription requests and tests results access.
- Working group in place to ensure the design, implementation and deployment of systems improve clinical workflows – encouraging clinically led co-design.
- Network-wide Pathology and Radiology procurement and initial implementation; interoperability pilots.

Within 2 years
(by December 2027)

- At least two digital innovation events hosted at DBTH.
- Two pilot projects launched, increasing the use of AI within clinical settings.
- Patient experience improved through joined up care and intuitive digital systems.
- Develop a digital clinic skills baseline survey to understand the digital demographic of the organisation.

Within 3 years
(by December 2028)

- For patient groups suitable for virtual monitoring, 80% are utilising the technology.
- Clinicians have embedded digital systems/ tools into routine practice to improve care and aid decision making – reducing variance in care, including AI-driven decision support tools integrated into clinical workflows.
- Reduce administrative time on clinicians by 25% through the use of Artificial Intelligence.
- Over 40% of patients actively using digital tools to manage their care.

Within 4 years
(by December 2029)

- NHS App being used as the single patient front door.
- Over 60% of patients actively using digital tools to manage their care.
- DBTH is recognised nationally as a leader in nursing and AHP digital transformation, shaping the future of care delivery.
- Full Pathology and Radiology integration across networks; semantic interoperability with EPRs.

Analytics and Data Quality

The Trust's ambition for analytics and data quality is to enhance information and reporting, aligning digital transformation with workforce resilience, operational efficiency and better patient outcomes.

By 2029, we will deliver a modernised, efficient, and responsive digital infrastructure, underpinned by a skilled workforce and robust governance. Clinical coding will be fully brought in-house with enhanced quality and cost-efficiency; data quality will be at national best practice levels; and users across the Trust will benefit from streamlined access to reliable, actionable insights.

Achieving this ambition will ensure the Trust remains agile, future-ready, compliant with national standards. This ambition is founded on five pillars:

Strengthening clinical coding

A strategic shift is planned to bring previously outsourced coding services back in-house. This move is anticipated to be both cost-effective and quality-enhancing.

It will be supported by automation tools such as auto-coding for simple cases. By automating routine tasks, skilled coders can be re-deployed to more complex cases where human expertise is critical. This supports broader efficiency goals while safeguarding the quality and accuracy of coded clinical data. Training and implementation of upcoming standards such as ICD-11 are also core components, ensuring the team remains compliant and future-proof.

Technological integration

Leveraging Office 365 tools - including Copilot - will drive efficiency in administrative tasks, collaboration, and data handling across all digital functions.

Additionally, further investment in AI-based validation tools is planned to support Data Quality Assurance (DQA), allowing automation to handle high-volume validation tasks while reserving human input for more complex areas. Embedding DQA colleagues within clinical divisions will increase visibility and enhance collaboration, ensuring that data issues are addressed promptly and in context.

Improving data quality

Preparation for the new Electronic Patient Record (EPR) system is a strategic priority for the Trust. Pre-EPR data cleansing using automated tools is underway to ensure high levels of accuracy and readiness. Cloud computing will be explored to modernise the Trust's data analytics infrastructure. Linked to this is the implementation of DevOps processes, which will enhance project delivery by improving

deployment management, version control, and auditing of changes in data environments.

The Trust will continue to benchmark clinical coding quality against national averages, supporting better coding depth and income assurance. Maintaining the highest levels of Data Security and Protection Toolkit audit performance remains a key objective, reinforcing the Trust's reputation for secure and compliant data practices. In DQA, the goal is to place the Trust within the top 25% nationally for data quality, leveraging the Secondary Uses Service Data Quality Dashboards and business intelligence tools to monitor and improve performance.

Advancing data development practices

A more robust data architecture will be implemented to minimise issues such as system locks and blocks. A formal archiving policy will be established to determine which data is retained for reporting and which can be archived or removed. The introduction of a Digital Portal will centralise access to key resources- such as reports, forms, and system status updates - helping end-users engage more effectively with digital tools and services.

Improving user adoption and engagement is a key challenge to be addressed. A digital catalogue of available reports will be developed to reduce duplication and increase transparency of data and insights available to better inform decisions-making.

Additionally, the ongoing development of business rules and clinical flags will ensure that as reporting tools evolve, data integrity and consistency are maintained.

The Trust will invest in advancing the analytical capabilities by embracing Data Science as a key driver for identifying areas for improvement and risk by utilising the industry standard software. This will allow scenario-based data modelling to be created to ensure the Trust has the highest level of insight to deliver on challenging national standards.

Developing a resilient, right-sized workforce

Recognising an aging workforce and the importance of retaining skilled colleagues within the analytics and data teams, we will prioritise targeted upskilling, appropriate training in the latest relevant technology, flexible workforce planning, and enhanced wellbeing initiatives. These will include a further rollout of hybrid and flexible working practices, which have become increasingly viable with the continued digitisation of health records. These changes are expected to improve colleague satisfaction, reduce turnover, and enhance the Trust's competitiveness as an employer of choice.

To create the conditions to achieve our ambitions, plans will be underpinned by strong governance, communication, and change management. Digital champions and divisional leads will support implementation at the local level, whilestructured project oversight and regular reviews will ensure progress is tracked and risks managed. Colleague engagement, user feedback, and transparent reporting will be used throughout, to ensure that digital initiatives deliver real value on the ground.

Measuring our improvement

Within 1 year
(by December 2026)

- To create a forum to discuss live data dashboard opportunities for clinical care – including infection prevention, falls. 'One single version of the truth'.
- Training plan developed for applicable roles within the team and role types within the workforce.
- Specific roles aligned with Divisions with time spent working directly in the Divisions to increase engagement and faster issue resolution.
- Page on the Hive created detailing the service that is offered in each team and the team members. Ensure that all teams are represented at the outside of projects which will have an impact.
- All key Business Rules developed into a central area that drives consistency in reporting and enhances the One Source of the Truth ethos.
- International Classification of Diseases (ICD) -11: Full implementation of the new coding standards with relevant training and update to reporting complete.
- Analytics "Business Partners" established.

Within 2 years
(by December 2027)

- Increase income to the Trust by at least 5% through more accurate and timely coding. Development of auto-coding in specific cases will be rolled out building off the back of the EPR implementation.
- Data cleansing element of the EPR completed and signed off to the agreed standard.
- Increase the number of unique users of the dashboards to 10% of Trust workforce to facilitate better operational decisions and less duplication.
- Removal of low level tasks and integrate analysis functions which can be completed by Office 365.
- Creation of a single, central page for reports that can be accessed by all colleagues.

Within 3 years
(by December 2028)

- DevOps built into future projects to ensure low risk to future development work and ensure business continuity and resilience remain.
- In line with the EPR programme the full deployment of a new Data Warehouse in line with the wider Trust Strategy. Providing improved resilience and reporting power as well as ingestion of new data sources.
- Move into the top 35% in the country for depth of coding and achievement of benchmarking criteria.
- Data being a trusted, core driver of workforce planning, quality improvement and patient safety.

Within 4 years
(by December 2029)

- AI has been embedded in business as usual with improved validation results. Also the ability to re-look at the size and scope of the workforce as part of natural movement of colleagues.
- Data warehouse has a high level of resilience and remains live and functional for 99% of the time.
- Move into the top 25% in the country for depth of coding and achievement of benchmarking criteria.
- Being a nationally recognised organisation for the use of data to drive quality improvement and assurance metrics.

Digital Workforce, Engagement and Culture

We will continue to develop and support our highly skilled and engaged Digital team, which is recognised as an effective and valued partner to the Trust's clinical service areas.

Our Digital team will support and enable a digitally empowered and confident workforce in the wider Trust, providing colleagues with a great digital experience with effective software and hardware that works in the way they need to provide excellent clinical services.

In alignment with the 'What Good Looks Like' framework (Supporting People), we will invest in digital skills and capabilities to support the adoption and effective use of new software and hardware technologies by the Trust's workforce.

Our teams will receive training and education to support digital transformation and adoption of the new EPR, maturing NHS 365 implementation, and associated changes to workflows in the transition from paper to digital. They will have opportunities to contribute to current state process mapping and designing and producing the future digital state, including increased use of online collaboration within the NHS 365 platform, artificial intelligence (AI), and clinical decision support (CDS) enabled tools.

With digitally enabled workflows and modern, reliable, high performing hardware and software integrated with medical equipment, the Trust can expect an environment that supports flexible working and reduction in workforce pressures and increases time for direct patient care and other value adding services.

With the EPR at the core of all patient interactions, our workforce will only need to enter information once.

The system will fully integrate with existing platforms to maximise its benefits, giving teams access to a single, comprehensive patient record and task automation across all sites- and ultimately across the region. This will enable seamless collaboration between sites and providers, support remote working, and drive continuous improvement in patient services.

We will implement a cyber-security strategy that strengthens our culture of data security across the Trust. By aligning all colleagues towards the same goals, we will enhance our ability to detect and respond to incidents effectively, protecting our systems, data, and the essential clinical services that depend on them.

Measuring our improvement

Within 1 year
(by December 2026)

- All research projects have digital involvement.
- Digital literacy benchmarked with agreed action plan.
- Digital Champions network established within Divisions with at least five in each Division.
- Provide a suite of additional role-based Information Governance & Cyber based learning packages for all colleagues through Divisional Information Governance & Cyber Champions.
- Digital Academy Established.
- Increase the number of certified clinical safety officers to 3 per Division, providing 'in house' training and ensure the clinical safety assurance is business as usual, culturally embedded within the organisation.
- Act as clinical lead in EPR design workshops, ensuring nursing and AHP workflows are fully represented. Define clinical safety standards for nursing documentation, medication management, and care planning.

Within 2 years
(by December 2027)

- Ensure a robust governance process to apply digital safety assurance to all digital system upgrades.
- Introduction of cyber security strategy.
- Contribution to national policy and best practice for digital nursing and AHP leadership.
- Improve coordination on our adherence to information and security standards by strengthening the collaboration of Information Governance (IG), Clinical Safety Reporting and Digital Services Teams.
- Set up a bespoke Microsoft Teams channel for collaborative Digital and Technical Assessment Criteria (DTAC) and Clinical Safety Reporting and Management.
- Ensure more than 95% of clinical systems in use have a Clinical Safety Officer (CSO) assessment in place.
- Gap Analysis undertaken of Excellence in Informatics Accreditation (through skills development network).

Within 3 years
(by December 2028)

- Development and Implementation of a post-EPR Smart Information Systems Asset Register accessible to all digital colleagues through a 'role-based' control process.
- National exemplar of high-performing digital champions – supporting the 'people' of DBTH.
- Provide focussed access to additional learning packages through ESR.
- Ensuring 75% plus of our clinical workforce are educated and equipped with our digital projects and aligned to national frameworks.
- Ensure 100% of clinical systems in use have a CSO assessment in place.
- Achieve Excellence in Informatics Accreditation (through skills development network).
- Monitor the DPIA, DTAC and CSR compliance for all embedded systems post full ESR implementation.

Within 4 years
(by December 2029)

- Online collaboration is normal for colleagues and emailing attachments has fallen by 80%.
- Digital literacy programme recognised nationally as an exemplar (e.g. awards, national body recognition).
- Achieve full compliance with the objectives and principles of the CAF_DSP Toolkit year on year.
- We will continue to adhere to CAF based Information Governance & Cyber Security standards, to further ensure the availability, security and integrity of information, acknowledging the complexities of access to records, particularly for vulnerable groups.
- Ensuring 85% plus of our clinical workforce are educated and equipped with our digital projects and aligned to national frameworks.
- Maintain 100% of clinical systems with a CSO assessment in place.
- Fully embed the EPR across all services, with workflows optimised and evidence of reduced duplication.

Governance and tracking

There is comprehensive tracking and assurance in place for the delivery of the Digital Enabling Plan:

Board: Both Finance and Performance Committee and Audit and Risk Committee receive regular updates on digital progress, including our Digital Enabling Plan measures.

Operational leadership and oversight: Trust Leadership Team receive a regular update on digital progress.

Digital assurance: Digital Data and Technology Group receive regular updates and monitor delivery against the delivery themes.

We will make sure we keep our colleagues and patients informed and engaged throughout by:

- Colleague engagement through existing forums and communication methods.
- We will involve our patients, their families and carers through focus groups when developing and designing digital solutions.

Glossary

There are a number of acronyms in our Digital Enabling Plan.

To help, we have created this handy glossary of terms. Looking for something specific? If you're on a Windows PC, press CTRL and F together and search.

AAC: Accelerated Access Collaborative

AHP: Allied Healthcare Professional

AI: Artificial Intelligence

CAF: Cyber Assessment Framework

CDS: Clinical decision support

CSR: Corporate Social Responsibility

CSO: Clinical Safety Officer

DevOps: software development methodology that combines and automates the work of software development (Dev) and IT operations (Ops)

DQA: Data Quality Assessment

DSPT: Data Security and Protection Toolkit

DTAC: Digital Technology Assessment Criteria

EPMA: Electronic Prescribing and Medicines Administration

EPR: Electronic Patient Record

FDP: Federated Data Platform

HIMSS: Healthcare Information and Management Systems Society

ICB: Integrated Care Board

ICD-11: Eleventh revision of the International Classification of Diseases

ITIL: Information Technology Infrastructure Library

LIMS: Laboratory Information Management System

NHS: National Health Service

NHSE: National Health Service England

NICE: National Institute for Health and Care Excellence

PACS: Picture Archiving and Communication System

PAS: Patient Administration System

PRSB: Professional Record Standards Body

PWA: Progressive web app

SDI: Service Desk Institute

SNOMED CT: Systemised Nomenclature of Medicine – Clinical Terms

SUS DQ Dashboards: Secondary Uses Service Data Quality Dashboards

Appendix 1: National Context

In July 2025, the government published the NHS 10 Year Plan- Fit for the Future. The plan is a bold reimagining of healthcare in England, driven by the urgent need to modernise, make the NHS sustainable, respond to rising demand, address an ageing population, and improve patient outcomes.

The plan outlines three major shifts:

Hospital to Community: More care delivered locally- at home or in neighbourhood hubs.

Sickness to Prevention: Prioritising early intervention and healthy living to reduce long-term illness.

Analogue to Digital: Embracing AI and digital tools to streamline services and empower patients.

Analogue to Digital

The shift from analogue to digital is intended to take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be.

"Despite the wider technological revolution in healthcare happening globally, the NHS remains a distinctly analogue service. We have not got the basics right: staff are still forced to put up with obsolete computer systems and paper records. Nor have we done enough to create the digital tools that will give patients real control over their healthcare in the future.

In the next decade, the NHS must not only catch-up: it must lead. We will harness the NHS' unique advantages - world-leading data, procurement power and the means to deliver equal access - as we create the most digitally accessible health system in the world."

***Fit for the Future: 10 Year Health Plan for England*; Chapter 3: from analogue to digital - power in your hands.**

Specific outcomes of the shift from analogue to digital outlined in the plan include:

- Ensuring rapid access for those in generally good health and freeing up physical access for those with the most complex needs, by moving 'from bricks to clicks'.
- Giving patients real control over a single, secure and authoritative account of their data - a single patient record - to enable more co-ordinated, personalised and predictive care.
- Transforming the NHS App into a world-leading tool for patient access, empowerment and care planning.
- Using continuous monitoring to help make proactive management of patients the new normal, allowing clinicians to reach out at the first signs of deterioration to prevent an emergency admission to hospital.
- Building a 'HealthStore' to enable patients to access approved digital tools to manage or treat their conditions.
- Introducing single sign on for healthcare colleagues, and scaling the use of technology to reduce the burden of bureaucracy and administration, freeing up time to care and to focus on the patient.

Appendix 2: Regional Context

The Trust has long maintained strong working relationships with our local partners. Our Digital Enabling Plan is fully aligned with the digital transformation strategy developed by the South Yorkshire Integrated Care Board (ICB) and Nottingham and Nottinghamshire Integrated Care Board (ICB).

ENGAGEMENT & COLLABORATION

PURPOSE

To work together to optimise our use of digital services and technologies, creating a sustainable landscape of core systems and tools to elevate our digital maturity and help people in South Yorkshire communicate, connect and engage with health and care services safely and with confidence.

PARTNERSHIP OBJECTIVES

- Provide inclusive digital and online services in South Yorkshire.
- Enable better information flow between care settings by prioritising convergence and interoperability.
- Work together to find efficiencies in a financially constrained environment, procuring scalable solutions.
- Optimise existing core systems and tools.
- Develop and deliver digitally mature services in a sustainable way.

PROGRAMMES

- Digital Inclusion & Accessibility
- Shared Care Record
- Digital Primary Care
- Digitising Social Care
- Provider-led Digital Requirements
- Digital Workforce (via Digital Workforce and Skills Strategy)

PARTNERSHIP PRIORITIES

- Digital Maturity
- Artificial Intelligence
- Technology Enabled Care
- Sustainability
- Clinical Safety
- Research and Innovation
- Benefits and Impact

The strategy provides a framework for effective collaboration, supporting service delivery and patient engagement by enabling more confident use of digital services across our workforce and communities.

Our South Yorkshire and Bassetlaw Acute Federation is committed to digital convergence and has plans to join up care through better, shared use of information and technology. This includes:

- Shared information through Electronic Patient Record (EPR) system. Implementation due to commence in February 2026.
- The Trust will be part of a programme to implement a new Laboratory Information Management System (LIMS), which will transform pathology services across South Yorkshire.
- The use of systems for storing and updating workforce records will be harmonised across the region, and we are also exploring digital convergence across electronic document management systems, cancer management systems and order communications systems.

Appendix 3: Local Context

As a Trust, we have a role within the health and social care community to respond to the priorities of the local 'place' and regional Integrated Care Boards (ICBs) to meet local population needs. The Trust is a key stakeholder in the delivery of Place Plans for both Doncaster and Bassetlaw. As a Trust, we have a role within the health and social care community to respond to the priorities of the local 'place' and regional Integrated Care Boards (ICBs) to meet local population needs. The Trust is a key stakeholder in the delivery of Place Plans for both Doncaster and Bassetlaw.

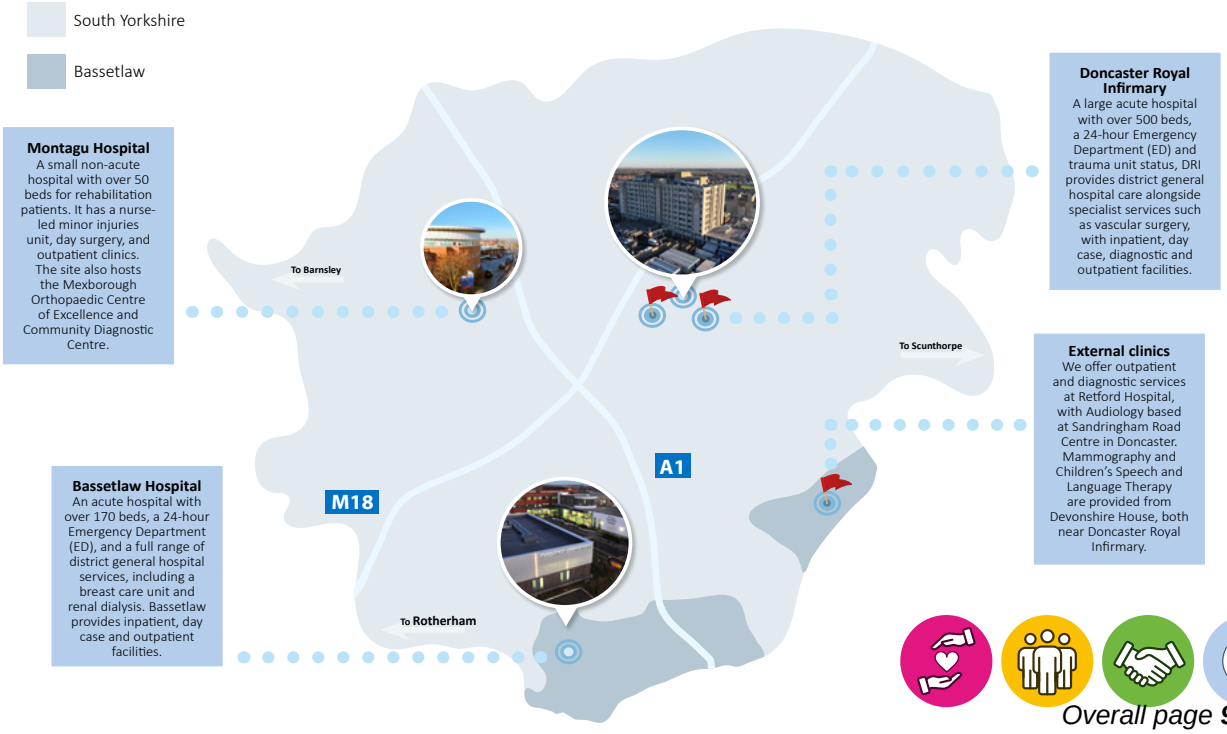
Our digital plans also align to South Yorkshire ICB and Nottinghamshire ICB strategies, along with the South Yorkshire and Bassetlaw Acute Federation's Clinical Strategy and the NHS Long term Plan.

Doncaster Place Plan

- Develop neighbourhood health services.
- Improve communication and promote initiatives that support personal wellbeing.
- Promote positive health strategies and campaigns.
- Raise awareness of, and provide support to access, local services.
- Increase activities for older people, and for those who are isolated or lonely.
- Promote the benefits of being active for mental health and wellbeing.
- Support access to apprenticeships and employment opportunities.
- Raise awareness of, and publicise, community mental health services.

Bassetlaw Place Plan

- Provide integrated support for the wellbeing of Bassetlaw citizens, with community-based, person-centred approaches covering welfare, housing, social activities, employment and health.
- Develop a joint transport strategy to better understand community needs, make best use of collective resources, and improve efficiency and experience.
- Deliver the right support at the right time through integrated health and care pathways in both community and acute settings.
- Strengthen communications and engagement through shared approaches, putting Bassetlaw people at the heart of service design.
- Create sustainable and effective services, supported by an integrated workforce, digital and estates infrastructure, and making the best use of the Bassetlaw purse.



NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Document designed by DBTH's
Communications and Engagement Team

2511 - B5 MEDIUM TERM PLANNING FRAMEWORK

Information Item | Zara Jones, Deputy Chief Executive | 11:50

5 minutes

REFERENCES

Only PDFs are attached

B5 - Medium Term Planning Framework.pdf

B5 - Appendix NHSE Medium Term Planning Framework.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Medium Term Planning Framework**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	James Tabor, Associate Director of Planning, Performance and Improvement			
Appendices:	1 - Medium Term Planning Framework			
Purpose of the report	~~Assurance~~	~~Decision required~~	Information	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			

Executive Summary – Key messages and Issues

The medium-term planning guidance has now been published and is attached for information. Due to the late publication there is insufficient time to provide a thorough analysis and report for the Board of Directors for October, however the key headlines are:

- Commitment to a multi-year planning approach with 3-year numerical plan submissions and 5-year narrative submissions.
- Expectations for primary care, mental health services and community care performance to deliver the strategic shift to prevention and community care.
- A step change towards constitutional standards in performance expectations in relation to key acute sector targets, such as 4-hour emergency expectations rising from 78% to 82% next year, and a 7% improvement expected in RTT 18-week performance.
- A slightly later submission timeline than the initial draft document, with initial submissions expected in December and a final submission around January.

Further Board assurance on the planning process will follow including the Trust approach to achieving the aims set out in the framework and deliver broad improvements for patients, our workforce and our partners in an efficient and transformative way.

Recommendations

The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	The framework aims to dramatically reduce waiting times and improve access to care through neighbourhood health models and digital-first services, enhancing patient experience and outcomes.
People	It commits to empowering staff through better leadership, reduced bureaucracy, and improved working conditions, including tackling discrimination and enhancing job planning.
Partnerships	It strengthens collaboration across NHS, local authorities, and voluntary sectors to deliver integrated care and co-designed neighbourhood health services.
Pounds	A reformed financial regime introduces multi-year planning, fairer funding distribution, and productivity targets to ensure sustainable investment and efficient use of resources.
Health Inequalities	Health inequality data is not currently broken down in the IQPR .
Legal/ Regulation:	The framework introduces new oversight models, regulatory standards for managers, and statutory changes to commissioning responsibilities, ensuring accountability and compliance.

<table>
<tr><td>Partner ICB strategies</td><td>The document sets out ICB, provider and joint expectations</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>N/A</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

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

Medium Term Planning Framework –

delivering change together 2026/27 to 2028/29

Contents

Foreword

Dear colleague,

Today we are publishing the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 – marking the beginning of a new way of working in the NHS.

It **signals the end of the short-termism** that has held the local NHS back for so long, providing local leadership teams and boards with the opportunity to break the cycle of 'just about managing' by creating the environment and headroom to fix the fundamental problems we face, while in parallel improving care in the immediate term.

It further **closes the gap between the national centre and service**: the fact that much of what is contained within this document has been co-produced with hundreds of leaders from primary care, acute, mental health, ambulance and community services is testimony to the collective desire to genuinely embrace the change the public told us all they wanted, and drive improvement in every part of the country.

But most importantly, **it marks the return of locally-led ambition** in the NHS – creating the platform for NHS boards and leaders to truly listen to their communities and drive the change they want and need.

And we're already seeing the early impact that new-found ambition is having: for the first time in years, elective waiting lists have started to fall, access to primary care is improving with more people saying it's easier to contact their GP than a year ago, corridor care incidents have fallen sharply and 12 hour waits are down year-on-year for the first time since the pandemic. We've even seen a sharper uptake in flu vaccinations across staff and the public in the early part of this year's campaign.

The same commitment to accelerating improvement is going to need to be seen right across the NHS as we go into the next few months: we need to deliver a strong and safe winter, continue our drive to improve elective performance and maintain our firm grip on the money as this is what unlocks future freedoms.

Just a few short months ago we published the 10 Year Health Plan: today's publication shows how that reform agenda will drive faster delivery of care now while creating a platform for sustained improvement in the future. It completely rewires how the NHS works, setting out how a new operating model and financial regime will rightly return freedom and innovation to the frontline of the NHS.

Resetting these foundations will enable the NHS to accelerate the delivery of neighbourhood health services, radically transform its approach to quality, and finally embrace the opportunities of digital health to drive improvements in every aspect of its work.

All of this means that the NHS is now able to commit to even more ambitious delivery targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry. At the same time, the Planning Framework sees a return to some of the basics that have taken a back seat over the last decade: ensuring providers take the time to better understand what their patients and staff are telling them, and making sure they take action when they fall short.

In short, this is the most ambitious plan the NHS has published in a generation. Over the next 3 years it will return the NHS to much better health – with waiting times dramatically reduced, access to local care restored to the level patients and communities expect, and unnecessary bureaucracy slashed so that savings are poured back into frontline services and staff.

None of what is set out in this Framework is going to be easy to deliver – but the emerging energy for change generated through the 10 Year Health Plan has started to create new optimism in the NHS.

We will continue to challenge ourselves when we fall short of what patients and communities need. Equally, we give you a clear commitment to break down any unnecessary barriers in your way – as we hope we have started to demonstrate over the course of this year.

Our collective challenge goes well beyond improving the care we provide our patients – it's about ensuring we are the community of staff and leaders that seize the opportunity to put the NHS on a sustainable footing: safeguarding it for generations to come, winning back the public's faith, and most importantly saving, extending and improving many more lives.

Thank you to all of you who have committed time and effort this year – either through contributing to the 10 Year Health Plan or helping shape this new approach to delivery. Keep up the hard work – it's very much appreciated.

Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care

Sir James Mackey, Chief Executive, NHS England

Introduction

The NHS is undergoing the biggest change process since its inception: moving away from an era where unparalleled levels of bureaucracy, complicated rules and unnecessary processes have constrained and restricted transformation to a new way of working where local leaders are empowered to drive the change their patients, communities and staff want, and need, to see.

Six months ago, despite a £22 billion injection of additional funding made available through the Autumn Statement, the NHS was predicting a deficit of £6.6 billion for the current financial year, the Public Attitudes Survey showed record-low public confidence in the NHS, staff surveys reflected worrying levels of dissatisfaction among our workforce, and the variation gap between the best and worst performers in the NHS had never been bigger.

In short, service confidence to deliver the commitments the NHS has made to improve access to care and reduce waiting times during this parliament was at an all-time low: due, in part, to a growing disconnect between the centre and the service and an operating model that had become overly bureaucratic and that stifled local innovation and change.

Yet, given the opportunity to contribute to the development of the 10 Year Health Plan, local health and care staff and NHS leaders talked with genuine optimism about what the future could look like – but only if we dramatically changed course on how the NHS is run: empowering local leaders to take more control and moving away from the annual cycle of short-term, centrally directed planning and finance that made it hard to drive real change over the medium and long term.

The 3 strategic shifts and wider transformation areas of the 10 Year Health Plan offer a blueprint for reimagining services, unlocking productivity and redirecting resources to where they can deliver the greatest impact. By embracing this approach, systems and trusts can cut waiting times, improve performance against constitutional standards, and deliver better outcomes for individuals.

The proposed abolition of NHS England is already helping to fundamentally re-set the relationship between the centre and the service, so that local NHS leaders can be more supported and empowered to drive accelerated change and improvement on behalf of their patients and staff.

Reviving an ambitious NHS

The early response from local NHS leaders has been fantastic. There's been a significant, system-wide and disciplined effort to get a better grip of the money, meaning we could start the financial year with plans that projected balance – collectively recognising some of the challenges that lie ahead in fulfilling that ambition. So far this year, these plans are being held in aggregate and for most of the NHS.

The leadership community has also stepped up to the opportunity to shape the way in which we operate in future: ICB leaders have collectively drafted the Model ICB and have redrawn the map of ICBs to create the platform through which we can do much more effective strategic commissioning going forward, drive greater productivity and better target our resources.

The broader leadership community from acute, mental health, ambulance, community and primary care has worked together throughout the summer developing plans that will see us accelerate delivery of the 10 Year Health Plan. That work forms the basis of many of the commitments set out in this document.

At the same time as more effectively planning for the broader changes we need to see, the NHS has delivered overall improvements in the rate of elective recovery on both referral to treatment waiting times and reducing waiting lists, significant reductions in spending on inefficient use of agency staff, and improvements in access to primary care.

That early progress gives us the foundation to accelerate the pace of reform. The 3-year revenue and 4-year capital Spending Review 2025 (SR25) settlement gives us both the opportunity to move away from annual financial and delivery planning cycles and a real terms increase in funding. Revenue funding will increase by 3% in real-terms over the SR25 period up to £226 billion in 2028/29, and capital spending will increase from £13.6 billion in 2025/26 to £14.6 billion in 2029/30 – equivalent to a 3.2% average real-terms growth across the full SR25 period. This represents a 31.4% and 50% real-terms funding growth in revenue and capital, respectively, since 2019/20.

Regaining public confidence in the NHS is dependent on delivering change that local communities can see and experience – better access to urgent care when they need it; reduced waiting times for elective care; and more convenient access to primary care – all of which can only be delivered and accelerated if we manage our finances well.

But it goes beyond winning back the confidence of the public: improving access to care and reducing waiting has a clear impact on future economic growth. Improving population health and tackling sickness in a more productive way directly impacts on reducing the drivers of health related inactivity, which in turn can make us more productive as a nation. It's from that economic growth that future investments in the NHS will come. On a macro scale, we can also act as a catalyst for stimulating demand for innovative health technologies, creating a robust market for UK life sciences businesses, and supporting research and development that accelerate product development and commercialisation.

The NHS has signed up to some challenging delivery commitments between now and the end of 2028/29, including:

Elective, cancer and diagnostics

- Elective (including diagnostic) reform and activity to deliver 92% 18-week referral to treatment by the end of 2028/29.
- Improve performance against key cancer standards: Maintaining performance against the 28-day Faster Diagnosis Standard (FDS) at 80% and improving 31 and 62 day standards to 96% and 85% respectively.
- Improve performance for diagnostic waiting times so that the rate of those waiting over 6 weeks is 1% (DM01 measure).

Urgent and emergency care

- Improve A&E waiting times, so that 85% of patients wait no more than 4 hours, as well as reducing the number who wait over 12 hours.
- Improve Ambulance Category 2 performance to an average of 18 minutes.

Primary care and community services

- Improve access to primary care, including reducing unwarranted variation in access. Ensure 90% of clinically urgent patients are seen on the same day. We will consult with the profession on this new ambition and approach.
- Maintain the additional 700,000 urgent dental appointments per year.
- At least 80% of community health service activity occurring within 18 weeks.
- Community pharmacy: maximise pharmacy first and roll out new services (emergency contraceptives and HPV vaccination).

Mental health, learning disabilities and autism

- 73,500 people accessing individual placement and support and providing 915,000 courses of NHS Talking Therapies treatment.
- 94% coverage of mental health support teams in schools and colleges, reaching 100% by 2029.
- Reduce the number of inappropriate out of area placements.
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction year-on-year.

Delivering all these priorities between now and 2028/29 will only be achievable if we change the way we work together.

This document sets out how we are moving to a new operating model, resetting the financial framework and creating much greater opportunity for local autonomy through the new neighbourhood health approach, a new foundation trust model and the creation of integrated health organisations. It also sets out the early progress being made on reforming our approach to quality, workforce and neighbourhood health, while setting the scene for embracing a crucial new principle that services should be delivered digitally as the default wherever possible. All the work to date has been supported and developed by leaders from across the NHS and much of it is being published in draft this autumn so that the broader health and care leadership community can contribute to these important policy developments.

Using the reform agenda to fix today while building a more sustainable future

For too long, the delivery and reform agendas have been seen as separate conversations in the NHS.

The lack of progress in recovering delivery since the pandemic and the urgent need to dramatically change the NHS operating model to return freedoms and innovation back to local NHS organisations means **our central leadership challenge over the next 3 years is how we use the reform agenda to accelerate delivery in the short-term while creating new ways of working** that provide the platform for much more sustainable, locally-driven improvement in the future.

The Medium Term Planning Framework provides us with the road-map to achieving this. The reforms to the financial regime set out in this document can help us to accelerate the long-overdue changes to the delivery of outpatient care. Taken together, they can have a substantial impact on waiting lists in the immediate and medium term.

The changes we have set out to reform the NHS App will improve direct communication with patients who are waiting for their care – helping us to reduce 'did not attend' rates, which can have a big impact on reducing waiting lists.

Similarly, embracing interoperable technology supports better communication between acute and primary care providers – enhancing how we can use Advice and Guidance, which allows us to provide more appropriate care and reduce waiting times for our patients.

Accelerating the delivery of neighbourhood services – supported in this document by changes to the operating model and the financial regime – can have a dramatic impact on urgent and emergency care performance, simply by reducing the number of frail patients that require hospital beds, freeing up more capacity and increasing the amount of elective work we can deliver.

To support this, the Medium Term Planning Framework sets out the priority deliverables and the reform opportunities that ICBs and providers need to deliver for the next 3 years and the broader strategic aims that will need to be reflected in 5-year plans developed by each organisation.

The priorities in this document are deliberately high-level. We are setting a clear direction on the top priorities the NHS needs to deliver, while allowing local autonomy to meet the needs of local populations. Strategic aims are set out in section 2. Headline targets and multi-year performance expectations are set out in section 3. Supporting publications will provide further detail on the key actions and interventions.

To support a shared understanding of the expected pace of progress, ICBs and providers must develop robust and realistic 5-year plans that outline improvement against these priorities, based on the principles outlined in this guidance.

1 Incentivising delivery and creating the conditions to transform care

1.1 Financial context and discipline

The multi-year settlement provides the foundation on which we can move away from annual to medium-term financial and delivery planning cycles.

Provider and system finance directors and CEOs have been working with the national finance team to develop a new approach that enables:

- **better alignment of incentives to enable more robust delivery** – payment schemes, best-practice tariffs, deconstructing fixed payment and UEC payment model
- **a move to fairer distribution of funding across the NHS** – ICB allocations will move toward the fair sharing of resources and reflect funding streams established in recent years to cover deficits and pay for additional elective activity. Careful consideration will be given to the pace with which we achieve this move. In parallel, a review is underway of components of the broader NHS funding formula to identify any improvements that can further enhance the calculation of fair funding. A review of the Carr-Hill formula for general practice is also under way
- **longer-term planning** – to support more robust delivery and improved decision-making locally
- **a new approach to capital** – maximising value from increased public and private capital through a reformed capital regime

This new approach will be underpinned by far greater transparency of increasingly granular financial data – with NHS England committing to publish trust-level productivity statistics on a routine basis to provide transparency on performance. Costing dashboards will also be made available to drill down into provider costs to better understand cost variation.

NHS England will bring together existing tools (including, Patient-Level Information and Costing Systems (PLICS) dashboards, Model Health System, and Health Expenditure Benchmarking), so they are more consistent and coherent. This will increase and simplify the information available, enabling providers and others to interrogate more granular cost data and support more informed spending decisions.

Existing measures of productivity recognise technical efficiency gains (unit cost reductions, shorter lengths of stay, and increased activity per WTE). We are also designing a different approach that identifies and incentivises left shift, prevention, and the use of technology to ensure that productivity measures do not penalise trusts for moving lower-complexity activity into more appropriate settings.

In support of better alignment of incentives and to enable more robust delivery, we plan to dismantle block contracts and are proposing to:

- introduce a new UEC payment model for 2026/27, comprising a fixed element (based on price x activity) and a 20% variable payment
- develop an incentive element of the UEC payment model with clinical, financial and operational groups

Findings from the dismantling block contracts work will inform future planning requirements, including the pace of change.

New best practice tariffs will be proposed as part of the 2026/27 Payment Scheme to incentivise a shift to day cases, outpatients, and more efficient ways of working, including the use of technology and alignment with the GIRFT 'Right Procedure, Right Place' approach. A consultation on these proposals will take place later this autumn.

The proposed new payment model for UEC is also designed to help unlock funding for neighbourhood health as demand for acute services reduces. A financial / incentive model is currently being developed with pilot sites, available for adoption in 2026/27.

A review of the broader funding formula for the NHS is underway to ensure funding is allocated fairly across the system. The use of funding streams such as deficit support funding and elective recovery funding have become so widespread over the last few years that careful consideration needs to be given to the pace with which we achieve the move to a fair shares model. The conclusions of this work will be detailed in the financial allocations and supporting technical guidance.

Allocations for capital will also be released this autumn, alongside updated guidance on new delegated limits. Business case templates will also be made available through NHS England regional teams to support planning and delivery.

Full details of changes to the financial framework, including multi-year revenue and capital allocations, and updated assumptions will be set out in the accompanying technical guidance published as part of the Medium Term Planning Framework package.

ICBs and providers must now take responsibility for implementation of these changes as part of their work to develop multi-year plans. All ICBs and providers will be expected to deliver a balanced or surplus financial position in all years of the planning period. Plans should incorporate:

- delivery of the 2% annual productivity ambition, as a minimum
- delivery of a break-even financial position without deficit support funding by the end of this planning horizon, other than where, exceptionally, a different expectation is agreed with NHS England
- adherence to other requirements, including guidance on managing provider/commissioner funding changes and a new board risk assessment process

Where deficit support funding (DSF) is in place, non-DSF financial positions should be reported transparently to boards.

Taken together, these measures represent the biggest shake-up of the NHS financial regime in more than a decade – with the aim of significantly strengthening local decision-making, enabling boards to plan much more effectively, and providing local leaders with a rules based transparent framework to drive transformation, not only in their own organisations but as part of their broader system.

1.2 Productivity

In 2024/25, acute hospital productivity grew by 2.7%, and this positive trend has continued into 2025/26, with 2.4% growth in Q1. Despite this, productivity is still below pre-COVID levels. Since 2019/20, the NHS workforce has grown much faster than activity, highlighting the need to decouple workforce growth from service delivery growth. Reversing this trend is essential for long-term sustainability.

While recent productivity gains are encouraging, significant inefficiencies and unwarranted variation persist across the system. There must now be sustained and targeted action to drive further improvements in productivity throughout the remainder of this financial year and over the next 3 years.

This effort has 2 components. **First, we must get the basics right** – reducing inpatient length of stay, improving theatre productivity, and returning to pre-COVID levels of activity per whole-time equivalent (WTE). **Second, we must seize the major opportunities** offered by technology, service transformation, and tackling unwarranted cost variation. This includes accelerating the shift to a digital-by-default approach and embedding more efficient models of care across the NHS. This focus must extend across all parts of the NHS, including acute, community, mental health, learning disabilities and autism services, and primary care, to ensure we deliver maximum value for every pound spent.

SR25's revenue settlement locks in a requirement to deliver a sustained 2% year-on-year improvement in productivity over the next 3 years. Achieving this as a minimum target is essential to restoring the NHS to its pre-pandemic productivity levels and is a prerequisite for financial sustainability and future efficiency gains.

To support delivery, NHS England will share improved and updated productivity and efficiency opportunity packs, with analysis of these opportunities for all NHS providers. NHS providers and commissioners should use this analysis to identify the local improvement actions they can take over the full planning horizon.

Trust-level productivity measures will also be published monthly as official statistics in development and will be incorporated into the NHS Oversight Framework, supporting transparency and accountability.

Delivering the productivity transformation at scale is fundamental to the plan. It will enable the NHS to reform and respond to growing demand, improve patient outcomes, and maintain long-term financial sustainability.

As part of the wider productivity and transformation agenda, systems are expected to make demonstrable progress on 2 long-term shifts in the models:

1. UEC: transition to digital-first and clinically prioritised access

ICBs and providers should accelerate the shift to a more structured, digital-first UEC model, using clinical prioritisation and scheduling to improve patient experience and reduce avoidable demand.

This shift involves moving away from traditional walk-in demand to models that support patients to access the right care, in the right setting, at the right time, based on clinical urgency and individual need. This includes:

- expanding digital and telephony-based triage and booking mechanisms
- increasing access to same-day or next-day scheduled care where clinically appropriate

This will help protect emergency departments for the most unwell patients and address crowding – one of the greatest safety risks in UEC.

Organisations should set out in their plans how these approaches will be scaled during 2026/27, including through collaboration with primary care, 111, and community urgent care providers.

2. Outpatients: shift to a digital-first, patient-led model

ICBs and providers must continue to progress towards a digitally enabled, patient-led outpatient model that improves access, efficiency, and patient experience. Priorities include:

- expanding the use of Advice and Guidance and digital triage tools
- empowering patients with greater choice and control over their follow-up care – including access to patient initiated follow up (PIFU), remote consultations and digital monitoring

This transformation should result in a sustained reduction in unnecessary outpatient follow-up activity (OPFU), freeing up capacity to reduce long waits.

Given the variation in baseline position, a uniform national target will not apply. Instead, providers and commissioners must:

- model the level of OPFU opportunity and compare it against the reduction required locally to accelerate delivery of referral to treatment and long-wait recovery objectives
- develop plans that reflect local opportunity and ambition, aligned to the scale of change required

Plans are expected to be suitably ambitious and progress will be assessed as part of routine oversight arrangements, specifically recognising the evidence that a significant proportion of follow-ups may be clinically unnecessary or avoidable through better use of digital tools and pathways.

2 Resetting the foundations: a new operating model

Over the course of the last few months, we have created the foundations of a radically different way of working: a clearer operating model, a consistent set of rules, and a service more confident in its ability to deliver reform.

The 10 Year Health Plan provides the vision: a system in which care should happen as locally as it can, be digital by default, and be in a patient's home if possible, in a neighbourhood health centre when needed, or in a hospital if necessary. The operating model now being embedded provides the vehicle to get there.

This new approach is rooted in simplicity and discipline: the NHS is moving to a rules-based system where everyone knows what is expected and what follows.

Success will be rewarded with greater freedom; challenge will be met with real support; and persistent failure will be confronted fairly but firmly. By replacing duplication with clarity and bureaucracy with guardrails, we want to enable leaders to act with ambition and staff to focus on what matters most: better care for patients and communities.

Every part of the system has a clear role:

- **the Centre sets national outcomes**, codifies standards, builds shared platforms once and well, and removes barriers
- **regions are the leadership interface**, with a single line of sight across performance, finance, workforce and quality, responsible both for grip and for support
- **ICBs are becoming strategic commissioners**, moving resources into prevention and community capacity, tackling inequalities and commissioning for value (quality of care and optimal efficient cost)
- **providers**, through a revitalised foundation trust process, are responsible for collaboration, productivity and quality, with earned freedoms for those who deliver and proportionate intervention where standards slip
- where integration adds most value, **integrated health organisation contracts** will enable end-to-end redesigning of pathways, with efficiencies reinvested into better and more effective ways of working
- at the frontline, **neighbourhood teams** will be established to support our communities. Working with social care colleagues, they will deliver proactive support for people with frailty and long-term conditions. They will provide urgent and acute community services, rehabilitation and prevention – and support improved access to care, especially general practice. Their work will be enabled by digital tools and shared care records

The NHS Oversight Framework is the backbone of this system. It will bring fairness, proportionality, consistency, transparency and predictability, measuring access, quality, finance, people, productivity and delivery of the 3 shifts: presenting this information clearly in league tables to ensure that everyone – including for the first time the public – can see how organisations are performing relative to their peers, and what comes next. Boards will be expected to use this to drive improvement.

This model will be supported and enabled at all levels by service transformation through technology, with a default preference that patients interact with services digitally, wherever possible and clinically appropriate.

A suite of documents will sit alongside the Medium Term Planning Framework to bring this to life and to support ICBs and providers to develop 5-year plans that will allow them to transform their services. They are designed to create the conditions for the NHS to start implementing the ambitions of the 10 Year Health Plan.

- **Model Region and ICB blueprints** are now published, with the **Model Neighbourhood Framework** expected in November.
- **The Strategic Commissioning Framework**, which will be shared in October, builds on the Model ICB blueprint to provide commissioners a clear scope for their evolved role.
- A draft **foundation trust framework**, which will be published for consultation in November as well as **a system archetypes blueprint** explaining the interplay of the new contract models set out in the 10 Year Health Plan (integrated health organisations, multi-neighbourhood provider contracts and single neighbourhood provider contracts) and a draft integrated health organisation blueprint.

The new Strategic Commissioning Framework will enable the NHS – led by the ICBs – to create a much greater focus on outcomes and to incentivise systems and providers to prioritise

investment where the impact on patients' lives has the greatest potential to be transformative.

Working with ICBs, we will commit to developing a shadow set of outcome measures for 2026/27 building on the NHS Outcomes Framework and international best practice, supporting ICBs to drive better patient outcomes in their commissioning of both internal and commercial contracts.

The NHS Oversight Framework will continue to bring consistency and transparency to performance management and will be updated to include a comprehensive set of metrics to account for different organisations.

Commissioning responsibility for **vaccination and screening** will move to ICBs – likely from April 2027, subject to the passage of legislation. In 2026/27, NHS England will continue to develop the commissioning and contracting framework that will support ICBs with their new responsibilities for vaccinations and will expand our digital service systems to other providers and vaccinations, in line with the 10 Year Health Plan. Furthermore, subject to consultation on changes to the Human Medicines Regulations, NHS England will enable community pharmacy to deliver vaccinations off-premises, where commissioned.

Providers must continue to deliver regional public health programmes in 2026/27, in line with programme standards, guidance, service specifications and quality assurance requirements.

2.1 Unleashing local potential – a foundation trust framework; integrated health organisations; and oversight of trusts and system models

The publication of the 10 Year Health Plan has unleashed real enthusiasm for re-empowering boards, with early design work on the new foundation trust model being based on excellent governance, organisational self-awareness and transparency: where providers must demonstrate how they will deliver high-quality, efficient services and provide evidence of being good at participating within collaboratives as well as leading their own organisation.

A draft foundation trust framework will be published for consultation in November.

A draft system archetypes document will be published in the same timeframe, setting out how integrated health organisations (IHOs) will be a contract-based delivery method, not a new organisational form, and will explain how IHO contracts work alongside multi-neighbourhood and single-neighbourhood contracts. IHOs will work with the wider provider landscape to deliver high-quality care efficiently, including through sub-contracting arrangements and, where appropriate, delegation of commissioning. We will issue further detailed guidance in a Model IHO blueprint document later this year.

While the draft model is still being designed, early consideration is being given to how:

- NHS England will assess provider capability to take on an IHO contract, with contracts commissioned by ICBs
- IHO contract holders will work to deliver the shift of resources from hospital to community through an integrated and preventative delivery model aligned to neighbourhood health working
- IHO contracts will be responsible for a defined population, building on existing working to improve population health outcomes, allocative efficiency, access and quality. More detail will be given in the model system archetypes publication expected in the autumn

These draft models are being developed in tandem with the design of new oversight arrangements, including reviewing the current oversight model, metrics and provider capability.

The new approach to oversight is being driven by 3 core principles:

- **oversight should drive improvement**, not bureaucracy
- **peer support and tailored interventions**, which are sufficiently aspirational and valued, especially when organisations acknowledge their own challenges

- **oversight metrics must reflect system-minded behaviours**, including addressing inequalities and left shift

We will continue to work with providers and ICBs to refine the NHS Oversight Framework so that it genuinely supports improvement. We will also amend the NHS Oversight Framework to expand to a more comprehensive set of metrics and to account for new models for provision of services, in addition to governance and transaction adjustments for 2026/27, while ensuring alignment with the Care Quality Commission on provider capability.

2.2 Delivering neighbourhood health at pace

Delivering neighbourhood health at pace is central to returning patient and community trust in the NHS, breaking down siloed working among our staff and finally getting control of improving urgent care by providing more convenient and appropriate services in every neighbourhood in the country.

An NHS that isn't consumed by a near continuous cycle of 'just about managing' to deliver urgent care services is realisable – but only if we put our collective leadership effort into making neighbourhood care a reality. The impact on patient and staff morale will be exponential. The delivery of neighbourhood care has to be a priority for every leader in the NHS because it will create more space to do elective work, reduce waiting times, improve the quality of care and make headroom for leaders to focus on innovation.

Most care is already delivered in our communities and neighbourhoods, and many community-based services will continue as they are today. But for those patients that are using multiple services – or are referred from one service to another – we can make a big difference to the individual, as well as to staff, quality of care and productivity, if we can join up or integrate services and teams better. There are also opportunities to improve care through the provision of digital services, empowering patients to manage their own care or to receive digitally-enabled treatment in their own home, complementing community-based services.

The impact we can have by organising ourselves better around the patient on priority long-term conditions such as cardiovascular disease and diabetes won't just transform how patients get their care, it will dramatically improve productivity in how we deliver services going forward.

This is not just about NHS services working more closely together but also about improved joining up of care across NHS, local authority and voluntary and charitable sector services. By doing this, we will keep more care in people's

neighbourhoods and use our hospitals only for patients who truly need to be treated in them.

There are examples of neighbourhood health working across the country and in every ICB. The evidence from these examples shows they have a significant impact, not just on making services more convenient to access, but supporting improvements in urgent and emergency care, access to primary care and improving patients' satisfaction. Starting now and accelerating over the next 3 years, we want to deliver even more care in our neighbourhoods, providing more joined up care for high-priority cohorts through integrated neighbourhood teams (INTs), and make a material difference to patient experience and hospital demand.

In implementing neighbourhood health, the immediate focus must be on:

- improving and tackling unwarranted variation in GP access for the whole population
- reducing unnecessary non-elective admissions and bed days from high priority cohorts – people who have moderate to severe frailty, people living in a care home, people who are housebound or at the end of life
- enabling patients requiring planned care to receive specialised support closer to home

Starting this year, we will bring forward a roadmap for the delivery of the NHS App functions as described in the 10 Year Health Plan:

High-functioning systems will want to go further and faster and should be looking to set up integrated teams and services for other cohorts, in areas such as children and young people and mental health and learning disability, autism and ADHD.

To support moving at pace, we will produce:

- a draft **model neighbourhood framework**, which will set out the definitions, goals and scope of neighbourhood health, along with priority actions for 2026/27
- a **national neighbourhood health planning framework**, co-produced with the Local Government Association and local authority colleagues, setting out how the NHS, working in active partnership with local authorities and others, can plan for the delivery of the broader set of neighbourhood goals
- **model system archetypes**, which will outline different archetypes for the commissioning and provision of neighbourhood health services, including the 3 new contract types: single and multi-neighbourhood provider contracts, and integrated health organisation contracts
- **model neighbourhood health centres archetypes**, which will describe different archetypes of provision of neighbourhood health services that can be used to inform the better utilisation and enhancement of existing estates, together with new-build solutions, where appropriate

From April 2026, ICBs and relevant NHS providers should:

- identify GP practices where demand is above capacity and create a plan to help decompress or support to improve access and reduce unwarranted variation
- ensure an understanding of current and projected total service utilisation and costs for high priority cohorts of those with moderate to severe frailty, living in care homes, housebound or at the end of life
- create an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions. These plans should be consistent with national standards for urgent community response services, which require 7-day availability and rapid response. Systems should ensure funding and commissioning covers a minimum 12 hour "community urgent care" offer, supervised by senior clinical decision-makers and operating at a multi-neighbourhood level. Local ICBs must confirm how this will be resourced and delivered

Plans should also include establishing integrated neighbourhood teams, ideally contract-based, working with local authorities and starting in areas of highest need. Further details will be set out in the Model Neighbourhood Framework.

However, providers and systems should not wait for guidance to be finalised where there are local opportunities to rapidly create an approach to neighbourhood delivery that will improve delivery of services this winter. Local leaders are strongly encouraged to work collaboratively to identify these opportunities where they are confident of delivering immediate impact – supporting improved access to urgent and emergency care now.

2.3 Shifting from sickness to prevention

The 10 Year Health Plan is clear that we need to shift from an NHS that focuses on treating patients to one that improves the lives of the population by preventing ill health or slowing the exacerbation of ill health. This approach will improve the outcomes and experiences of patients and improve the management of demand for general practice and acute care services.

ICBs must ensure their 5-year plans support the following preventative goals:

- a significant focus on tackling obesity. Specifically:
  - in 2026/27, to be making demonstrable progress in delivery of new obesity service models to improve advice and support, access to treatment, and effective management of obesity, including providing access to weight loss medications and strengthening specialist provision, including complications of excess weight clinics for children and young people
  - by the end of June 2028, to have provided access to National Institute for Health and Care Excellence (NICE) approved weight loss treatments for an initial eligible cohort of around 220,000 adults
  - by the end of March 2029, to be making 250,000 referrals to the NHS Digital Weight Management Programme a year
- supporting the target of a 25% reduction in CVD-related premature mortality over the next 10 years, including working in partnership with local authorities to test the new NHS Health Check online service and to scale it across the country
- implementing opt-out models of tobacco dependence in routine care
- reducing exposure to antibiotics to meet thresholds set in recent guidance and addressing problematic polypharmacy to reduce avoidable harm
- demonstrating how they will reduce health inequalities in the exercise of their functions

Further detail on emerging national standards and legislation related to prevention will follow.

2.4 Doing digital differently

The 10 Year Health Plan sets out how we will take the NHS from the 20th century technological laggard it is today to the 21st century leader it has the potential to be.

The health service must become one that is digital-by-default, a principle widely established across government and private services worldwide, but one the NHS has not embraced. A core element of this is giving patients a 'doctor in their pocket', available through the NHS App.

Starting this year, we will bring forward a roadmap for the delivery of the NHS App functions as described in the 10 Year Health Plan:

1. **Delivering My NHS GP** - using AI-assisted triage models and data-driven pathways to guide people to the service they need quickly and provide those who need an appointment with the ability to book one.
2. **Transforming Planned Care** – putting patients in control of their treatment pathways by giving them one place to manage all their appointments, referrals and interactions – while bringing efficiencies that reduce referral-to-treatment times.
3. **Managing My Health** – empowering people to manage their health and the health of their dependants by giving them targeted access to prevention services – helping to reduce future demand before sickness develops or worsens.

Through these features, the NHS App has the potential to transform how NHS services are delivered and unlock a range of benefits, including:

- reducing future demand by intervening before sickness develops or worsens
- getting patients to the right service, first time
- reducing the cost of delivering NHS services
- streamlining patient journeys to deliver better outcomes with fewer interactions
- meeting patient needs as efficiently as possible through automation and effective capacity management
- improving the experience of NHS services

Getting this right doesn't just mean making appointments and other transactional services available online. It means fundamentally rethinking our care models to make the best possible use of technology and innovation and to deliver a high-quality care model at scale accessed through the NHS App, wherever possible.

But we will need to go further, looking beyond the digitisation of transactional and administrative services and more fundamentally rethink care pathways. Modern technology and innovation provide new opportunities to empower patients to manage their own care and receive treatment digitally, rather than face-to-face, wherever clinically safe and accessible for the patient. This enables better care, better health outcomes, a better patient experience and lower cost. We will set out the implementation of this approach through the modern service frameworks, ensuring the clinically-led design of ambitious, affordable and clinically safe digital-first pathways. This shift will free up capacity for those who need it, while making a material contribution to financial sustainability.

To expand the range of options available to patients, work will continue to establish NHS Online – a new 'online hospital' to digitally connect patients to expert clinicians anywhere in England from 2027. Using the NHS App, patients will have the option of being referred to the online hospital for their specialist care following a GP appointment. This new model of care will enhance patient choice and control, while helping to reduce patient waiting times.

Those providers leaning heavily into the digital agenda are already achieving substantial performance improvements and cash-releasing productivity benefits. For example, acute trusts leveraging the NHS Federated Data Platform have achieved an average increase of 114 elective surgeries per month per trust and a 35% reduction in delayed discharge days.

Providers and commissioners must therefore prioritise adopting and embedding a modern infrastructure to continue realising these benefits. From April 2026, the NHS must begin to:

- fully adopt all existing NHS App capabilities as a priority, including making at least 95% of appointments available after appropriate triage via the NHS App across all care settings. More widely, providers should ensure full

coverage of patients' abilities to manage their medicines, to view waiting times and contact information, to receive and complete pre- and post-appointment questionnaires, and to implement digital PIFU in line with GIRFT guidance. This should be in place no later than the end of 2028/29

- ensure all providers in acute, community, and mental health sectors are onboarded to the NHS Federated Data Platform (FDP) and using its core products to support elective recovery, cancer, and UEC. Trusts should use the FDP for data warehousing and implement the canonical data model. ICBs should use the population health management suite of tools from the FDP for strategic commissioning and adopt the FDP System Coordination Centre and other performance management tools. This should be achieved by 2028/29
- move all direct-to-patient communication services to NHS Notify, terminating local arrangements, and exploit NHS App-based 'push' notifications as the preferred method of contact. Transitions should start in 2026/27, with providers completing migration by the end of 2028/29
- move to a unified access model, using AI-assisted triage, that can effectively guide patients to self-care or to the appropriate care setting, through a single user interface delivered via the NHS App but with an integrated telephony and in-person offering
- achieve full compliance with the minimum standards set out in the Digital Capabilities Framework, including ensuring 100% coverage of electronic patient record systems as soon as possible
- implement all core national products and services specified in the forthcoming national product adoption dashboard by the end of 2027/28, prioritising: deploying the Electronic Prescription Service; deploying the Electronic Referral Service APIs; consolidating NHS. Net Connect into the national collaboration service; and integrating all existing NHS App capabilities. This applies to acute, community and mental health providers
- providers should deploy ambient voice technology (AVT) at pace, with due regard to the national AVT registry, and adopt the latest in digital therapeutics for both supportive and wrap-around care (and for direct clinical delivery where services have the appropriate regulatory approvals – typically Class IIa)

2.5 Transforming our approach to quality

The publication of the 10 Year Health Plan ushered in a new era of transparency, driving higher quality care across the NHS. Over the summer, we have worked with system leaders to develop plans to deliver some of the core commitments within the plan, including:

- developing the purpose and scope for a new National Quality Board (NQB) **Quality Strategy** to be published by the end of March 2026. Following initial discussion with the NQB, wider stakeholder engagement is now taking place to inform the vision and implementation approach that the strategy will set out
- establishing the approach to introducing **modern service frameworks** (MSFs), which will support more consistent delivery of high-quality, evidence-based, **digital-by-default** care in conditions where there is potential for rapid and significant improvements in both quality and productivity. The criteria and methodology are being tested through the development of a first set of 3 MSFs, focused on CVD, serious mental illness and sepsis, with further MSFs on dementia and frailty to follow. Task and finish groups are being set up for each, and the frameworks will be co-designed in partnership with clinicians, people with lived experience and system partners

We are also progressing a set of immediate priorities to improve care quality:

- **National Care Delivery Standards** are currently being developed to ensure the consistent delivery of high-quality and equitable care every day of the week. In November, we will confirm the scope of the new standards and publish them in March 2026
- the **Emergency Department Paediatric Early Warning System** (PEWS) will be launched in 2026. All hospitals will be expected to ensure a change plan is in place to add PEWs to their transition and complete this transition by April 2028
- a **Single National Formulary** will be introduced within the next 2 years

All ICBs and providers must continue to implement the NHS Patient Safety Strategy, including embedding the Patient Safety Incident Response Framework to support a systems-based approach to safety and ensuring patient safety specialists are appointed and trained and that patient safety partners contribute to safety-related governance committees. It also involves ensuring full implementation of all 3 components of Martha's Rule in all acute inpatient settings, as set out in the new NHS Standard Contract requirement.

From April 2026, and as guidance is published, ICBs and providers are also expected to:

- use the new NQB quality strategy to guide local action to improve the quality of care in the highest priority areas for their population and service users
- implement modern service frameworks as they are launched
- implement the National Care Delivery Standards to ensure consistent high-quality care across the week
- plan for the introduction of a Single National Formulary, prioritising the following efficiency savings in 2026/27 to create headroom for adopting innovations: use of best value Direct Acting Oral Anticoagulants, SGLT-2 medicines and the wet AMD Medical Retinal Treatment Pathway
- continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation while meeting statutory NHS Continuing Healthcare duties. ICBs should prepare for full transition to AACC Data Set v2.0 and its digital infrastructure by March 2027, replacing the current quarterly collection to improve monitoring
- undertake local process and workflow re-engineering to make sure all colleagues are using digital systems and to remove duplicate paper-based processes, ensuring maximal use of the NHS Federated Data Platform
- for all hospitals with a paediatric inpatient setting, implement the Paediatric Early Warning System by April 2027

Improving the quality of our maternity services

In June 2025, the Secretary of State announced an independent investigation into maternity and neonatal care and a taskforce to agree and oversee the resulting action plan.

Ahead of the action plan being finalised, all ICBs and providers are expected to take immediate action to improve care and ensure women are listened to. This includes:

- implementing best practice resources as they are launched, such as the forthcoming maternal care bundle, new approaches to avoiding brain injury in childbirth, the specification for maternity triage, and the Sands National Bereavement Care Pathway for stillbirth and neonatal death
- using the national Maternity and Neonatal Inequalities Data Dashboard to identify variation in practice and put in place interventions for improvement
- participating in the Perinatal Equity and Anti-Discrimination Programme to support leadership teams to improve culture and practice

The **Maternity Outcomes Signal System** (MOSS) will be implemented across all NHS trusts by November 2025, enabling the use of near real-time data to monitor key safety indicators such as stillbirth, neonatal death, and brain injury rates. Signals in MOSS prompt a local safety check to prevent further harm and maintain high quality care.

This near real-time data, the maternity and neonatal performance dashboard and the new inequalities dashboard mentioned above, alongside gathering patient experience information and active staff engagement, gives teams, leadership and boards vital insight into the quality of their services. They should stay continuously curious, actively using this information to understand how their services are performing and whether they are meeting the expectations of the women and families they serve. Where there are incidents or things go wrong, they should engage proactively with families, be honest and open, seeking to learn and to implement changes quickly to prevent incidents in future.

2.6 Understanding and improving the patient experience

The British Social Attitudes survey published early this year showed that satisfaction rates are at a record low and continuing to drop. We all have a collective responsibility to address this with absolute urgency.

The progress we're making in improving access and reducing waits – providing care in a faster and more convenient way – will help with this, but there's more we can be doing now to better understand why some patients are dissatisfied with the service they receive.

A number of NHS organisations already run inpatient surveys and capture patient experiences in real time. This helps boards better understand the issues patients face and helps local teams identify the changes they need to make to improve the experience of care.

Between now and the end of 2025/26, all NHS trusts will be expected to:

- complete at least one full survey cycle to capture the experience of people waiting for care: Have they had cancellations? Has anyone been in touch? What do they think has got worse since they have been on the waiting list? What information do they need to manage their condition well? This should support delivery teams to improve the experience of waiting and, where necessary, re-prioritise patients who may need to be treated faster
- capture near real time experiences with a renewed focus on ensuring effective discharge processes. Trusts should triangulate inpatient survey results, relevant Friends and Family Test feedback and PALS complaints data to identify areas where improvement is needed. A resource pack will be published on NHS England's website in November to support organisations to do this

Improving experience of care will be a central feature of the Quality Strategy, due to be published in 2026. This will include cross-cutting improvement priorities which will enhance everyone's outcomes and experiences.

2.7 Reconnecting with our workforce, and renewing and strengthening leadership and management

Delivering the 10 Year Health Plan will require an engaged and empowered workforce. Creating that means truly listening to what our staff tell us are the barriers they face and acting to address those concerns.

Earlier this year we published a 10 Point Plan to improve the working lives of resident doctors: tackling those non-pay issues that we've long since known about but not committed to fully resolving.

It sets a new standard: we need to be unwavering in our commitment to understanding the challenges our local staff face and to fixing those issues.

The annual Staff Survey provides a rich source of data for every organisation, but too often the findings it generates don't elicit the organisational response our staff and teams want and need.

Over the course of the last few years, the use of national pulse surveys alongside annual staff surveys has sometimes created a confused picture of what staff are trying to tell us. We will commit to working with staff experience leads from the NHS to revise our approach to how we use these tools to better support local boards to be more innovative in how they measure and improve staff experience. We will conclude this ahead of the publication of the latest staff survey results.

In the meantime, every NHS board will be expected to use the 2025/26 staff survey findings to commit to:

- a full and detailed analysis of all free text comments generated through their staff survey
- identifying, as a minimum, 3 areas where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within their organisation and developing detailed action plans to resolve those issues within year wherever possible

Calling out all forms of discrimination

Discrimination, racism, antisemitism, Islamophobia and aggression have no place in the NHS: during the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stand against racism.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome, and in particular where racism, antisemitism, Islamophobia and discrimination are not tolerated.

We also expect organisations to continue to tackle sexual misconduct, including regularly assessing progress on the Sexual Safety Charter, in line with the letter of 20 August.

Leadership

Successive reports – most recently from General Sir Gordon Messenger and Dame Linda Pollard – have made clear the vital role of high quality leadership in the NHS, and this has never been more important than it will be in the coming years.

While leadership is everyone's responsibility, our very senior leaders (chairs, CEOs and executive directors) carry specific accountabilities and impact. They must set the tone, standards, and direction that enable colleagues across the health and care system to lead and deliver effectively, improve how services are delivered, and support the vision of the 3 shifts.

The reforms to the NHS operating model set out in Chapter 2 are designed to create the space for leaders to lead, incentivise those who do it well, and support those who need it.

The regulation of managers – widely welcomed across the NHS leadership community – will, when enacted, provide additional clarity on the standards expected and accountability for upholding them, just as is in place for clinicians and other professionals within the NHS.

But the high expectations we rightly have of our leaders must come with the tools and support needed for success – something which has been severely lacking in recent years.

As a first step, we will publish the new **Management and Leadership Framework** during the autumn, setting a code of practice and standards and competencies for clinical and non-clinical leaders and managers at 5 levels, from entry level to board. ICBs and providers should embed this Framework into recruitment and appraisal practices, with all leaders and managers self-assessing against the Code and standards and senior leaders obtaining 360 degree feedback. Digital tools will be provided during 2026/27 to facilitate this.

Going further, over 2026/27 we will continue progress to establish a new **College of Executive and Clinical Leadership**. A national curriculum and interactive online modules will be published in 2026/27, offering time-efficient leadership and management development at each level.

National leadership programmes will also be updated, and ICBs and providers should incorporate these national offers as part of personalised development pathways for leaders and managers, linked to agreed development needs and career plans and our new appraisal system.

This new consistent and standards-based approach will help the leaders of today both improve their own practice, and identify and support the leaders of tomorrow.

Finally, it is vital that the benefits of excellent leadership are retained within, and well-spread across, the NHS. Regional teams will work with national colleagues to develop a talent database of our strongest leaders to guide challenged systems and organisations.

2.8 Genomics, life sciences and research

Research in the NHS is vital for generating the next generation of treatments and improving health outcomes, and clinical trials can provide a significant benefit to participating patients by giving early access to new treatments and technologies.

All NHS providers must meet the site-specific timeframes of the government's 150 day clinical trial set-up target. To support embedding research as part of everyday care, research activity and income should be reported to boards on a 6-monthly basis. This should include details of study set-up performance, how they are meeting the terms of research contracts outside the NHS HM Treasury allocations, commercial research income and how capacity building elements of commercial contract income are used, as set out in the research finance guidance.

From April 2026:

- ICBs should ensure clinical trials are proactively supported, including by reducing the time they take to set up, by following standards and guidance set out in Managing research finance in the NHS
- providers are expected to deliver services in line with the NHS Genomic Medicine Service service specification, including the delivery of genomic testing services and testing strategies as well as clinical functions for cancer, rare disease and population health and the new genomics population health service

3 Trajectories for operational performance and transformation

As outlined earlier, 2026/27 marks the beginning of a new method of planning, with priority targets set for the SR25 period and ambitions covering the first 5 years of the 10 Year Health Plan. Achieving these targets is the bedrock of delivering the shifts outlined in this framework. Without progress, we will fail to realise the ambitions in the 10 Year Health Plan and lose any progress we have made in stabilising the NHS for the future.

Alongside meeting these key targets, the NHS must develop plans that enable systems to deliver healthcare that follows best practice standards and meets the needs of local populations. The NHS Oversight Framework will allow monitoring of performance against plans, while also tracking delivery across a broader range of standards.

Performance improvement has slowed in 2025/26, but we cannot allow this to continue if we are going to capitalise on the opportunity the 10 Year Health Plan and SR25 has created. These targets will be supplemented with appendices on the key actions and interventions that will drive our success.

3.1 Elective, cancer and diagnostics

We are committed to returning to the constitutional standard of 92% of people waiting less than 18 weeks for treatment, and to continuing to improve performance against the 3 cancer standards for 28-day diagnosis, 31-day treatment and 62-day referral to treatment. We have made significant progress over the past year and need to build on this momentum, driving further radical transformation, including introducing a new model for planned care that meets the 10 Year Health Plan commitment of "ending outpatient care as we know it".

This plan is rightly ambitious and will require a significant shift in the way trusts work, but also how ICBs, trusts and primary care work together to change the way most patients access planned care in the future. Our aim is for patients to receive more specialised support closer to home – that means working with GPs, community and neighbourhood teams and being digitally enabled where appropriate.

The key priorities will be:

- general practice is asked to continue prioritising the use of Advice and Guidance prior to, or instead of, a planned care referral where clinically appropriate (excluding referrals for urgent suspected cancer). There should be a move to all referrals going via Advice and Guidance for the 10 specialties at provider level which have the most potential for this model to be effective. We expect ICBs to support this, and bring it to life, through their strategic commissioning for 2026/27
- to support this increased use of Advice and Guidance, we encourage systems to ensure all referrals receive appropriate clinical triage, which we expect to flow through a single point of access. This will ensure more patients wait less time to receive a diagnosis and start an appropriate form of treatment
- to move toward the e-Referral Service (e-RS) being used for all Advice and Guidance requests from primary care, with effect from July 2026, where these requests are managed within the e-RS user interface, and from October 2026 where a third-party service is used. We will work with regions and providers to ensure rapid but manageable roll-out supported by appropriate platforms, including improvements to the functionality of e-RS
- to start to plan with ICBs and primary care how greater access to specialist advice and direct access to diagnostics for specific specialties, when aligned to neighbourhoods, could support GPs to manage more patients without the need for referral. Further details will be set out in the Model Neighbourhood Framework

Further details on how ICBs, trusts and general practice should work together to plan for this new neighbourhood health approach for elective pathways will be set out in the model neighbourhood framework.

For those patients who do require specialist outpatient care, we expect providers to continue identifying and acting on opportunities to improve productivity and ensure timely access. This includes:

- significantly reducing the number of routine, clinically low-value follow-up appointments. This will be supported by GIRFT's specialty-level good practice guides and the first group of these will be available in December, with

other pathways to follow. We are exploring whether further changes are required to the payment for follow-up activity and will advise of this in due course. Where there is greatest variation in the management of follow-ups, there will be rigorous performance management. By releasing capacity from clinically low-value follow ups, we will allow new patients to be seen and diagnosed

- conducting comprehensive reviews of clinic templates and standardising these in line with GIRFT's specialty-level good practice and job planning guides
- expanding 'straight to test' pathways and one-stop clinics where clinically appropriate, starting with the 10 largest specialties by volume and expanding, with the aim of including all clinically appropriate specialties by March 2029

Further guidance in productivity opportunities relating to outpatient care are set out in the productivity section of this document. Delivering improved referral to treatment performance is closely correlated with reducing waiting lists at national and provider level. Nationally, we expect to see the waiting list reduce during 2026/27 and while the local requirement will vary by provider, reductions in waiting list sizes will be expected at all trusts.

As well as ensuring patients are treated in order of clinical priority, providers and ICBs should appropriately manage their waiting lists, including through thorough validation and the application of referral to treatment guidance and local access policies to assure themselves of their data quality. This is particularly important in carefully managing any service changes that may affect reporting, such as EPR installations and upgrades. There is a growing range of digital tools available to support data quality and address other issues, and all providers will be expected to use the NHS Federated Data Platform or equivalent technology to deliver these improvements.

Children and young people (CYP) continue to face longer waiting times for planned care, despite the disproportionate impact of long waits on their development and longer-term outcomes. Systems and providers are required to put in place targeted actions to increase activity and improve performance for their CYP population. This should include developing ringfenced CYP capacity within the ICB footprint using existing NHS estate by running regular dedicated paediatric surgery days in either a day surgery or hub setting, with an aim to increase CYP activity delivered through surgical hubs.

Management attention needs to be maintained on meeting cancer standards and securing further improvements to early diagnosis. This should include the continued prioritisation of diagnostic (including CDC) and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways to the USC pathway and diverting lower-risk people to more appropriate access routes for their condition. Cancer alliances will continue to be a source of expert performance improvement advice and support to providers, ICBs and wider system partners. Regions will continue to encourage close working and co-ordinated support across alliances and diagnostic networks to tackle the key performance challenges across their areas.

Diagnostic activity will need to increase to support delivery of both planned care and cancer standards. All systems have already been provided with activity and performance targets that need to be achieved by March 2029, and significant progress is expected in 2026/27. To support this, CDC capacity should be fully utilised and operating hours extended where possible to deliver the activity that has been commissioned, and – as neighbourhood health teams mature – organisations should consider how CDC capacity can be made available to neighbourhood teams as well as providers. Systems should ensure that these targets are achieved through a mix of capital-funded capacity increases, improved productivity (digital and services throughput) and demand optimisation that reduces the use of tests with limited patient benefit. This should include implementation of decision support tools like i-Refer-CDS. To support demand optimisation, NHS England and the royal colleges are launching a campaign this autumn – Right Test, Right Time – which encourages clinicians to focus on test referrals that add most value to patient care.

Working with local providers, ICBs will continue to hold responsibility for commissioning levels of activity for providers to deliver the performance requirements set out in this guidance. They will need to take steps in-year to mitigate demand growth in excess of agreed growth assumptions. This will require close working between primary and secondary care, with neighbourhood health teams playing an increasing role over time.

Given the interdependence between referral to treatment and diagnostic performance, we are taking a consistent approach in setting individual targets at provider level (for example, a percentage improvement as well as a performance floor). This will support planning locally by giving a clear and consistent message about performance improvement requirements on a like-for-like basis across delivery areas.

Success measure	2026/27 target	2028/29 target
Improve the percentage of patients waiting no longer than 18 weeks for treatment	Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment
Improve performance against cancer constitutional standards	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	
	Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards by March 2027	Maintain performance against the 31-day standard at 96% and 62-day standard at 85%
Improve performance against the DM01 diagnostics 6-week wait standard	Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test)	Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test

3.2 Urgent and emergency care

It has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less to be seen, treated and discharged from A&E.

During that time, in parts of the NHS, we have normalised asking our staff to deliver sub-optimal care, and some of our patients have all but given up hope of expecting a reliable service in urgent care.

This document sets out expectations for next year and beyond, but we are also taking immediate steps to improve performance and service quality throughout this winter. This will include a major focus on reducing crowding in our emergency departments, ensuring that patients unlikely to require admission are seen in urgent treatment centres (UTCs), same day emergency care and other suitable points of delivery and that children are seen within 4 hours. This will allow our emergency departments to start focusing on the sickest patients and reduce the risks associated with crowding that have become normalised in recent years.

Throughout 2026/27, this will result in a service that is UTC-first and by default for patients who are less likely to require admission, and pathways for children that support more rapid assessment and treatment, with the aim that these cohorts of patients are treated within the 95% standard again. We will work with NHS providers and the relevant professional bodies (RCEM, RCPH, RCP etc) to develop this approach over the coming weeks and ask how we can best improve standards of care for the sickest and most unwell patients.

The priority will then be to improve core operational performance against constitutional standards each year by developing services and pathways that align with the neighbourhood health model, while continuing to improve clinical and operational processes inside hospitals. This will allow acute emergency care to be safeguarded for those who will benefit from it most, while unified and more efficient urgent care can be delivered in the community.

To achieve this:

- ICBs and providers must ensure patients are directed or conveyed to the most appropriate care for their urgent or emergency care needs, reducing avoidable ambulance conveyances to hospital. This will require fully utilising core services such as 111 and increasing the rate of impactful interventions such as ‘hear and treat’

- ICBs and providers must deliver more urgent care in the community by expanding neighbourhood health services, aiming to reduce total non-elective admissions and bed days, with a specific focus on frail older people, given rising demand pressures. ICBs and providers must have robust ways to measure the impact of neighbourhood health, and take remedial action if non-elective demand in this population group continues to increase
- ICBs should specifically assess total resources spent on those living with frailty and shift a proportion of those resources to better community provision, to ensure safe and effective care away from an acute hospital setting wherever possible, and to short-stay frailty attuned care when people do require admission
- ambulance services must continue to be planned in accordance with the published ambulance service specification. This includes acute trusts and ambulance services working collaboratively to reduce ambulance handover times toward the 15-minute standard
- acute trusts should embrace new standards and guidance on how to achieve our ambitious 4-hour performance target and use these to drive the necessary step-change, aligning with the soon to be published Model Emergency Department and clinical operational standards for the first 72 hours in hospital
- providers must have a renewed and rigorous focus on ensuring that patients who are less likely to require admission are directed to a UTC by default, and that there are agreed clinical and operational processes for non-admitted patients to be seen, treated and discharged within 4 hours to reduce overcrowding in departments and improve safety
- providers must also continue to improve emergency department paediatric performance, with the expectation of returning to 95% over the coming months. Current data indicates this is more than possible if paediatric assessment units are effectively utilised and the issue is properly addressed
- to improve our ability to respond to patients in mental health crisis and ensure the needs of mental health patients are met in an appropriate environment, we will establish mental health emergency centres in Type 1 emergency departments
- we need a whole-system effort to continue to reduce discharge delays. This should include improving in-hospital discharge processes, making best use of community beds, and increasing home-based intermediate care capacity
- ICBs and providers must ensure early action to improve flu vaccination uptake among staff and the public, helping to keep patients and colleagues safe
- systems should accelerate the transition towards a more structured, digital-first UEC model, with appointments and scheduling according to clinical prioritisation and ultimately a better patient experience (see section on productivity)

Success measure	2026/27 target	2028/29 target
4-hour A&E performance	Every trust to maintain or improve to 82% by March 2027	National target of 85% as the average for the year
12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
Category 2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes

3.3 Primary care

Central to the broader reforms we are delivering is continuing to focus on improving access to **general practice** – this is critical to not only managing wider system pressures but also rebuilding the public's faith in its NHS. Building on existing general practice action plans, in 2026/27 all ICBs must:

- ensure practices are delivering the 2025/26 GP contract (including recent 1 October changes) and the 2026/27 GP contract from April, including improving and providing good access whether by phone, online or walk in throughout core hours. This includes all patients knowing on the day how their request will be managed, and increasing the number of people who can see their preferred healthcare professional
- put in place action plans to continue to improve contract oversight, commissioning and transformation for primary care, and tackle unwarranted variation, including identifying and planning how to support those struggling to deliver access or other elements of the GP contract
- ensure additional capacity is commissioned to meet demand out-of-hours and over surge periods including bank holidays and weekends
- support primary care providers to deploy ambient voice technologies, ensuring the time freed up is used to see additional patients

Success measure	Target for all years 2026/27 to 2028/29
Same day appointments for all clinically urgent patients (face to face, phone or online)	90% We will consult with the profession on this new ambition
Improved patient experience of access to general practice (ONS Health Insights Survey)	Year-on-year improvement

To support primary care access and increase the role of **community pharmacy**, ICBs must:

- embed pharmacy-first approaches, ensuring that local commissioning discussions utilise available pharmacy capacity to support primary care pressures
- continue developing the relationships between general practice and community pharmacy to support access to pharmacy services
- introduce prescribing-based services into community pharmacies during 2026/27
- expand access to emergency contraception through community pharmacies
- maximise use of the Discharge Medicines Service to reduce medicines harm and reduce readmissions
- make HPV vaccination available at pharmacies for women and young people who missed out on vaccination at school
- ensure all community pharmacies have fully enabled the capability for patients to track their prescription status using the NHS App
- ensure all primary care services enable patients to request and manage their medicines online
- transition all messaging to NHS Notify, using NHS App-based 'push' notifications as the default option

For **dental services**, the government has set out a manifesto commitment to deliver 700,000 additional urgent care dental appointments against a pre-election baseline in every year of the parliament. Additional capacity has been put in place in 2025/26 to ensure an urgent care safety net is in place. ICBs will be asked to continue to secure necessary capacity, including working to implement dental contract reforms that are expected to be taken forward from April 2026 following consultation in summer 2025. In 2026/27, all ICBs must:

- deliver their contribution to the government's commitment to deliver an additional 700,000 urgent dental appointments in England against the July 2023 to June 2024 baseline period
- successfully implement dental reforms to ensure the additional manifesto target is incorporated into contractual activity (subject to consultation)
- implement locally driven quality improvement approaches for dentistry, ensuring clinical leadership and communities of practice are in place to support improved access and the introduction of new pathways for high needs and complex patients

Success measure	Target for all years 2026/27 to 2028/29
Deliver 700,000 additional urgent dental appointments against the July 2023 to June 2024 baseline period	Each ICB to deliver their share of the urgent dental appointment target every year (2026/27 to 2028/29)

3.4 Community health services

Timely and effective community health services will be critical to shifting care out of hospital and into the community to deliver our ambitions for neighbourhood health. Community health services deliver both planned and reactive provision, often for the most complex patients. Variation in capacity, provision and long waiting times have existed for too long in community health services.

In 2026/27, all ICBs and community health services providers must:

- increase community health service capacity to meet growth in demand, expected to be approximately 3% nationally per year
- actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits

- identify and act on productivity opportunities, including ensuring teams have the digital tools and equipment they need to connect remotely to health systems and patients, and expanding point-of-care testing in the community. To support this, community health service productivity metrics will be published later this financial year
- continue to standardise core service provision as defined in Standardising community health service
- consider where digital therapeutics, such as for MSK treatment, could be deployed at pace where those therapeutics have appropriate regulatory approval

Success measure	2026/27 target	2028/29 target
Address long waiting times for community health services	At least 78% of community health service activity occurring within 18 weeks	At least 80% of community health service activity occurring within 18 weeks

3.5 Mental health

Mental health care isn't just important to the service users who rely on care and support being available when they need it; it is critical to the smooth running of health economies right across the NHS.

We all accept that more must be done to improve the mental health of the nation. The quality of mental health services and the ability to access them – especially for those in crisis and children and young people – must improve to address current unmet needs and reduce the risk of future harm.

There are also significant opportunities to improve quality and productivity in mental health services. There is unwarranted variation in the direct and indirect contacts per whole time equivalent hours worked within children and young people's community mental health services and this contributes to long waiting times. We must also reduce average lengths of stay in adult acute mental health beds and complete the job on 3-year plans to localise care, reduce out-of-area placements and end the commissioning of locked rehabilitation inpatient services.

Achieving these improvements will take leadership at every level. Nationally, we will commit to working with local NHS mental health providers to set a new approach for mental health in 2026, including through the upcoming MSF for serious mental illness, led by a new national lead for mental health alongside the mental health NHS leadership community.

In 2026/27, all ICBs and mental health providers must:

- continue to expand coverage of mental health support teams in schools and colleges ahead of the ask for full national coverage by 2029
- develop a plan for delivering their local approach to establishing mental health emergency departments co-located with or close to at least half of Type 1 emergency departments by 2029
- use ring-fenced funding to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity through access to Individual Placement and Support for people with severe mental illness
- reduce inappropriate out-of-area placements and locked rehabilitation inpatient services. From 2027/28 onwards, ICBs should only commission mental health inpatient services for adults and older adults that align with the NHS Commissioning Framework
- reduce longest waits for CYP community mental health services by improving productivity, and reducing local inequalities and unwarranted variation in access
- identify and act on productivity opportunities including, in children and young people's community mental health services, increasing the number of direct and indirect contacts per whole time equivalent hours worked, and reducing the average length of stay in adult acute mental health beds

- ensure mental health practitioners across all providers undertake training and deliver care in line with the Staying safe from suicide guidance, which sets out the latest evidence in understanding and managing suicide

Success measure	2026/27 target	2028/29 target
Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	77% coverage of operational mental health support teams and teams in training	94% coverage, reaching 100% by 2029 (operational mental health support teams and teams in training)
Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	63,500 accessing Individual Placement and Support by the end of 2026/27 805,000 courses of NHS Talking Therapies by the end of 2026/27 with 51% reliable recovery rate and 69% reliable improvement rate	73,500 accessing Individual Placement and Support by the end of 2028/29 915,000 courses of NHS Talking Therapies by the end of 2028/29 with 53% reliable recovery rate and 71% reliable improvement rate
Eliminating inappropriate out-of-area placements	Reducing the number of inappropriate out of area placements by end of March 2027	Reducing or maintaining at zero the number of inappropriate out of area placements

3.6 Learning disabilities, autism and ADHD

People with a learning disability and autistic people too often experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. To improve health outcomes and access to and experience of care, in 2026/27 all ICBs and providers must:

- reduce the very longest lengths of stay in mental health hospitals
- reduce admission rates to mental health hospitals for people with a learning disability and autistic people
- optimise existing resources to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published

The government will publish plans for the reform of SEND in due course. We expect ICBs and providers to work with NHS England and the Department of Health and Social Care to respond to those reform plans once published, and to continue to meet their statutory duties in the meantime.

Success measure	2028/29 target
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people	Deliver a minimum 10% reduction year-on-year

3.7 Workforce

The ambitions outlined in the 10 Year Health Plan will require a fundamental shift in the way the NHS deploys, retains and trains its workforce. The forthcoming 10 Year Workforce Plan will set out how. In advance of this, providers' plans should set out the workforce assumptions to deliver the shifts from hospital to community and sickness to prevention, while taking full advantage of productivity improvements, for example, from the shift from analogue to digital. **Workforce plans must triangulate with finance and activity plans**. Providers must also:

- **fully implement** the 10 Point Plan to improve resident doctors' working lives, with action plans informed by feedback and national survey results, and progress reported publicly
- **demonstrate progress in reducing sickness absence rates**, which are higher in the NHS (5.1%) than in other industries and are a significant driver of expensive temporary staffing use. Providers must set out how they intend to support the 10 Year Health Plan ambition to reduce sickness absence rates to the lowest recorded national average level (approximately 4.1%)
- **continue to reduce agency staffing usage** in support of the ambition to eliminate this by August 2029
- **implement the reformed statutory / mandatory training framework due for publication in March 2026**, alongside a new approach to staff safety management
- **implement the reforms to consultant job-planning** to improve productivity and staff satisfaction (specifically, a trust-wide process for demand and capacity planning linked into service-level activity plans). Effective service-level job planning is essential to delivering innovation, education and training because it ensures clinical capacity is aligned to both service and education and training needs, providing transparency for funding allocation. Providers must:
  - for each year, ensure that 95% of medical job plans are signed-off in line with the business cycle, underpinned by service-level demand and capacity planning
  - by the end of 2026/27, ensure a system for monitoring and assurance is in place for tracking job planned activity
  - by the end of 2027/28, achieve tracking of job planned activity for the full year
  - by the end of 2028/29, ensure multiprofessional service level activity and job planning are in place

Success measure	2026/27 target	2028/29 target
Reduce use of bank and agency staffing	Trusts to reduce agency and bank use in-line with individual trust limits, as set out in planning templates, working towards zero spend on agency by 2029/30 Annual limits will be set individually for trusts, based on a national target of a 30% reduction in agency use in 2026/27, and a 10% year-on-year reduction in spend on bank staffing	

4 Next steps and plan submission

The 10 Year Health Plan stipulates that organisations should develop 5-year strategic plans that set out how they will deliver the 3 shifts and improve productivity of their services. These 5-year plans will need to be supported by 3-year numerical returns that describe what the organisation will deliver from 2026 to 2029. This timetable sets out the key outputs expected from the NHS and describes the planning process across the 3 phases.

The planning timetable - expectations for phase 2

Organisations will be expected to submit their 3 year plans as part of their first submission. This will be reviewed and assured by NHS England regional teams. Regional teams will provide feedback on the plans, and organisations will resubmit, alongside their 5-year strategic plans.

	Phase 1: Foundational		Phase 2: Plan development		Plan acceptance	
National planning timetable	July: Engagement with regional/ ICB leadership	August: Medium-term planning framework cascaded	September	October: Planning framework updated with ambitions and expectations	November	December: First submissions	January: Full plan submissions	February	March: Final plan acceptance
Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers	Review of first submission, provide feedback to organisations, discussions of areas for improvement including support from national directors	Plan assurance and acceptance	
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers	Integrated planning	Respond to regional feedback, finalise plans and board sign-off	Respond to outcome of plan assurance	Prepare to implement plans
Provider activities	Set up process, governance and build robust evidence	Complete foundational work	Integrated planning	Respond to regional feedback, finalise plans and board sign-off		
Outputs		Underlying financial position Block contract reviews	First submission = numerical plans (3-year workforce, finance and performance) Board assurance statements	Full submission: 5-year plans Updated numerical plans Board assurance statements		

Providers and ICBs will be expected to return the following plans to NHS England:

Submission	Requirement
First submission	• 3-year revenue and 4-year capital plan return • 3-year workforce return • 3-year operational performance and activity return • integrated planning template showing triangulation and alignment of plans • board assurance statements confirming oversight of process
Full plan submission	• updated 3-year revenue and 4-year capital plan return • updated 3-year workforce return • updated 3-year operational performance and activity return • integrated planning template showing triangulation and alignment of plans • 5-year narrative plan • board assurance statements confirming oversight and endorsement of the totality of the plans

The phase 2 planning process

Each NHS organisation is expected to develop their own integrated plans that set out:

- their strategic ambitions
- how they will meet their local population health needs. Plans should reflect the needs of all age groups and explicitly children and young people
- their transformation ambitions, demonstrating how they will implement the 3 shifts set out in the 10 Year Health Plan while improving productivity
- evidence of partnership working and co-operation with other NHS organisations, local authorities and the voluntary, community, faith and social enterprise sector
- how they will meet the standards set out in this document

These plans should be developed in collaboration with their NHS partners and in discussion with NHS England regional teams. Although system plans are no longer required, it is still important that plans are based on cooperation and partnership-working.

Organisations' boards should be engaged in the development of plans and are expected to complete board assurance statements demonstrating that they are satisfied that plans are robust and deliverable. Organisations will be required to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in-year, which must be assured by the board as part of the final plan submission process. To support the management of in-year risk, NHS providers and commissioners should identify specific and timely actions that could be taken to reprioritise existing budgets to address unforeseen pressures, guided by the principles in HM Treasury's 'Consolidated Budgeting Guidance'.

We will ask for the first submission of plans before Christmas. This will include the 3-year numerical plans covering workforce, finance and performance trajectories, as well as board assurance statements. This first submission does not include the narrative plans. Final plans will be expected in early February, including refreshed numerical plans, 5-year plans and updated board assurance statements. Neighbourhood health plan requirements will be set out in the Neighbourhood Health Framework and these will not need to be submitted to NHS England as part of this planning round.

Plans will be assured by NHS England regional teams who will provide specific support to those organisations who face the biggest challenges in meeting our collective ambitions. NHS England national programme teams will also provide support where required and ensure that transformation expertise is targeted and aligned.

We will share further guidance on what should be included within the 5-year narrative plans. ICBs should ensure that their 5-year strategic commissioning plans encompass the statutory requirement for joint forward plans (JFPs) agreed by the ICB and their partner trusts.

2511 - C PEOPLE

2511- C1 GUARDIAN OF SAFE WORKING REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 11:55

Mohmmad Khan, Guardian of Safe Working

10 minutes

REFERENCES

Only PDFs are attached

C1 - Guardian of Safe Working Quarterly Report.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Guardian of Safe Working Quarterly Report**			
Executive Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Mohammad I Khan, Guardian of Safe Working Hours			
Appendices:	N/A			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1, 2			

Executive Summary – Key messages and Issues

This report includes data for a four month period between 1 May 2025 and 31 August 2025. The reporting system in use is HealthRota and all the data presented is taken and categorised as per this software.

The total number of Exception Reports (ERs) filed in this period was 153. The majority of Exception Reports have been by trainees working in larger specialties like General Medicine, Obstetrics/Gynecology and General Surgery. The majority of ERs were submitted in relation to additional hours worked, reflecting the high workload of resident doctors, often compounded by rota gaps, sickness, strike, inadequate locum provision, extra cover and planned leave. There have been 12 reports in relation to missed educational opportunities in this 4 month period.

The Board of Directors can be assured that the vast majority of Trainee doctors are able to work safely. Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics. The Medical Education team regularly engages with the speciality departments to support resident doctors to maximise their training opportunities.

Recommendations

The Board is asked to note and take assurance from this quarterly report.

Healthier together – delivering exceptional care for all	
Patients	Resident doctors support the delivery of safe and effective patient care.
People	The Guardian of Safe Working Hours role supports the resident doctor workforce.
Partnerships	The Guardian of Safe Working Hours is part of regional and national networks to share learning and knowledge.
Pounds	The report describes the usage of medical bank/agency and the application of fines.
Health Inequalities	None identified
Legal/ Regulation:	-
Partner ICB strategies	-

Assurance Route	
Previously considered by - including date:	N/A

<table>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

YES</td><td>Highlight only where this report is outside of the Board Risk Appetite below.
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Mohammad I Khan, Guardian of Safe Working Hours

Report date: 4 November 2025

Executive Summary

The total number of Exception Reports (ERs) submitted from 1 May 2025 until 31 August 2025 is 153. The vast majority of ERs were filed by foundation year (FY) doctors or residents in their earlier journey in training (144 vs 9 by ST4 or above) indicating the pressure the doctors early in their careers are faced with especially in the major busy specialties.

NHS Employers have published a new framework with reforms to the ER system after agreements between the government and the BMA resident doctors committee. There are several significant changes to the current processes and NHS trusts will need to implement the new process by 4 February 2026 which will apply to all doctors and dentists employed under the 2016 Terms and Conditions of Service. This will also require the software operators like Healthrota to update the minimum data set to ensure the recording of ERs is in line with the agreed reforms.

The highest number of ERs have been submitted by trainees working in General Medicine, General Surgery and Obstetrics/Gynaecology during this period. The majority of ERs are submitted in relation to additional hours worked, reflecting the high workload of Resident Doctors, often compounded by rota gaps, sickness and inadequate locum provision/cover.

The Board of Directors can be assured that the vast majority of trainee doctors are able to work safely. Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics. Departments have been requested to identify where this remains a challenge and to support Resident Doctors to maximise their training opportunities. Medical Education team members engage with specialities to safeguard training opportunities for doctors.

Introduction

This report sets out the information from the Guardian of Safe Working Hours (GOSWH) with regards to the 2016 Terms and Conditions for resident doctors to assure the Board of the safe working of resident doctors. This report is for the period 01 May 2025 to 31 August 2025. The Board should receive a quarterly report from the Guardian as per the 2016 contract, which will include:

• Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade

• Details of fines levied against departments with safety issues

• Data on rota gaps, vacancies and locum usage

• A qualitative narrative highlighting areas of good practice and / or persistent concern.

Table 1. Number of exception reports by month, 1 May 2025 to 31 August 2025.

Month	Complete	Pending	Total
May 2025	48		48
June 2025	28		28
July 2025	16		16
August 2025	57	4	61
Grand Total	**149**		**153**

There is seasonal variation in Exception Reporting (ER) with the highest number of monthly reports usually occurring during the winter months and also in August to October time period.

Table 2. Number of exception reports by specialty, 1 May 2025 to 31 August 2025.

Specialty	05-2025	06-2025	07-2025	08-2025	Grand Total
General medicine	36	22	11	38	107
General surgery	4	1		10	15
Obstetrics + gynaecology	5	4	2	6	17
Urology	2	1	3	5	11
Paediatrics				1	1
ENT	1				1
U&EC				1	1
Grand Total	**48**	**28**	**16**	**61**	**153**

Over this 4 months' period, the majority of ERs have been submitted by trainees working in General Medicine, Obstetrics / Gynaecology and General Surgery.
No exception reports were received from both the GP training schemes for which the Trust is the lead employer.

Table 3. Reasons for submission of Exception Reports, May 2025 to end of August 2025

Difference in total hours of work (including opportunities for rest breaks)	132 (86%)
Min daily working rest of 11 hrs reduced to <8	8 (5%)
Unable to attend scheduled teaching/training attendance	9 (6%)
Clinic/theatre/session attendance cancelled	2 (1.5%)
Inadequate supervision	2 (1.5%)
Total	**100%**

During this 4 month period, the vast majority (86%) of ERs were submitted in relation to additional hours worked with or without missed breaks, reflecting the high workload of resident doctors requiring them to stay late in order to ensure patient safety. Six percent of reports (9) were made in relation to missed educational opportunities and in 7 of these cases the reasons were linked to work areas being understaffed or having a busy shift with sick patients leading to trainees missing scheduled teaching sessions. Most of these ERs were filed by FY 1 doctors working in General medicine missing educational opportunities due to workload and understaffing. The remaining 2 ERs were both filed by ST3 from the same speciality due to cancellation of the training session. Senior members of the divisional team are responsible for facilitating Trainees to attend by reviewing the barriers to attendance within their Specialty and mitigating these but at times it is not always possible to arrange cover at a short notice. There were also 2 ERs for inadequate

supervision / support during the shift (FY1/2 in General Medicine). The first one was from a fresh FY1 doctor settling in the post and took longer to complete tasks which also led to missing scheduled teaching while the second one was from a FY2 doctor who was asked to provide acute cover on top of planned activity due to sickness and the shift ended up being quite busy with inadequate supervision.

Table 4. Number of exception reports by doctors' grade, May 2025 to August 2025.

FY1/2	CT1/2	ST1-3	ST4-8	Total
116	4	24	9	153

The vast majority of ERs were filed by Foundation year doctors indicating the pressure the doctors early in their careers are faced with especially in the major busy specialities.

Table 5. Comparison for TOIL vs Payment where applicable, 1 May 2025 to 31 August 2025

Exception Reports with TOIL granted	11%
Exception Reports with payment	89%

a) Work schedule reviews

There has been one recent review of a rota in Urology as mentioned in the previous Board report, led by specialty doctors on the same rota due to the out of hours' intensity on the non-resident rota. However, in this quarter, there have been further 9 ERs filed by trainee in Urology for 9 shifts where the minimum rest period at night was breached for non-resident on call (NROC). This was previously escalated and communications had taken place with the Urology team members with steps identified in order to resolve this. However, this seems to be an ongoing issue despite implementation of positive steps. Discussions are currently ongoing with urology and further work schedule review has been requested to identify steps which could be taken and the Board will be updated in the next report.

b) Locum bookings

The data below details bank and agency shifts covered by training grade doctors.

Table 6. Hours covered by bank usage in respective specialities, 1 May 2025 to 31 August 2025.

Row Labels	May	Jun	Jul	Aug	Grand Total
Acute Medicine	1409.5	1051.25	1328.5	513.75	4303
Anaesthetics and Critical Care	105	30	210	123.5	468.5
Anaesthetics and Maternity				16	16
Anaesthetics and Theatres	49.5	189	52.5	304.5	595.5
Breast Surgery	316	275.5	205.5	223	1020
Cardiology (Medical)	156.75	201.5	227.25	180.75	766.25
Care of the Elderly	450	814.75	877.25	956.5	3098.5
Emergency Medicine	8072.5	7216.5	7495.5	7041.75	29826.25
Endocrinology and Diabetes	11.5	99.75	195.75	113	420
ENT	390.5	383	306.5	285.75	1365.75
Gastroenterology	126	190.25	263.5	201.25	781
General Medicine	241.75	33	60	33.5	368.25
General Surgery	538	292.5	482.25	235	1547.75
Haematology			62	17	79
Infectious Diseases	42	247.25	260.25	49.5	599
Intensive Care	39	52	39	26	156
MEOC Orthopaedic and Trauma		13			13
Neonatal Medicine				13	13
Obstetrics and Gynaecology	1216.5	1206	1385	1367	5174.5
Orthopaedic and Trauma Surgery	2819	2771	3130	2940.5	11660.5
Paediatrics	12				12
Paediatrics and Neonates	1065.75	927	1068.75	860.5	3922
Renal Medicine	217.5	266	390.5	61.5	935.5
Respiratory Medicine	77.75	389	555.25	391.5	1413.5
Rheumatology	61.5	161.25	86.75		309.5
Stroke Medicine	4	31	42	62.75	139.75
ULH Acute Med (Extra Cover)		8			8
Urology	221.5	213	293.5	421.5	1149.5
Vascular Surgery	139	109	194.5	58.5	501
Grand Total	**17782.5**	**17170.5**	**19212**	**16497.5**	**70662.5**

As expected, most of the hours covered by bank usage is for busy specialties like Acute & Allied / Emergency Medicine, Orthopaedics / Trauma, Obstetrics and Gynaecology.

Table 7. Reasons for locum and bank usage, 1 May 2025 to 31 August 2025.

Count of Job No	Column Labels				
Row Labels	**May**	**Jun**	**Jul**	**Aug**	**Grand Total**
Additional session	45	17	10	16	88
Annual Leave	24	37	70	48	179
Compassionate/Special leave	7	2	1	3	13
Deanary gap - Vacancy	227	185	210	169	791
Entrustability		3		11	14
Exempt from on calls for health reasons	28	40	22	4	94
Extra Cover	60	61	45	35	201
Induction/Rotation		1	7	78	86
Less Than FT Trainee Gap	83	85	110	92	370
Maternity/Paternity leave	58	72	89	63	282
Restricted Duties	10	17	11	8	46
Sick	92	116	78	70	356
Strike			155		155
Study Leave	11	1	2	10	24
Vacancy	1215	1158	1185	1120	4678
Grand Total	**1860**	**1795**	**1995**	**1727**	**7377**

Table 8. Cost for the locum cover.

Row Labels	May	Jun	Jul	Aug	Grand Total
Acute Medicine	90880.84	65403.09	86182.33	28117.34	270583.6
Anaesthetics and Critical Care	7350	2906.24	18843.5	9867.25	38966.99
Anaesthetics and Maternity				1636	1636
Anaesthetics and Theatres	3335	13116.5	3505	23976	43932.5
Breast Surgery	14189.87	13549	10143.75	11556.25	49438.87
Cardiology (Medical)	9867.72	12637.31	15939.5	11575	50019.53
Care of the Elderly	23479.44	48756.83	55633.87	53652.04	181522.18
Emergency Medicine	574213.44	531825.93	561217.93	500944.2	2168201.5
Endocrinology and Diabetes	747.5	4554.33	14889.77	5445.75	25637.35
ENT	26202.84	26628.71	22676.18	20960.16	96467.89
Gastroenterology	8483	11453.75	19681.88	10692.95	50311.58
General Medicine	15190.51	0	606.25	0	15796.76
General Surgery	23496.28	13675.65	23654.27	13813.75	74639.95
Haematology			5989.38	0	5989.38
Infectious Diseases	3270	12202.03	16636.2	2355	34463.23
Intensive Care	2126.67	2835.56	2126.67	2034.5	9123.4
MEOC Orthopaedic and Trauma		1179.75			1179.75
Neonatal Medicine				0	0
Obstetrics and Gynaecology	95696.23	94312.75	100273.73	106160.84	396443.55
Orthopaedic and Trauma Surgery	173225.06	173408.02	194705.1	188715.94	730054.12
Paediatrics	0				0
Paediatrics and Neonates	75683.77	67141.92	80480.31	63772.34	287078.34
Renal Medicine	10903.5	12434.78	25061.1	2380	50779.38
Respiratory Medicine	3744.4	23152.72	31366.13	21358.74	79621.99
Rheumatology	5410	14140	7557.5		27107.5
Stroke Medicine	160	1265	2000	3976.5	7401.5
ULH Acute Med (Extra Cover)		0			0
Urology	12888.5	12028.26	17552.5	26987.4	69456.66
Vascular Surgery	4075	1810	14146.1	2278.12	22309.22
Grand Total	**1184619.57**	**1160418.13**	**1330868.95**	**1112256.07**	**4788162.72**

The majority of locum cover was to provide staffing for rota gaps, sickness, vacancies, leave/ extra cover or additional sessions. The number of locum shifts covering rota vacancies has overall remained steady.

c) Vacancies

In this period, monthly rota vacancies have stayed stable at around 50 WTE (was 46 in previous quarter).

Table 9. Trainee vacancies by specialty, May 2025 to August 2025.

	VACANCIES (WTE)	Posts	May	June	July	August
Medicine	CT/ST GPST 1-3	25	0.9	0.9	0.9	0
	ST3+	22	3.4	3.4	3.4	7.2
	Elderly Medicine	**22**	**2.8**	**2.8**	**2.8**	**2.5**
	FY1	3	0	0	0	0
	FY2 (No FY2 placements)	No FY2 placements				
	CT/ST GPST 1-3	15	2.8	2.8	2.8	2.5
	ST3+	4	0	0	0	0
	Renal	**7**	**1**	**1**	**1**	**0**
	FY1 (No FY1 placements)	No FY1 placements				
	FY2	6	1	1	1	0
	CT/ST GPST 1-3	No CT/GPST placements				
	ST3+	1	0	0	0	0
U&EC	**Urgent & Emergency Care**	**37**	**11.4**	**11.4**	**11.4**	**11.1**
	FY1	5	0.2	0.2	0.2	0
	FY2	5	0.2	0.2	0.2	2.5
	CT/ST GPST 1-3	25	11	11	11	8.6
	ST3+	2	0	0	0	0
Women's & Children's	**Obstetrics & Gynaecology**	**29**	**4.4**	**4.4**	**4.4**	**7.9**
	FY1	3	0.2	0.2	0.2	0
	FY2	3	0	0	0	0.5
	CT/ST GPST 1-3	12	0.2	0.2	0.2	3.4
	ST3+	11	4	4	4	4
	Paediatrics	**35**	**2.4**	**2.4**	**3.2**	**4**
	FY1	4	0.2	0.2	1	0.2
	FY2	3	0	0	0	1
	CT/ST GPST 1-3	20	2.2	2.2	2.2	2.8
	ST3+	8	0	0	0	0
	GU Medicine	No longer taking GUM trainees				

	VACANCIES (WTE)	Posts	May	June	July	August
Surgery & Cancer	ENT	8	2.2	3	3	2
	FY1	No FY1 placements				
	FY2	2	0	0	0	0
	CT/ST GPST 1-3	3	1.2	2	2	2
	ST3+	3	1	1	1	0
	General Surgery	27	5.8	5.8	5	4.9
	FY1	10	2	2	1.2	0
	FY2	2	0	0	0	1
	CT/ST GPST 1-3	7	3	3	3	3.2
	ST3+	8	0.8	0.8	0.8	0.7
	Ophthalmology	12	0	0	0	0
	ST3+	2	0	0	0	0
	Urology	6	8.2	8.2	8.2	10.2
	FY1	2	0	0	0	0
	FY2	2	1	1	1	1
	CT/ST GPST 1-3	No CT/GPST placements				
	ST3+	2	0	0	0	2
	Trauma & Orthopaedics	6	3.6	3.6	3.6	3.6
	FY1	No FY1 placements				
	FY2	1	0	0	0	0
	CT/ST GPST 1-3	5	3	3	3	3
	ST3+	5	0.6	0.6	0.6	0.6
	Vascular	8	2	2	2	1.2
	FY1	3	0	0	0	0.2
	FY2	1	No FY2 Placements			0
	ST3+	4	2	2	2	1
Clinical Specialties	Anaesthetics	16	0.4	0.4	0.4	0
	FY1 (No FY1 placements)	No FY1 placements				
	FY2	No FY2 placements				
	CT/ST GPST 1-3	11	0	0	0	0
	ST3+	5	0.4	0.4	0.4	0
	ICT	12	0.9	0.5	0.5	0.2
	FY1 (No FY1 placements)	No FY1 placements				
	FY2	6	0.4	0	0	0
	CT/ST GPST 1-3	4	0	0	0	0.2
	ST3+	2	0.5	0.5	0.5	0
	Total	332	50.4	50.8	50.8	55.8

c) Fines

A total of 16 fines have been levied during this period (ST3=9, FY2=4 and FY1=3). Urology received 9 fines for 9 shifts where the minimum rest period for NROC was breached. 3 fines were applied to renal medicine, 2 to emergency medicine and one each to general medicine and general surgery (5 for breaching maximum shift length of 13 hours and 2 for missed breaks). The money collected from the fines is held in the corporate account of GOSWH which can be used for the benefit of resident doctors at the Trust with a proportion of fine being paid to the doctor as well as shown below:

Penalty Rate to the Doctor	Penalty Rate to the GOSW
£32.64	£54.44
£37.79	£62.99
£27.59	£45.97
£56.68	£94.46
£56.68	£94.46
£37.79	£62.99
£37.79	£62.99
£56.68	£94.46
£56.68	£94.46
£56.68	£94.46
N/A	£39.73

N/A	£39.73
£56.68	£94.46
£56.68	£94.46
£56.68	£94.46
£56.68	£94.46

Qualitative information

A new initiative named "Medical Education Engagement Group" facilitated by the Chief People Officer has been started to bring the relevant stakeholders together on a quarterly basis and work together to improve working streams.

The last Resident Doctor's Forum (RDF) meeting took place on 17 September 2025 which was better attended as compared to the previous RDF.

The NHS 10 point plan for improving resident doctor's working lives was discussed as well as plans for a Hybrid meeting with provision of lunch to improve resident doctors' engagement. Due to complexities of using funds from the GOSWH account, the plan for hybrid meeting in November has been postponed until early next year. The ER reform and the changes being implemented were discussed and some of these changes include:

1. Providing access to doctors for submitting ERs within 7 days of starting at the Trust with remote access (fines for breaches)
2. Automatic approval for up to 2 hours of additional hours' work within 10 days (trainee can choose TOIL or Payment)
3. Supervisors will no longer be required to review/ approve ERs (this responsibility has been shifted to Medical HR teams)
4. ERs have to be treated as confidential and can't be shared without trainee's consent (fines for breaches)
5. Changes to the systems used for ER reporting with a list of mandatory fields
6. GOSWH reports to be standardised to a national template

Summary

Ongoing exception reports highlight high workloads for resident doctors, especially in the busy specialities despite significant improvements. High workload and understaffing are the usual causes for resident doctors being unable to undertake educational opportunities. It is a busy time for NHS trusts to implement the proposed changes to the ER reporting and processing procedures by February 2026.

Engagement

The regional Guardians meeting was planned for 5 November 2025 but has been called off by NHS Employers due to their need to focus on the ER reform process. The local guardians have volunteered to run an informal meeting on the same day with presentations on pressing issues including the implementation of the ER reforms.

The Guardian is involved in the working group at the Trust to implement the NHSE 10 point plan for improving resident doctors' working lives.

An ongoing drive to raise awareness of exception reporting, and to encourage attendance and participation in the RDF is part of the Guardian's Role:

- Induction with new doctors, especially FY1s, and additional teaching sessions to reinforce the importance of Exception Reporting and addressing any underlying barriers to submitting ERs took place in August with a follow on session booked in a few months. Resident doctors' reps have been successfully appointed to represent trainees in forums and this has been a very positive change.
- There is ongoing work collaboratively with the Freedom of Speak Up Guardian and Trust SuppoRTT Champions. Several Engagement sessions have already occurred with October 2025 being named as Speak up month and further sessions may be planned as and when needed. A special GMC/DBTH engagement session on "Speaking Up structure, processes and best practice" was held virtually on 15 October 2025 following the in person event in June 2025.

Recommendation

The Board of Directors can be assured that a clear majority of trainee doctors are able to work safely. Trainees and the supervisors are used to the new system of reporting through Healthrota and there is positive feedback on the ease of using the app. Monthly regular meetings run between GOSWH and HR colleagues to action any outstanding ERs and make decisions. This also helps in regularly chasing supervisors for timely action on open ERs to ensure they are dealt with in a timely fashion although moving forwards supervisors won't need to review ERs for the resident doctors.

Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps preclude attendance at educational sessions. This requires local resolution within those affected specialties and resident doctors are encouraged to discuss this issue with their Educational Supervisors for additional support.

2511 - C2 FREEDOM TO SPEAK UP BI-ANNUAL REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 12:05

Paula Hill, Freedom to Speak Up Guardian

10 minutes

REFERENCES

Only PDFs are attached

- C2 - Freedom to Speak Up (FTSU) Bi-annual Report.pdf
- C2 - Appendix 1 - NHSE Being Fair Tool.pdf
- C2 - Appendix 2 - Speaking Up data infographic 25 - 26.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Speaking Up (FTSU) Bi-annual Report**			
Sponsor:	Zoe Lintin, Chief People Officer & Executive Lead for Speaking Up			
Authors:	Paula Hill, Lead Freedom to Speak Up Guardian			
Appendices:	1. NHSE Being Fair Tool 2. Q1 & Q2 Speaking Up Data Infographic 2025 – 2026			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
	To provide a comprehensive account of Speaking Up (FTSU) activity and performance against the 2024-2028 Speaking Up Strategy (including regulatory requirements and best practice), from April 2025 to October 2025. It highlights areas where significant progress has been made and milestones achieved, whilst also identifying areas where a greater focus is still required. The report also ensures that the Board is sighted on the national Speaking Up (FTSU) picture, including changes to the FTSU guidance and governance structures and the potential impact and changes for consideration by DBTH Board. Finally, it considers themes and trends in national and local reporting, and explores how the learning from these concerns can develop our insight and ensure learning and improvement.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2			

This report highlights key Speaking Up activity in the first two quarters of 2025-2026, drawing particular attention to:

- The impact of global tensions on local behaviours/wellbeing and the impact this has had on local readiness for change, Speaking Up activity and the need for wider support.
- The continued changes in Speaking Up confidence, and continued work to explore and address this.
- The changes in Speaking Up activity, particularly relating to who is speaking up and the increase in anonymous cases.
- The positive performance against the 2024-2028 Speaking Up Strategy (now Plan) particularly in relation to raising the profile of Speaking Up and education and training, alongside areas where further work is needed to embed success in relation to processes for identifying and supporting colleagues who feel they have been treated differently after Speaking Up and strengthening wider governance and assurance processes.
- Revision of the 2025 Reflection & Planning Tool, and why this final completion has been deferred until wider information is available to inform holistic decision making.

The content of this paper was presented at the People Committee on 21 October 2025 and the committee confirmed that significant assurance had been taken. The People Committee also acknowledged the need for DBTH to consider the relevant outcomes of DBTH Way in Action & Speaking Up Peer Review prior to its refresh of the NHSE Reflection & Planning Tool for 2025-2027. As this defers actions from the 2024-2026 version of the tool, and the previously agreed “Deep Dive” into behaviours at the Trust, the People Committee members agreed to receive a focussed Speaking Up report in February 2026 (earlier than scheduled) to ensure that timely progress is being made and future actions are understood.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board is asked to consider and take assurance from the information presented in this Bi-annual report, including the actions agreed by the People Committee and look to also support the presentation of a focussed Speaking Up report to Board in March 2026 (4 months), to enable greater assurance in relation to timely progress against deferred actions and compliance with national regulation and guidance.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>Speaking up supports patient safety with themes being identified through reporting and data analysis to encourage learning.</td></tr>
<tr><td>People</td><td>Speaking up supports colleague experience with themes being identified through reporting and data analysis to encourage learning.</td></tr>
<tr><td>Partnerships</td><td>Collaborative working with other trusts on FTSU activity and regionally on a Deanery Training Program</td></tr>
<tr><td>Pounds</td><td>Improved colleague experience positively impacts on wellbeing and retention, thereby reducing the need for temporary workforce and associated costs</td></tr>
<tr><td>Health Inequalities</td><td>Barriers to speaking up are explored as part of the strategy development work and this takes into account inequalities.</td></tr>
<tr><td>Legal/ Regulation:</td><td>No legal implications</td></tr>
<tr><td>Partner ICB strategies</td><td>-</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Presentation to People Committee on 21 October 2025 with significant assurance taken</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Further report in February 2026</td></tr>
<tr><td>Indicate if the assessment is in line with current risk appetite or not YES</td><td>Sector Risk Appetite levels:
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>People
Finance</td><td>Reputational
Innovation</td><td></td></tr>
</table></td></tr>
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1. Introduction

This paper is presented in line with the 2024-2028 Speaking Up strategic themes and provides an update on DBTH Speaking Up (FTSU) activity since the last bi-annual Report to Board in May 2025. It uses the results of the National Guardian's Office (NGO) data collection, DBTH FTSU Guardian activity and performance against the DBTH FTSU Reflection and Planning Tool actions, and the CQC Action plan to provide an overview of organisational performance and assurance.

The paper also discusses the key national and local influences on Speaking Up over the last five months and considers the impact of these on our performance to date and future direction.

2. National Context and Local Response

The Speaking Up (FTSU) agenda is poised for change following the recommendations of the Dash Review in July 2025. Dr Penny Dash's review of patient safety across the health and care landscape in England, which was commissioned by the Department of Health and Social Care, looked at six bodies and how they worked within the wider health and care landscape, with a particular focus on patient safety. The six bodies considered included the Care Quality Commission, the National Guardian's Office, Healthwatch England and the Local Healthwatch networks, the Health Services Safety Investigations Body (HSSIB), the Patient Safety Commissioner and NHS Resolution. Dr Dash's nine recommendations focus on streamlining the patient safety landscape and improving accountability.

Recommendation 6, titled, Streamline functions relating to staff voice, has a direct impact on the removal of the National Guardian's Office from 31 March 2026. However, the recommendation also clearly states that Local Guardian functions should remain in NHS & Social Care organisations with a greater alignment to, and oversight from ICBs, NHSE (DOHC) and CQC. The framework of Guardians and Champions (Ambassadors) is also still seen as "Best Practice" but it was felt that stronger governance and consistency is required.

It is recognised that a greater requirement for strong local governance in relation to self-assessment, listening, learning and improvement will be required. The national registration of Guardians and wider governance arrangements will transfer to NHSE and/or DoHSC from 2026-2027 however the exact details of these arrangements are still to be confirmed. Additional reading is available with this paper if required.

As part of the revised governance in relation to consistency across FTSU Guardian models and services (particularly across NHS organisations), a revised Guardian Framework has been developed and launched, suggesting best practice when recruiting and embedding Speaking Up services. This tool explores service structures, support, supervision, capacity, role specifications, banding, training and development and governance structures, providing links to NHSE Guidance, best practice for consideration and support structures for both FTSU Guardians and Non-Executive Directors who support Speaking Up. Additional reading is available with this paper if required.

One of the key governance arrangements that will continue to be instrumental in shaping Speaking Up at DBTH, is the NHSE/NGO Reflection & Planning Tool. The previous revision in 2024-2026, saw ten key actions identified to support and embed consistent change. In May 2025, the Board acknowledged that eight of the ten actions were successfully completed and two were ongoing (FTSU Peer Review and Local disadvantageous and/or demeaning treatment (Detriment) Guidance). This work has been paused or deferred to allow greater insight from the outcomes of the DBTH Way in Action and the FTSU Peer Review (the latter had been deferred due to capacity of the external Guardian), which will allow a more informed

refresh of the documents and enable us to drive forward the SU strategic delivery plan, demonstrating what we have heard and learnt from the reviews.

The revised timescale will also allow time for training and reflection for our new leaders, and assessment of FTSU service requirements in line with the newly published Guardians Framework.

Nationally we continue to see and feel change at pace and scale and this is reflected locally across Speaking Up activity, themes and engagement. Considering the impact of change on our DBTH colleagues requires consistent approaches to minimise harm during the process of change, with people-centred approaches, demonstrating early and open communication, and the provision of listening, learning and support, for all parties. It also requires all leaders to demonstrate fairness and transparency, by utilising appropriate tools, such as the NHSE Being Fair tool (Appendix 1) to reduce bias and support equality. This tool has been explored by the DBTH Just Culture Group due to its replacement of the NHSE Just Culture Checklist. Although it is predominantly for use in Patient Safety situations, the benefit of adopting its core principles in other situations has been acknowledged by the group.

We acknowledge that an increase in change on this scale will impact colleagues in different ways, and for those who are not ready for change or who are unhappy with the changes required and/or suggested, this may result in reduced compliance or increased concerns being raised through Speaking Guardians or partners, including staff side representative and People Business Partners. An increase in concerns raised about the processes employed during change (17%) and the leadership of that change (17%), in the first two quarters of 2025-2026, may suggest that this is not consistently applied across some areas of the organisation and requires a greater focus to sustain engagement and a required readiness for change across all colleagues.

Unfortunately the widespread global behaviours related to hate and extremism can be very unsettling for everyone, including our colleagues at DBTH. For some this has a personal impact by influencing behaviours that are not in keeping with the DBTH Way. These can also be amplified when colleagues chose to voice these behaviours using digital technologies such as social media platforms. Although concerns relating to such behaviours are small in number, they can greatly impact already marginalised or hard to reach groups and can trigger stressful events and a negative impact on wider wellbeing. This has seen some individuals react by escalating behaviours about the use of hate language and discrimination, while others, choose to voice fear as a reason to withdraw and change their social behaviours to enhance their psychological safety.

Although current Speaking Up activity suggests this is not widespread at DBTH, racism is still a key topic to address in the NHS and DBTH remains committed to becoming an Anti-racist organisation and is driving forward change at organisational and Doncaster Place level. A number of Speaking Up Champions and partners are supporting this work, ensuring the voice of their communities are heard and supported. The Doncaster anti-racism partnership continues with the steering group and representatives from several organisations. Recent developments include being shortlisted for a national award, launching an allyship video featuring colleagues from our organisations and a face-to-face event in October 2025 to consider future priorities

In May 2025, the National Guardian's Office published the findings of their review of internationally trained workers. The report acknowledges that these diverse colleagues form a significant part of the NHS workforce in England, with almost one in five NHS workers currently being non-UK nationals. These workers represent more than 200 nationalities, with the largest groups coming from India, the Philippines and Nigeria. Every day, they help sustain essential services across the country and they are vital to the health and wellbeing of

the population, and the report reflects that it is equally important that they are fully supported in their roles to be able to deliver services to the highest standards.

The review clarifies that overseas-trained workers face many of the same day-to-day workplace challenges as UK nationals but in addition may face issues such as language barriers, cultural adaptation challenges and workplace discrimination. Their views on speaking up confidently when things go wrong are shaped by several factors. However, their ability to speak up is essential, in terms of being able to lead rewarding careers, and critically, for patient care and safety.

The report shares that interestingly, the 2023 NHS Staff Survey revealed a growing confidence among workers recruited outside the UK in their ability to speak up and trust their organisation's response, while domestically recruited workers have shown stagnation or declines in some areas over the same period. The NGO review of overseas-trained workers identified four key themes:

- The transition challenges of settling into the UK.
- The influence of national culture and societal norms on speaking up perceptions and behaviours
- The enablers and barriers of speaking up
- The speaking up arrangements and support.

Based on these themes, four recommendations were made,

- Recommendation 1: Review and enhance the international recruitment guide and retention toolkit for NHS Employers and NHS England
- Recommendation 2: Tailoring Freedom to Speak Up arrangements to all workers
- Recommendation 3: Improving data collection and categorisation of overseas-trained workers to better measure speaking up progress
- Recommendation 4: Addressing cultural barriers

Full details of this review are available as further reading.

The National Guardian's Office (NGO) report on cases for 2024-2025 was published in August 2025 and highlights that 2024/2025 saw the highest number of cases reported to guardians since the programme began in 2016. It also highlights that:

• Workers continue to express positive views about the Freedom to Speak Up Guardian role

• Inappropriate attitudes and behaviours remain the most common theme of concern.

• Concerns related to worker safety and wellbeing are increasing.

• Confidence in organisations to address concerns is in decline.

• NHS trusts are showing a positive shift, with more full-time guardians being appointed.

The report also acknowledges challenges that influence Speaking up themes, including:

• Fear of detriment or a belief that speaking up will not make a difference

• Prolonged investigations and rigid human resource processes contribute to anxiety and negatively impact the wellbeing of those raising concerns.

• A lack of outcomes, delayed feedback, and breakdowns in communication weaken trust between workers and organisations.

• A perceived lack of compassionate responses from line managers and senior leaders when concerns are raised reinforces the belief that “nothing will change”.

Some of these themes, including an increase in concerns raised about inappropriate behaviours, the impact of concerns on personal wellbeing and the decline in psychological safety were presented to Board in May 2025 as part of the DBTH annual data for 2024-2025. This is also true of the challenges faced or experienced in relation to fear of being treated unfairly or differently after Speaking Up, the inconsistency in Speaking Up responses and the impact of delayed investigation and/or feedback.

3. Local Speaking Up Activity

The number of colleagues accessing FSTU Guardian services during Q1 & Q2 of 2025-2026, was 47 colleagues in 41 cases. This has been reported nationally as 47 in line with the NGO guidance on recording & reporting concerns. This figure includes concerns raised by learners during the two quarters.

Q1 of 2025-2026 has seen a small fall in the number of individuals raising concerns, with 22 colleagues raising concerns in 19 cases. This small decrease may be attributable to the continued reduction in multiple individuals raising concerns in teams or groups. This trend continued in Q2 with fewer multiple reports, however, a small increase in individual cases was seen meaning that a total of 25 individuals raised concerns about 22 cases. Both quarters saw concerns being raised predominantly by Nurses and Midwives (38.3%) and Administration and Clerical Staff (21.3%), with the three most predominant themes continuing to be Bullying and Harassment (19.1%), Inappropriate Behaviours (31.9%) and Worker Safety & Wellbeing (59.5%). However, when raising their concerns about worker wellbeing, colleagues also spoke about the impact of team cultures, leadership, and behaviours. The number of themes continues to reflect higher than the total number of reports due to colleagues highlighting more than one theme when they speak up. Feedback continues to grow, however some cases remain open beyond the 90 day best practice guide, and this continues to impact feedback numbers and compliance following delays.

No new Sexual Safety cases have been raised through the FTSU Guardian Service as the process now signposts cases directly to People Business Partner Service Activity against this work stream and will therefore now be reported to People Committee via other reports. However, for the purpose of this report data has been supplied by the Safeguarding and PBP teams to confirm that Q1 saw 4 sexual safety cases, with all 4 now closed and Q2 saw 3 sexual safety cases with 2 closed and 1 remaining open for support.

A reduction in patient safety concerns raised through FTSU Guardian services is suggested nationally to possibly be due to the successful implementation of Patient Safety Incident Response Framework (PSIRF) and may also reflect local increased confidence in speaking up through patient safety processes and structures, as indicated in the 2024 staff survey. However locally a small increase (17%) has been seen in Q1 and Q2 of 2025-2026. A full data infographic is provided as appendix 2.

3.1 Performance against Strategy

Performance against the DBTH 2024-2028 Speaking Up Strategic Enabling Plan throughout the first two quarters of the year has seen work take place to ensure the achievement of many of the key enablers identified in phases 1 and 2 and significant progress made in some areas of phase 3. However further ongoing work is still required in order to improve psychological safety, address Speaking Up barriers and strengthen governance and assurance processes at divisional and organisational level.

Further work is planned to address these throughout the remainder of 2025-2026 and specific actions will be reflected in the 2025-2027 Reflection & Planning Tool review (now planned for January 2026).

Key:

- ✓ Speaking Up work that has been completed and is being strengthened to become BAU.
- ❖ Speaking Up work that remains ongoing or requires further development.

Raising the profile of Speaking Up.

- ✓ This theme has significant achievement with continued sessions to raise awareness both though planned events and through increased visibility and walk rounds.
- ✓ Additionally work has taken place to raise the profile of Speaking Up across leadership teams to ensure Speaking Up is a priority for all leaders. This has continued to see strong engagement from many Nursing, Midwifery and AHP leaders. Further work is planned to engage our non-clinical colleagues and medical colleagues.
- ✓ Positive outcomes continue to be visible against this theme including the provision of revised accessible information on the HIVE, ensuring all aspects of Speaking up can be explored and considered. This resource also provides links to wider partners.
- ✓ DBTH Speaking Process Boards are now placed in the majority of areas and work is ongoing during October's Speak Up Month to refresh photos and pledges to ensure positive messages are available to encourage open conversations at local level. This work is being driven across all three sites.
- ✓ This work is linked to the Safe Learning Environment Charter (SLEC) and learner escalation pathways are also being shared as part of this process.
- ✓ Increased awareness and communication through continued SU and Just Culture roadshows, visible resources, and increased stories.
- ❖ A refresh of the publication 'Sharing what we have heard and what we have learnt' is planned due to the reconfiguration of Sharing how we care publication as part of the change to "Quality Summit"
- ❖ The SU Leadership champions' model needs further consideration. Although strong focus is given by a few leaders many more are required to achieve the buddying system and impact required.

Providing easily accessible, consistent, high quality Speak Up services.

- ✓ Roll out of the use of the Speaking Up Handbook for Mangers and Leaders as an integral part of the Speaking Up Process.
- ✓ Continuation of managers support sessions to allow reflection and increase confidence.
- ✓ Increased Speaking Up collaboration through the SU Guardian service and wider partners, including Patient Safety, People Business Partners, PNAs & PMAs, Leadership &OD, EDI lead and Safeguarding teams.
- ✓ The increased capacity from the development Guardian role has enabled further action across this theme through the ability to offer increase colleague and manager support as well as maintaining visibility.
- ✓ Instigation of the FTSU Peer Review which is expected to be completed and the report received by October 2025.
- ✓ Positive feedback received to suggest access to services is easy, however, consistency across departments and divisions remains a challenge. This should be positively impacted by wider work to deliver all three levels of Speaking Up Training over the next 2 years.

- ✓ Work is underway to consider the Speaking Up process and measure compliance. This has seen the continuation and further development of the revised feedback process which has successfully increased the numbers of those providing feedback. However this requires further review due to the lack of ability to identity those who may be feeling they have suffered unfair or demeaning treatment after speaking up.

- ❖ All timescales for cases have been measured from April 2025, following the introduction of the tools to support responses and the setting of compliance timescales. This continues to be a challenge and requires further work.

Embedding an open and transparent Speak Up culture.

Although a lot of activity has taken place in relation to this theme and some positive change has been seen against some of the planned outcome measures of the strategy, key concerns raised by some colleagues suggest that there is a decline in confidence relating to psychological safety, reflected in the 2024 staff survey results and in ongoing engagement sessions. This is currently voiced more by our medical colleagues. Activity and action can be measured as follows:

- ✓ Specific work to address the concerns about psychological safety raised by some of our medical colleagues. This work has been carried out collaboratively with the GMC and has been repeated again during Octobers Speak Up Month. The second event saw a larger number and variation in those attending and also those who did attend demonstrated a greater engagement and support for improving speaking up cultures across their teams.
- ✓ Revised SU Champions Network now allows champions to focus on the elements of the role they are most comfortable with. There has been an increase in the number of champions joining the network and a significant increase in champions' engagement with network sessions and wider training and development required to enhance the role.
- ✓ Increased enhanced training relating to behaviours and relationships in line with the Just Culture work stream and DBTH Way.
- ✓ Monthly Soundbite sessions have been delivered, focussing on the leadership behaviours that increase psychological safety and enable early, open conversations.

- ❖ Although the Trust now has 72 Speak Up Champions (at different stages of readiness) to be active in their own areas, further work is still ongoing with specific divisions to recruit consistently. This continues to be a key focus for the remainder of 2025-2026.

Identifying and tackling barriers to Speaking Up.

- ✓ Work has been introduced to focus on health inequalities to create understanding and connection across our most vulnerable groups. This has been through increased visibility in some areas and through discussions with leaders and mangers to identity who needs support and what support should look like.
- ✓ An increased number of colleagues who have previously experienced barriers have shared their stories of speaking up through FTSU Guardian services, SU Champions and SU Partners. Some have shared their stories wider to increase leadership understanding of the impact of barriers on speaking up. Recognition of this work at the "Be Diversified Event" celebrating bravery and courage.
- ✓ Continued engagement with our internationally trained colleagues, supporting their network with speaking up opportunities, processes, and resources.

- ✓ Completion of targeted training sessions to some of our most needed areas including Estates & Facilities.
- ❖ Further work to increase the number of colleagues who share their protected characteristics when Speaking Up.
- ❖ Further work is required to consider this theme in relation to wider work streams including anti-racism, just culture and wider ED&I.

Education, learning and improvement.

- ✓ Speak Up, Listen Up & Follow Up training has been delivered to leaders and senior managers across the Trust, with good engagement from clinical leads across most divisions. This has also been provided to targeted areas where multiple concerns have been raised and support has been offered to increase skills and confidence, although DNA rates are a concern and create a backlog in class availability.
- ✓ ESR readiness for all Speaking Up Courses from August 2025, which has seen greater number of colleagues engaging with the programme.
- ✓ The following training sessions have been delivered through Q1 and Q2 of 2025-2026:
    - 8 focussed face to face Level 1 sessions (delivered to areas by request of leaders)
    - 3 Speak Up Champions training days
    - 7 Level 3 sessions (Follow up for leaders)
    - 3 Soundbite sessions (Embedding a Culture of Psychological Safety)
- ✓ In additional to levels 1, 2, and 3 the FTSU Guardians have continued to support the corporate welcome events, all vocational training programmes and preceptorship programmes.
- ✓ Speaking Up level 3 training is now embedded into education planning for 2025-2026 and 2026-2027 enabling 30 training sessions to be made available to colleagues across all three sites.
- ✓ Introduction of level 2 training sessions from October 2025, also providing 30 sessions per year.
- ✓ Soundbite sessions to increase knowledge and confidence in relation to responding to concerns and creating a positive speaking up culture have been delivered from April 2025, but further work is required to increase attendance.
- ❖ Improved reports to evidence compliance across all levels of training (including e-learning) will be available from November 2025.

Governance and assurance processes

- ✓ Continued delivery of the Speaking Up feedback process however, further work is required to understand compliance, return rates and how to capture the appropriate information to allow us to respond to cases of suggested detriment.
- ✓ Completion of all but two elements of the DBTH Speaking up Reflection & Planning Tool for 2024. These two actions are still planned and have been delayed due to external impacts.
- ✓ Commissioning of the Speaking Up Peer Review, enabling learning for improvement to be identified.
- ✓ Agreement for Speaking up divisional performance activity to be included in the joint data set used as part of the wider just culture discussions with teams and explored at divisional governance forums.
- ✓ Active participation in learner feedback and escalation processes relating to SLEC and regional and national governance processes.
- ❖ Strengthen the Speaking Up information shared with the Data Triangulation Group, working to identify areas of best practice and those where further support is required.
- ❖ Support the Deep Dive into Bullying & Harassment and Inappropriate Behaviours concerns in line with a structured partnership methodology.

- ❖ Although much engagement has taken place with divisions to explore SU assurance processes, further work is still required to ensure consistency and compliance.
- ❖ Completion of the Speaking Up Peer Review planned for January 2025, now rescheduled for summer 2025 due to the changed availability of the external assessor.
- ❖ Development of the DBTH Detriment process in line with the NGO revised Guidance March 2025, now revised to January 2026.

4. Final note and recommendations

The information in this report is presented to demonstrate the work that has taken place in the first two quarters of 2025-2026 2024-2025 and considers how this compares nationally and against internal performance plans. It specifically identifies success against the strategic plan, particularly in relation to increased awareness, profile and education and training and highlights areas where further work is still needed to embed success in relation to increasing confidence in speaking up and strengthening its governance and assurance processes. It also confirms that this work is still in line with the trajectory of the four year strategic enabling plan. The report acknowledges where timescales have been revised in relation to some key elements of work, and offers robust rationale to support waiting for the outcome of wider cultural work that will influence future direction.

The Board is therefore asked to acknowledge and take assurance from the work that is presented in this Bi-annual report and to provide feedback, to inform strategic direction and service improvement.

Further reading:

National Guardians Office Annual Data Report "Culture is a patient safety issue" - A SUMMARY OF SPEAKING UP TO FREEDOM TO SPEAK UP GUARDIANS – August 2025
https://nationalguardian.org.uk/wp-content/uploads/2025/07/20250702-Annual-data-report-2425-Publishable-2.pdf

National Guardians Office Review of Speaking Up by Overseas Workers – Listening & learning. Amplifying the voices of overseas trained workers - May 2025

https://nationalguardian.org.uk/2025/05/01/review-of-the-speaking-up-experiences-of-overseas-trained-workers-in-england/

National Guardians Office "Requirements for recruiting and embedding FTSU Guardians – A guide for organisations and leaders.

https://nationalguardian.org.uk/wp-content/uploads/2025/05/NGO-recruitment-framework.pdf

Appendices:

Appendix 1 – NHSE Being Fair Tool can be accessed at https://www.england.nhs.uk/wp-content/uploads/2025/05/prn01822-i-being-fair-tool.pdf

A PDF version is also available as part of additional information provided.

Appendix 2 - Speaking Up Data Infographic 2024-2025

A PDF version is available as part of additional information provided.

Being fair tool: Supporting staff following a patient safety incident

This tool should only be used when concerns about an individual's conduct or fitness to practise are raised during a patient safety learning response. It is not for routine use.

Patient safety incidents are usually signs of underlying systemic issues that require wider system-level action. Action singling out an individual is rarely appropriate.

By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

However, in rare circumstances a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances that the being fair decision-making tool can help you decide what next steps to take.

Where criminal activity is suspected to have contributed to death or serious life-changing harm, you should refer the healthcare incident to the police and be guided by the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies.

Before using the tool, consider the following questions (Sidney Dekker, 2022):

- Who is hurt? (for example, staff, patients, family, public)
- What do they need? (for example, wellbeing support, information on what happened)
- Whose responsibility is it to meet that need? (for example, occupational health,patient safety team)

Preconditions of use	
Do the concerns raised relate to a patient safety incident?	If **no** – **do not use this tool**. This tool is designed to help decide next steps in relation to patient safety incidents. Other processes should be followed for: • **safeguarding concerns** – follow your organisation's safeguarding policies • healthcare incidents where **criminal activity is suspected** to have contributed to death or serious life-changing harm – refer to the police and use the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies
Has a patient safety learning response that takes a systems-based approach been started or completed?	If **no – do not use this tool**. Healthcare is complex, characterised by multiple interactions between different human and technological factors. A systems-based approach looks at their interplay to understand the wider system issues, not the actions of individuals. **Only use this tool if a learning response begins to raise concerns about an individual's actions.**
Will the tool be used jointly by a member of the patient safety team and the workforce team?	If **no** – **do not use this tool**. This tool is designed to combine systems thinking and safety science expertise relevant to the patient safety incident alongside workforce expertise in supporting staff

Questions	**Action to take**
Q1 Substitution test – to ensure wider system issues have been fully considered	
1a. Does the learning response indicate that staff in the same peer group as the individual involved and with comparable experience and qualifications would have acted in the same way in similar circumstances?	**If yes**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If no or unsure, continue by asking the further substitution test questions

1b. Was the individual included when their peer group received relevant training? **1c Have you considered the experience and background of the individual (including differences in training practices between organisations or internationally and cultural differences)?** **1d. Was supervision in line with expected practice?**	**If no to any,** or the answer is unknown, discuss with the individual's supervisor or education lead. Continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q2 Foresight test – **to ensure wider system issues have been fully considered**

2a. Does the learning response identify any agreed protocols or accepted practices that apply to the individual's action or omission in question? **2b. Does the learning response find these protocols to be workable and reflective of accepted practice?**	If **no to any**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q3 Deliberate harm test

Q3. Based on what is known, is there any suggestion of recklessness, wilful neglect or an intention to cause harm?	**If yes,** follow organisational guidance for appropriate action, including contacting any relevant external organisations: for example, professional regulatory bodies, the police or, if statutory safeguarding processes need to be adhered to, the relevant lead – that is, person in position of trust (PIPOT) for adult abuse and local authority designated officer (LADO) for child abuse.

If no, continue to Q4 Health test

4a Based on what is known, is there any indication of substance use by the individual (for example, drugs or alcohol)? **4b. Based on what is known, is there any indication of physical or mental ill health that may have affected the individual's actions?**	**If yes to either,** follow organisational guidance for health issues affecting work.

If no to both, continue to Q5 Mitigating circumstances

Q5. Does the learning response or other information identify any significant mitigating circumstances for the individual's actions?	**If yes,** action directed at the individual may not be appropriate. Follow organisational guidance for appropriate action.

If no, follow organisational guidance for appropriate management. This could include remediation,supervision, additional training or disciplinary action.

If required, revisit the tool as further information from the learning response becomes available.

This is a continuous process with restorative just culture principles maintained throughout.

DBTH Speaking Up

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

A summary of data from Q1 and Q2 2025-26

Number of cases brought to FTSU guardians in Q1 and Q2:

47 individuals (41 cases)

Cases grouped by profession level:

Allied Health Professionals	2.1%
Medical and Dental	14.9%
Commissioning	2.1%
Registered Nurses and Midwives	38.3%
Administration, Clerical	21.3%
Additional Clinical Services	4.3%
Estates & Ancillary	10.6%
Not known	6.4%

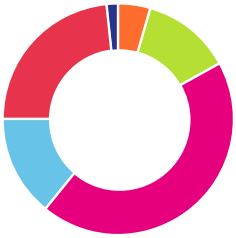
Themes of concerns

Number of people who raised concerns about...

Raised their concerns anonymously	3
Patient safety/quality	8
Worker safety or wellbeing	28
Bullying or harassment	9
Inappropriate behaviour	15
Disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment')	1

Internal data capture identified the following additional themes:

Fairness	4
Relationships	4
Systems and processes	11
Leadership	11



Summary of learning

- Less people have spoken up collectively in groups or teams across both quarters, which has impacted slightly on the number of people speaking up overall.
- The number of Bullying & Harassment cases has reduced across the two quarters but the number of inappropriate behaviours cases has increased.
- Worker wellbeing continues to be raised as a key impact of team cultures, leadership, systems and processes and inappropriate behaviours.
- The number of themes continues to reflect higher than the total number of reports due to colleagues highlighting more than one theme when they speak up.

Receiving feedback

Of those asked: 'Given your experience, would you speak up again?'

Total number of responses = 16

16 responded 'Yes'

Common themes from feedback

Numerous colleagues felt that the Guardian service was very easy to access, however one response suggested further promotion at local level, with more visibility would be good.

15 respondents felt their concerns had been or were being addressed, whilst one colleague felt this was not the case.

100% of these providing feedback felt the service was very supportive, even when difficult conversations needed to take place.

Some colleagues fed back that long time periods did not help the impact on personal wellbeing.

100% of those providing feedback felt that confidentiality had been maintained throughout the process.

LUNCH 12:15 - 12:45

2511 - D PARTNERSHIP

2511 - D1 DONCASTER & BASSETLAW HEALTHCARE SERVICES UPDATE

Discussion Item | Sam Wilde, Chief Finance Officer | 12:45

5 minutes

REFERENCES

Only PDFs are attached

- D1 - Doncaster and Bassetlaw Healthcare Services Ltd Update.pdf
- D1 - Appendix 1 - NHSE Correspondence Change in National Policy regarding subsidiaries.pdf

Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Doncaster and Bassetlaw Healthcare Services Ltd Update**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Mark Olliver, Managing Director - Doncaster and Bassetlaw Healthcare Services Ltd			
Appendices:	Appendix 1 – Letter from Glen Burley, NHS England			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 4			

Executive Summary – Key messages and Issues

This paper provides the Trust Board with an update on the business performance of its Wholly Owned Subsidiary (WOS) Doncaster and Bassetlaw Healthcare Services Ltd at the end of the first half of 2025/26. Financially, the business continues to track strongly, with profit levels exceeding budget significantly.

Recent instruction from HMRC and NHS England outlines potential regulatory changes that could impact on business activity. The board are asked to note these changes and comments relating to future business activity.

Attached with the paper (Appendix 1) is the letter received from NHS England, which is to be discussed with board members of Doncaster and Bassetlaw Healthcare Services at the next board meeting.

Recommendations

Board Members are asked to NOTE and TAKE ASSURANCE from the contents of this report

Healthier together – delivering exceptional care for all

Patients	
People	
Partnerships	Wholly owned subsidiaries are an organisational and governance form that NHS providers can legally adopt to manage part of their organisation. Subsidiaries can deliver many benefits to the NHS, offering an alternative to outsourcing services to the private sector. Successful businesses can allow Trusts to reinvest savings back into the NHS to improve patient care, income which would otherwise transfer into the private sector. Doncaster and Bassetlaw Healthcare Services Ltd (the subsidiary) was incorporated in October 2019. The business continues to perform favourably and, as a result, has been in a position to provide routine regular dividend patients to Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (the parent).
Pounds	
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	

<table>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td></td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td></td></tr>
<tr><td>Is this in line with Current risk appetite

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

This briefing document aims to provide the Trust Board with an update on the performance of Doncaster and Bassetlaw Healthcare Services Ltd during the first half of 2025/26.

The paper presents current financial business performance and also introduces some wider Key Performance Indicator (KPI) measures as requested by the Board, which will be included within future papers. Further business KPIs may be introduced in due course.

The document also includes information relating to potential VAT regulation changes. These potential changes are expected to have minimal impact on existing activities but will be taken account of in planning future developments. However, the business risk register will be updated to mitigate any changes quickly and effectively.

The strategic pillars remain the same and the business seeks to exploit commercial opportunities, by offering more cost effective and patient centric services when compared to those being supplied by existing private partners.

Financial Performance

Table 1: Year to date trading performance for Doncaster and Bassetlaw Healthcare Services Ltd

September 2025 (£k)	**Actual (£000)**	**Budget (£000)**	**Better/(Worse) (£000)**	**Budget for the year (£000)**
Turnover	**5,975**	**6,061**	**(86)**	12,123
Cost of Sales	(5,447)	(5,572)	**125**	(11,144)
Gross Profit	**528**	**486**	**39**	**978**
Gross Margin %	***8.9%***	***8.0%***	***0.9%***	***8.1%***
Admin Expenses	(398)	(443)	45	(886)
Profit before tax	**136**	**43**	**84**	**92**
Tax	(25)	(11)	(14)	(23)
Profit after tax	**102**	**32**	**70**	**69**

The Board are asked to note the following:

The year-to-date performance has delivered a pre-tax profit of £136k, against a budget of £43k, which is a favourable performance year to date of £84k.

The year-to-date gross profit margin is 8.9%, which is ahead of budget for both the half and fall year.

The business continues to demonstrate strong financial grip and control, with costs falling below budget levels set. Non-pay expenses continue to be managed efficiently and appropriately.

Table 2: Assets and Liabilities Register

Assets	
Stock	803k
Trade Receivables	1,026k
Accrued income/prepayments	950k
VAT Receivables	733k
Cash	312k
Total	**3,824**
Liabilities	
Trade creditors	1,105k
Accruals/Deferred income	1,201k
Intercompany	402k
Corporation Tax payable	156k
Total	**2,864k**
Net Assets	**960k**
Share Capital	550k
I&E Reserve	410k
Total	**960k**

The balance sheet above evidences good financial stability, with the Income and Expenditure reserve position of £410k sitting well above the minimum threshold level of £100k.

Key Performance Indicators KPIs

The business has developed a wider suite of key performance indicators and these have been highlighted below. The targets set have been pressure tested accordingly and they correlate and align with market assumptions and expectations. The table below outlines KPIs for pharmacy service performance, as a function of dispensing efficiency.

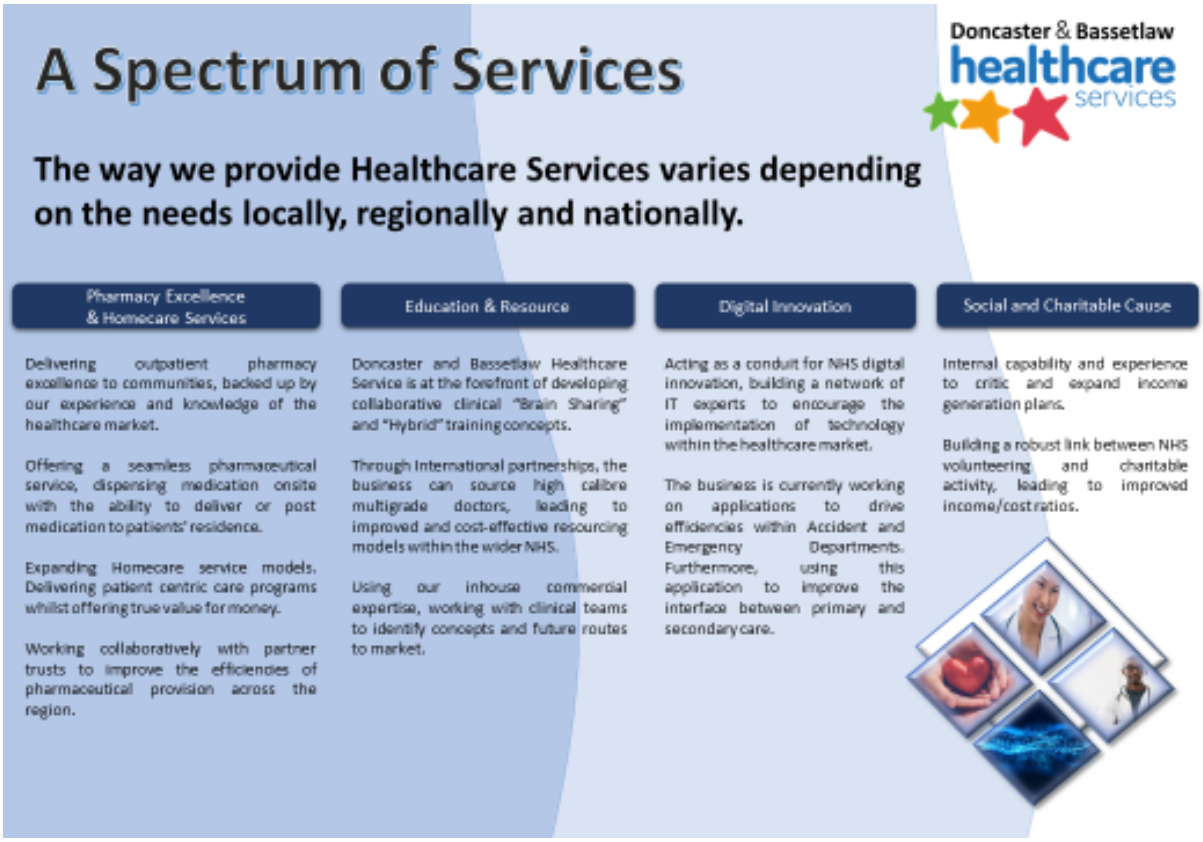
KPI Summary	Waiting time < 15 minutes	Waiting time < 10 minutes	Requested drugs not available %	Dispensing incidents
Target	**95.0%**	**75.0%**	**<1.50%**	**< 0.02%**
Jul-25	**96.7%**	**77.8%**	**1.18%**	**0.00%**
Aug-25	**97.2%**	**79.4%**	**1.36%**	**0.00%**

Two further annual KPIs have also been set, namely an annual Professional Standards Audit PSA (85%) and an annual Customer Satisfaction Survey (80%). These are currently being undertaken and will be reported to Board in future updates. The Customer Satisfaction Survey aligns to processes adopted within the community pharmacy setting.

The business continues to explore other ways to measure performance and success. Other areas of focus include Mystery Shopper activity and ways to gain constructive feedback from collaborative partners.

Strategic Plan 2023-26

The board are asked to note the following strategic aims of the business



Pharmacy excellence and Homecare Services

The outpatient pharmacy continues to perform strongly, with current numbers currently trending at 17% growth year on year. This growth is considerably greater than comparable market performance.

The board are asked to note that the imminent arrival of e-prescribing (across the NHS) will present the business with both opportunity and threat. Such systems provide patients with the ability to send prescriptions electronically to their pharmacy destination of choice. The Senior Leadership Team (SLT) are currently discussing operational implications with the Trust IT/Pharmacy teams and the business risk register will be reviewed accordingly, to mitigate all risks highlighted

In terms of Homecare services, the business is keen to explore further homecare options and requires Trust guidance and collaboration on this matter. At present the business is set up to support simple homecare service provision. However, future service(s) could adopt higher complexity and the business would increase capability accordingly. This process could require consideration into CQC registration along with the appropriate and required operational structural changes.

To expand on the existing pharmaceutical provision, the business is exploring the development of a 'Doctor Online' service, offering private consultations and the subsequent supply of medicines. This commercial opportunity could be quite lucrative, working in partnership with our local doctors. The opportunity will be explored in full, prior to any decisions being made.

Resourcing

The business continues to work with the Trust, to identify future opportunities that align to the resourcing requirements of the Trust. The remaining QIMET candidates, on the initial emergency medicine programme, have been interviewed and are due to commence employment shortly.

Current discussions are taking place with other specialities, to explore resourcing opportunities across the medium and long term. A number of delegates have just attended the annual conference in Nepal, including one of the Trusts' Divisional Directors. The team are currently exploring opportunities within gastroenterology and anaesthesia.

Expansion and Innovation

The business continues to explore all options for expansion and growth, working closely and collaboratively with the Trust to deliver improved service productivity and associated financial return.

Current conversations are focused on services pertaining to audiology, medical device sponsorship and medical imaging. These opportunities involve much complexity, centralising on potential LLP partnerships between multiple parties and associated tax intricacies. As a result, the business has continued to commission expertise and support from legal advisors.

One area of investigation relates to the establishment of a Limited Liability Partnership (LLP), focused on delivering out of hours radiology services. Such a model could offer an improved solution by providing a more cost-effective and incentivised operation (when compared to the existing arrangement). All potential commercial opportunities are being scrutinised in detail.

Regulatory and National Policy Changes – Updated Guidance

VAT Regime

HM Treasury has consulted on reforms to VAT refund rules under section 41 of the UK VAT Act 1994. It is believed, from conversations with representatives at Liaison Financial (the Trusts VAT advisors), that the Treasury seeks a preferred option of introducing a Full Refund Model.

At present, NHS Bodies report VAT under Section 41. This is sometimes referred to as 'Contracted Out Services' (COS). This is a complicated VAT regime that has evolved since it came into effect in the early 1990s. In its simplest form, it means the Trust can only reclaim VAT on services that it cannot do itself and cannot reclaim VAT on goods. Existing arrangements allow the subsidiary to dispense NHS drugs that are supplied by the Trust, and to reclaim the VAT back on the drug value accordingly.

Financial experts believe that Section 41 will be replaced by a "private sector" VAT regime that is much simpler for all organisations. The Trust has participated in a data collection exercise, collating information from 2023-24 and 2024/25. The data request has involved all government departments and NHSE are leading on the consolidation of data from all NHS bodies. Changes to VAT regulation would mean that both the Trust and subsidiary would have an equal standing, in terms of VAT reclaim.

However, the Trusts subsidiary business model has never prioritised VAT saving as a focus for strategic direction, which links in with the guidance from NHS England. Any proposed HMRC changes would not have an adverse financial impact on either the Trust or subsidiary, in terms of current or future business arrangements between both parties.

Subsidiary Resourcing

The Trust has received formal correspondence from Glen Burley, Financial Reset and Accountability Director NHS England and this has been included as appendix 1, for board perusal and consideration.

The letter signals tightening restrictions on the movement of current NHS employees into subsidiary activity. The subsidiary board will review and discuss all implications and subsequent business impact as appropriate.

The Trust Board should note that, from an operational perspective, Doncaster and Bassetlaw Healthcare Services has always focused on providing alternative healthcare solutions in competition with existing private healthcare providers. The current strategic pillars can continue to focus on expansion and growth and this new information does not impact on the current business model. A number of discussions are taking place and this new information doesn't necessarily effect this process.

Conclusion

Business financial performance continues to deliver strongly against budget and this is expected to continue throughout 2025-26.

Any suggested changes to VAT regulations will not have a detrimental effect on business performance and restrictions on employee transfer will also have limited operational impact on existing activities.

The business needs to continue to focus on providing alternative healthcare solutions across the NHS and beyond, acting as a disruptor and competitor to private healthcare businesses by offering complete healthcare solutions at highly competitive price points.

To:
- NHS foundation trust and trust:
  - chief executives
  - chairs
  - finance directors

cc.
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 September 2025

Dear colleagues

I want to update you on an important change in national policy regarding subsidiaries.

Over the past year, concerns have been raised about subsidiary models that involve transferring NHS staff into new organisations. Unions, particularly Unison, have been clear that this risks undermining the principle of a single NHS workforce and creates unnecessary anxiety for staff. We have listened carefully to those concerns and the Secretary of State has been clear that we must take action.

We therefore intend to change national guidance to confirm that new subsidiaries involving the transfer of NHS staff will now only be approved in a limited number of circumstances, and only where there is clear union support and protection of NHS terms and conditions, including pension access.

This is about shaping the future of the NHS workforce, ensuring fairness, and giving staff and their representatives confidence that their voice matters in decisions of this kind. It is also about providing clarity and consistency for trusts as they navigate challenging financial and operational pressures.

We will shortly consult on these changes. We want to work with you, with staff and with unions to agree the proposed changes and the detail of how this will work in practice. It is also about ensuring we strike the right balance between protecting staff and preserving the freedoms of foundation trusts to innovate in ways that strengthen, rather than fragment, the NHS.

Proposals involving the transfer of NHS staff currently under review will be paused with immediate effect while we undertake this consultation, unless they are supported by local unions.

Thank you as ever for your leadership and for working with us to make these changes a success.

Yours sincerely

Glen Burley
Financial Reset and Accountability Director
NHS England

2511 - E ASSURANCE & GOVERNANCE

12:50

2511 - E1 INTEGRATED QUALITY & PERFORMANCE REPORT

Discussion Item | Executive Directors | 12:50

20 minutes

REFERENCES

Only PDFs are attached

- E1 - Integrated Quality & Performance Report.pdf
- E1 - Appendix IQPR - September 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Integrated Quality & Performance Report**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Karen Jessop, Chief Nurse Zoe Lintin, Chief People Officer Dr N Mallaband, Acting Executive Medical Director Sam Wilde, Chief Financial Officer Denise Smith, Chief Operating Officer			
Appendices:	IQPR - September 2025			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			

Executive Summary – Key messages and Issues

Access

- Of 10 metrics. 3 were met for September 2025, 7 did not meet target.
- ED performance is off trajectory, along with Referral to Treatment (RTT) waiting time and performance to cancer standards
- 52 week wait performance is on trajectory, along with RTT wait to first appointment.

Quality

- Of 26 metrics, 8 were met for September 2025, 18 did not meet target.
- A recent mortality deep dive reviewed the mortality improvement work undertaken since 2023 and its impact. Improvements made across all areas, including clinical coding, sepsis, structured judgement reviews highlighting good care and mortality governance. This is reflected in the Trust's mortality rate returning within expected range.
- A plan is in place with Sheffield Children's Hospital for training and competency assessment of paediatric audiologists. Waiting list management ongoing with children assessed for priority, additional diagnostic capacity in-sourced for those waiting diagnostic. Close working with the national Elective Care Improvement Support Team on capacity and demand modelling, with an improvement trajectory for achieving waiting time standard for diagnostics.

People

- Of 7 metrics, 5 were off track in September 2025
- Work continues on job planning and appraisal performance, which is now above target.

Finance

- Of 10 metrics, 4 were met for September 2025

Recommendations

The Board is asked to receive the report for assurance.

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

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

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

September 2025

We care

Contents

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What is an SPC chart

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

Recalculations

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

Baselines

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

Summary icons

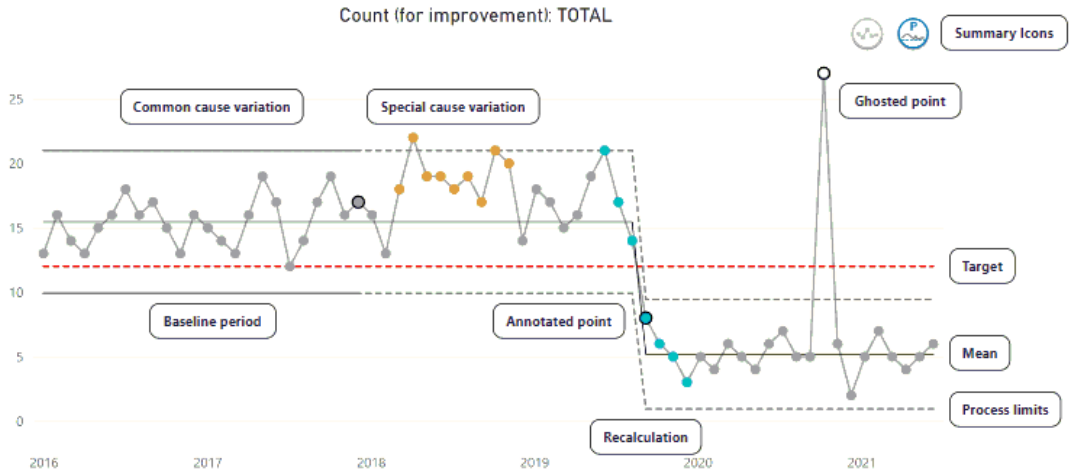
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

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

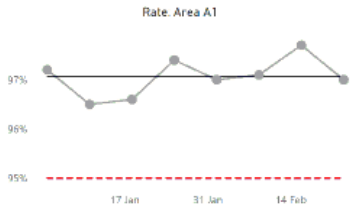
Annotations

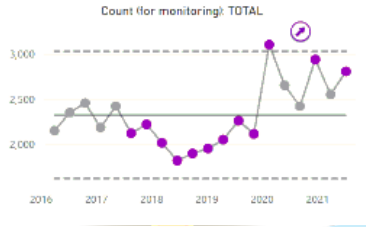
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



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

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





Icon descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (none)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(none)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
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↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
(none)				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

At a glance

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

Metric notes

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

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

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

Key performance indicators - Access

Metric	Standard 25/26	Latest month reported	Annual plan	Actual	Variance	Assurance Status	Variation Status
4 hour ED	78%	Sep-25	75.7%	69.8%	-5.9%	F	
12 hours in department	No more than 2%	Sep-25	3.4%	3.8%	0.4%	?	L
Ambulance handovers - 15 minutes	65%	Sep-25		59.4%		F	H
Ambulance handovers - 30 minutes	95%	Sep-25		91.0%		F	H
Ambulance handovers - 45 minutes	0%	Sep-25		2.6%		F	L
Ambulance handovers - 60 minutes	0%	Sep-25		1.1%		?	L
Average ambulance handover times	-	Sep-25	00:21:39	00:16:39	00:04:00	?	L
Mixed Sex Accommodation - nationally reported breaches in month	0	Sep-25		0		?	L
Diagnostic waiting times* Note this doesn't include RIS data	95%	Sep-25	54.0%	50.6%	-3.4%		
% patients waiting less than 18 weeks from referral to treatment*	65.8%	Sep-25	62.4%	61.2%	-1.2%	F	H
RTT % waits over 52 weeks for incomplete pathways *	< 1%	Sep-25	3.1%	2.7%	-0.4%	F	H
Percentage of patients waiting no longer than 18 weeks for a first appointment *	71.50%	Sep-25	68.9%	72.8%	3.9%	F	H
Cancelled Operations Not Rebooked within 28 Days	0	Sep-25		5		?	
28 day Faster Diagnosis Standard	80%	Aug-25	81.5%	76.4%	-5.1%	?	
31 day combined	96%	Aug-25	96.0%	95.5%	-0.5%	?	
62 day combined	75%	Aug-25	73.7%	65.0%	-8.7%	?	

Key performance indicators - Quality

					Current month			Year to date				
Section	Metric	Standard 25/26	Source & Description	Latest month reported	Local trajectory	Actual	Variance	Local trajectory	Actual	Variance	Assurance Status	Variation Status
Mortality	SHMI (12 month Rolling)	<100	NHS Digital - SHMI reports on mortality at trust level across the NHS in England using a standard and transparent	Jun-25	100	114.6	14.6	100	114.6	14.6	F	H
Mortality	SHMI (Monthly)	<100	NHS Digital - SHMI reports on mortality at trust level across the NHS in England using a standard and transparent	Jun-25	100	120.6	20.6	100	120.6	20.6	?	
IPC	Hospital Acquired MRSA (Colonisation) Cases Reported in Month	14	NHS Standard Contract 2025/26	Sep-25	1	1	0	6	13	7	?	
IPC	Hospital Acquired MRSA (Bacteraemia) Cases Reported in month	0	NHS Standard Contract 2025/26	Sep-25	0	1	1.0	0	1	1.0	?	
IPC	Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month	64	NHS Standard Contract 2025/26	Sep-25	5	7	2	29	42	13	?	
IPC	Number of Community Onset Healthcare associated (COHA) C.Diff cases in month		NHS Standard Contract 2025/26								P	
IPC	Hospital Acquired Pressure Ulcers (HAPU) Cat 4		Local Trust trajectory only	Sep-25	0	0	0	0	1	1.0	?	
IPC	e.coli	94	NHS Standard Contract 2025/26	Sep-25	7	8	1	47	50	3	?	
IPC	MSSA	0	NHS Standard Contract 2025/26	Sep-25	4	8	4	15	36	21	?	
IPC	Klebsiella	33	NHS Standard Contract 2025/26	Sep-25	3	4	1	15	17	2	?	
IPC	Pseudomonas	17	NHS Standard Contract 2025/26	Sep-25	1	2	1	8	11	3	?	
Falls	Severe harm falls	0	Local Trust trajectory only	Sep-25	0	0	0	0	9	9.0		
Complaints	Number of Complaints Received in Month		Local Trust trajectory only	Sep-25	0	109	109.0	0	405	405.0		
Claims	Claims CNST (patients) - new in month		Local Trust trajectory only	Sep-25	0	8	8.0	0	45	45.0		
Claims	Claims LTPS - (staff) new in month		Local Trust trajectory only	Sep-25	0	1	1.0	0	3	3.0		
FFT	Friends & Family Positive Response Score - Trust		NHS Standard Contract 2025/26	Sep-25	95%	87.9%	-7.1%	95%	88.4%	-6.6%	F	H

Key performance indicators - Quality

					Current month			Year to date				
Section	Metric	Standard 25/26	Source & Description	Latest month reported	Local trajectory	Actual	Variance	Local trajectory	Actual	Variance	Assurance Status	Variation Status
Audit & Effectiveness	% Over 18 in-hospital deaths scrutinised by Medical Examiner Team	100%	National Medical Examiner Standard	Sep-25	100%	100.0%	0.0%	100%	100.0%	0.0%		
Audit & Effectiveness	VTE - % of patients having a VTE Risk Assessment	95%	NICE guidance	Sep-25	95%	97.0%	2.0%	95%	97.1%	2.1%		
Nice Guidance	NICE Guidance Response Rate Compliance	90%	Mandated by NICE - within clinical audit programme of work	Sep-25	90%	98.5%	8.5%	90%	97.7%	7.7%		
Nice Guidance	NICE Guidance % Non & Partial Compliance (For Monitoring Only)	10%	Mandated by NICE - within clinical audit programme of work	Sep-25	10%	9.0%	-1.0%	10%	8.7%	-1.3%		
CHPPD	Planned Vs Actual CHPPD RM	90%	Local DBTH target	Sep-25	90%	85.6%	-4.4%	90%	87.0%	-3.0%		
CHPPD	Planned Vs Actual CHPPD RN	90%	Local DBTH target	Sep-25	90%	98.0%	8.0%	90%	98.8%	8.8%		
CHPPD	Planned Vs Actual CHPPD Total	90%	Local DBTH target	Sep-25	90%	96.8%	6.8%	90%	97.6%	7.6%		
Sepsis	Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of	90%	NICE guidance	Sep-25	90%	46.9%	-43.1%	90.0%	47.6%	-42.4%		
Sepsis	Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	90%	NICE guidance	Sep-25	90%	43.1%	-46.9%	90.0%	56.7%	-33.3%		
Patient Safety	Never Events - Reported in month	0	NHS Standard Contract 2025/26	Sep-25	0	1	1.0	0	2	2.0		
Patient Safety	PSIIs reported in month		Local trajectory only	Sep-25	0	1	1.0	0	5	5.0		

Key performance indicators - Finance

Metric	Standard/threshold 24/25	Latest month reported	Current month				Year to date (YTD)			
			Plan £'000	Actual £'000	Variance £'000		Plan £'000	Actual £'000	Variance £'000	
YTD distance from financial plan I&E	No variance to plan	Sep-25	(2,880)	(2,890)	(10)	F	(1,169)	(1,182)	(13)	F
ERF position	Month 11 FOT 2024-25	Sep-25	11,063	11,193	130	F	60,926	62,752	1,825	F
CIP delivery -vs Plan	No variance to plan	Sep-25	3,343	3,355	13	A	16,182	16,182	(0)	F
Total pay spend against plan		Sep-25	34,038	33,823	(215)	F	205,183	210,890	5,707	A
Reduction in Additional sessions	24/25 spend - 40% reduction	Sep-25	774	1,232	458	A	4,645	8,891	4,247	A
Reduction in Bank pay	24/25 spend - 10% reduction	Sep-25	1,346	1,338	(8)	F	8,077	8,350	274	A
Reduction in Agency pay	24/25 spend - 40% reduction	Sep-25	671	894	223	A	4,027	6,377	2,350	A
Capital position YTD versus plan	No variance to plan	Sep-25	1,896	2,632	736	A	21,210	6,465	(14,745)	F
Cash balance	No variance to plan	Sep-25	15,815	15,703	(112)	A	15,815	15,703	(112)	A
Payment policy (BPPC metrics)	To pay 95% of invoices by the due date	Sep-25	95.0%	80.0%	-15.0%	A	95.0%	77.6%	-17.4%	A

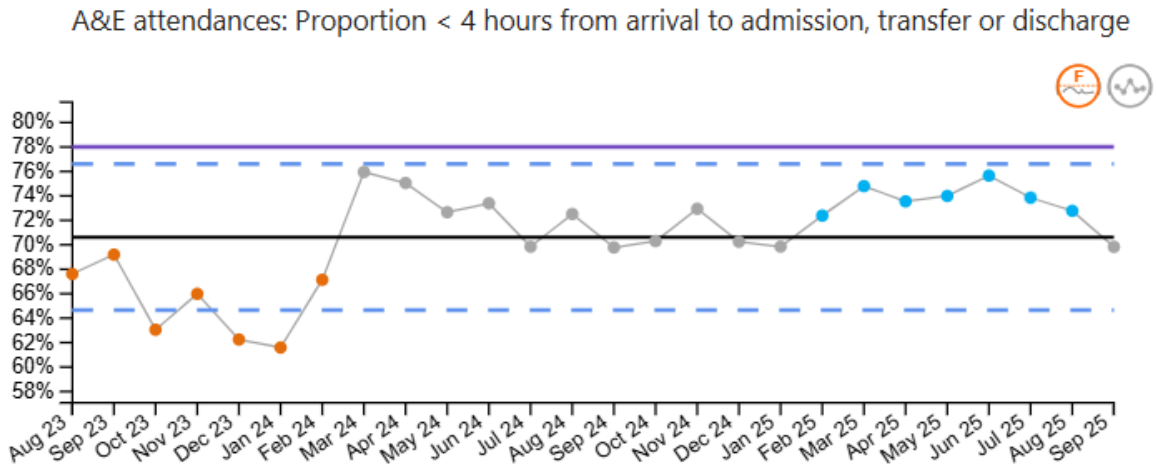
Key performance indicators - People

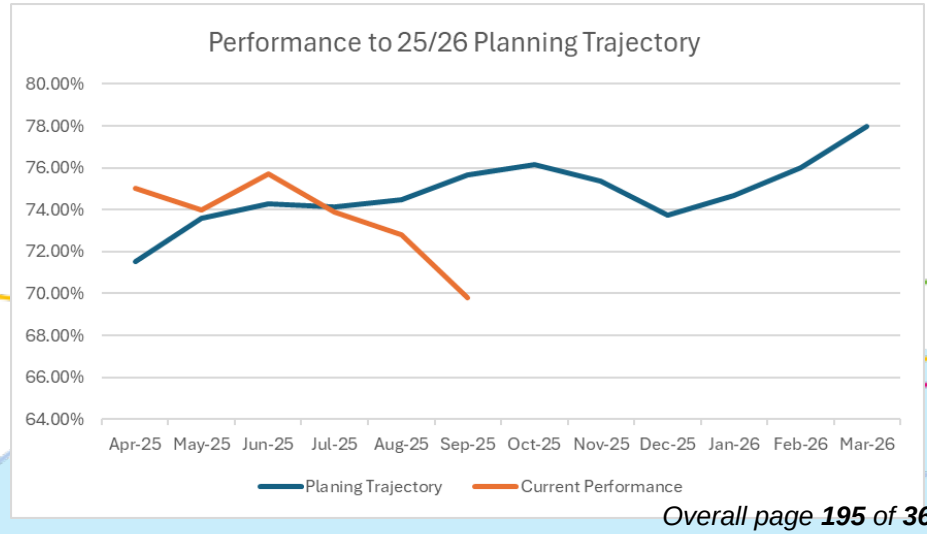
				Current month			Year to date				
Metric	Standard 25/26	Source & Description	Latest month reported	Local trajectory	Actual	Variance	Local trajectory	Actual	Variance	Assurance Status	Variation Status
Consultants with Signed Off Job Plans in EJP	95%	NHS England	Sep-25	90.0%	79.0%	-11.0%	90.0%	76.4%	-13.6%	F	H
Employee Turnover	10%	NHS Long Term workforce plan	Sep-25	10.0%	9.3%	-0.7%	10.0%	9.3%	-0.7%	F	
Overall Sickness Absence	5%	DBTH Trust agreed	Sep-25	5.0%	5.6%	0.6%	5.0%	5.6%	0.6%	F	
Time to hire (from TRAC authorisation - unconditional offer) A4C posts only	47 days	DBTH Trust agreed through review of National Benchmarking	Sep-25	47	72.2	25.2	47	72.2	25.2	?	
Completed SET Training	90%	DBTH Trust agreed	Sep-25	90.0%	87.8%	-2.2%	90.0%	89.7%	-0.3%	?	
Completed Appraisals	90% end July	DBTH Trust agreed	Sep-25	90.0%	92.5%	2.5%	90.0%	92.5%	2.5%	?	
Medical Appraisals completed	90%	NHS England	Aug-25	90.0%	83.0%	-7.0%	90.0%	83.0%	-7.0%	P	H

Assurance report

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

Summary of challenges & risks	In September 2025, 69.8% of patients were in the Emergency Department < 4 hours from arrival, against the trajectory of 75.7%. Common cause variation, **NO SIGNIFICANT CHANGE.** This process is not capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Emergency Department attendances were above plan in September, with 17,953 patients attending, against the plan of 17,742 which is a increase of 1.19% against plan. Actions to address the underperformance include: • Joint working with UTC to create a new front door model (implementation during Q3) • Improving the proportion of patients seen by a senior decision maker within 60 minutes of arrival • Improving non-admitted performance, with appropriate allocation of medical staff to these patients, particularly during peaks in demand • Daily review of breaches occurring between 4-5 hours to identify key themes for improvement
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

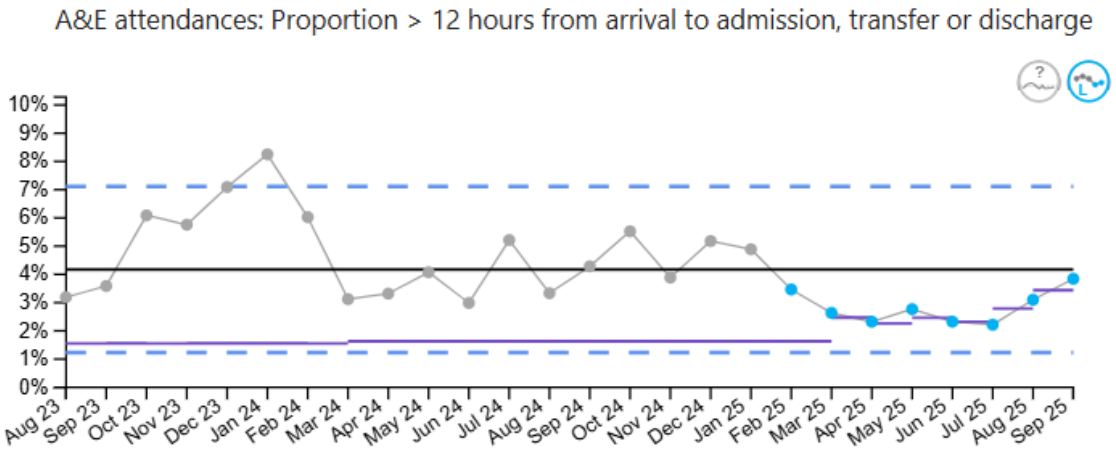


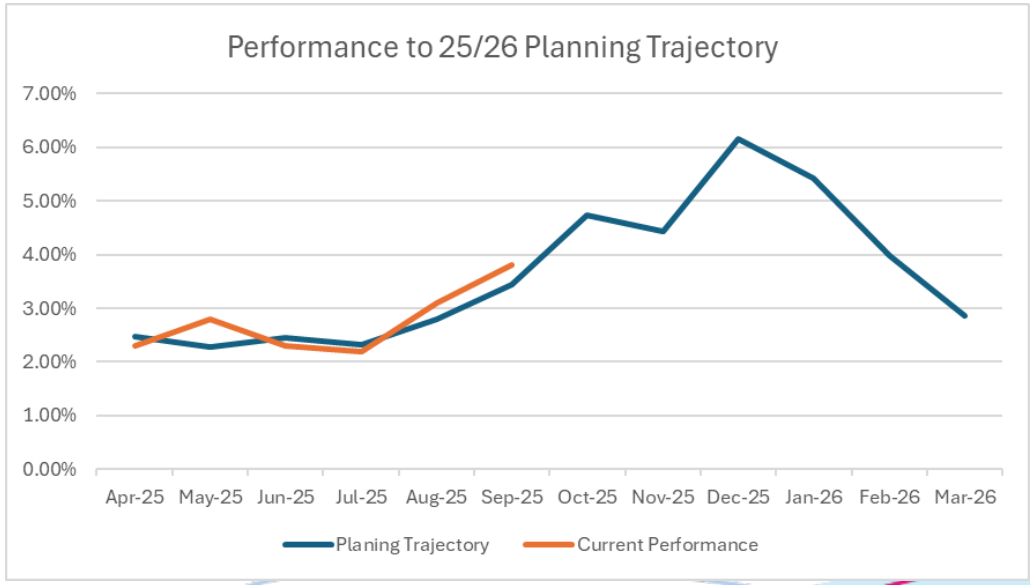


Assurance report

Proportion of patients in ED > 12 hours from arrival

Summary of challenges & risks	In September 2025, 3.8% of patients were in the Emergency Department > 12 hours from arrival, against the trajectory of 3.4% Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Increase of 0.74% in September compared to previous month. Key actions to improve performance • Maximising streaming to the primary care front door services at Bassetlaw and Doncaster • Improving the proportion of patients seen by a senior decision maker within 60 minutes of arrival • Monitoring the use 'Next Patient' SOP to maintain flow out of the Emergency Department to inpatient beds and to maximise utilisation of the discharge lounge.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care

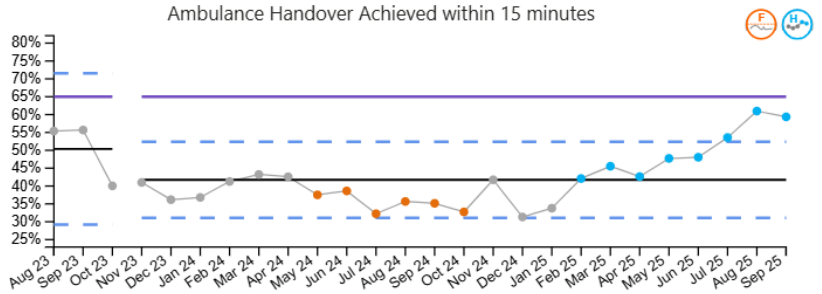


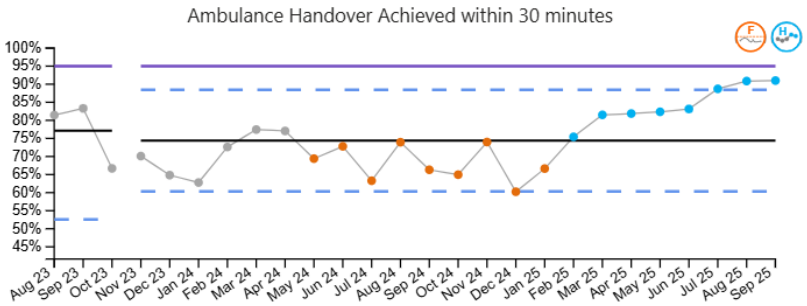


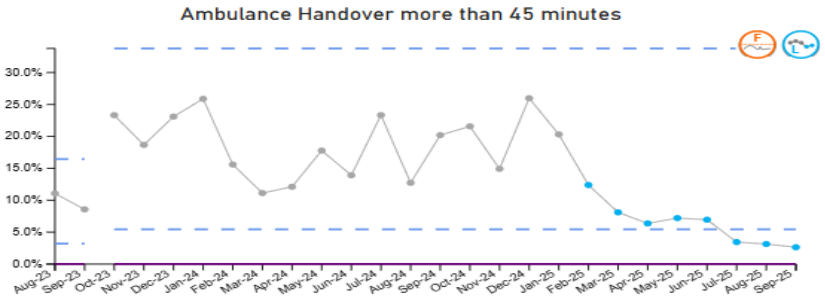
Assurance report

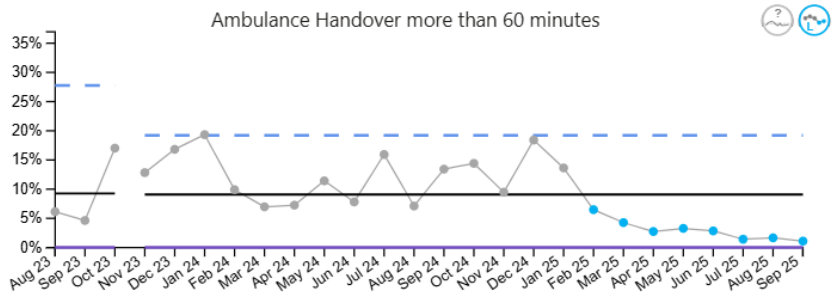
Ambulance handovers within 15 / 30 / 60 minutes

Summary of challenges & risks	In September 2025, 59.4% of ambulance handovers took place within 15 minutes against the standard of 65%, 91.0% took place within 30 minutes against the standard of 95%, and 98.9% took place within 60 minutes against the standard of 100%. 97.4% were within 45 minutes. **Ambulance Handover 15 and 30 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This process is not capable and will consistently **FALL BELOW** the target if nothing changes. **Ambulance Handover 45 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER.** This process is not capable and will consistently **FALL BELOW** the target if nothing changes. **Ambulance Handover 60 minutes** Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER.** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits. Re-basing has taken place in October 2023 as the volume of ambulance arrivals increased
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sustained improvement has been seen across all metrics. A joint improvement plan is in place with YAS to eliminate handover waits > 45 minutes from July 2025 at Doncaster, this will then be rolled out to Bassetlaw in November, in conjunction with EMAS.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3437 Timely access to emergency care





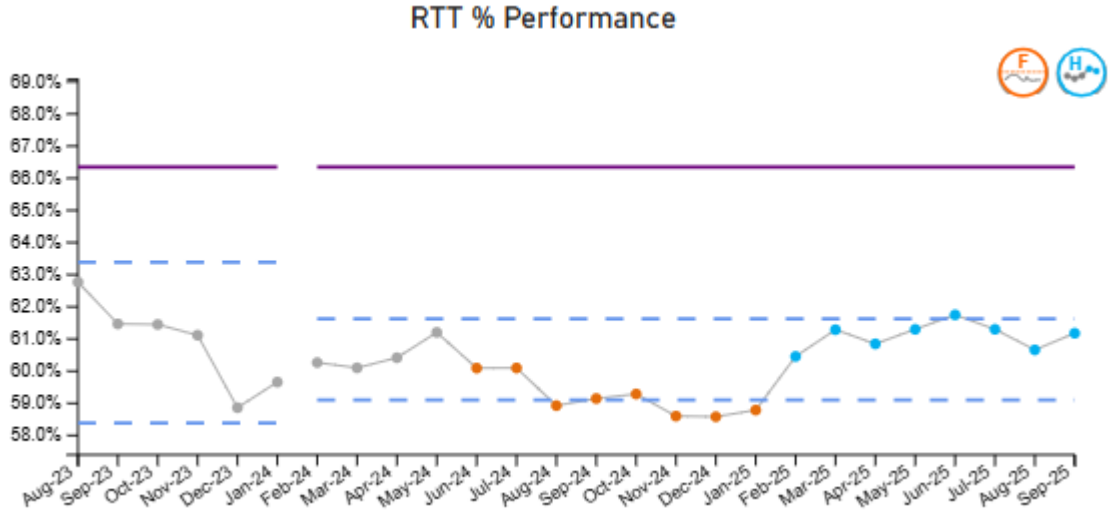


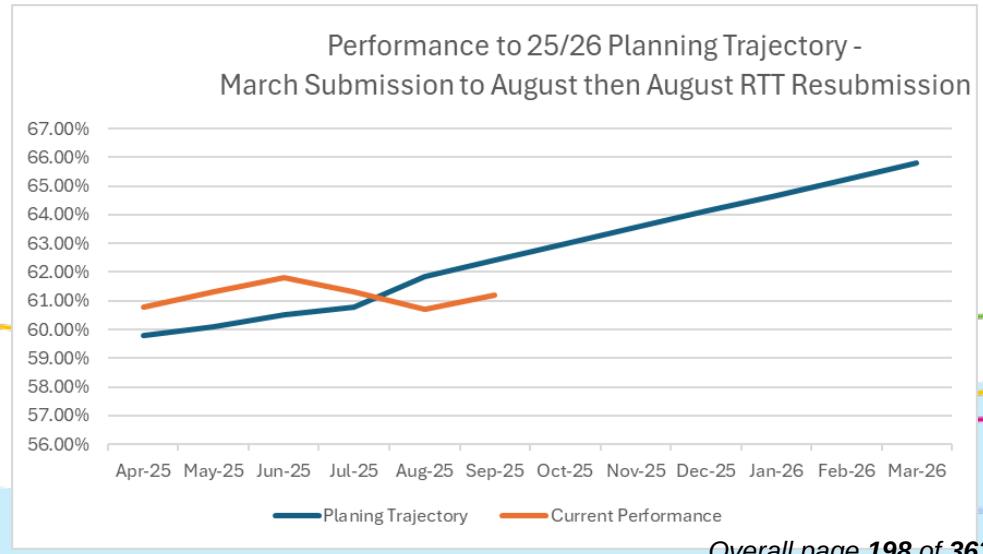


Assurance report

Proportion of patients waiting > 18 weeks from referral to treatment

Summary of challenges & risks	In September 2025, 61.2% of patients were waiting < 18 weeks from referral to treatment, against the planning trajectory of 62.4% Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This process is not capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• The Elective Care Improvement Support Team is supporting the Trust with demand and capacity modelling for T&O and ENT. This will be rolled out across all and will support with the development of improvement plans to reduce the number and proportion of long waiting patients. • Additional outpatient capacity in Urology and Endocrinology in place to increase capacity • Job plan reviews in Respiratory and Endocrinology • Recruitment of medical vacancies in Gastroenterology • Head of Elective appointed and to commence in post in December
Action timescales and assurance group or committee	Improvement trajectory in place for 65 weeks / 52 weeks Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

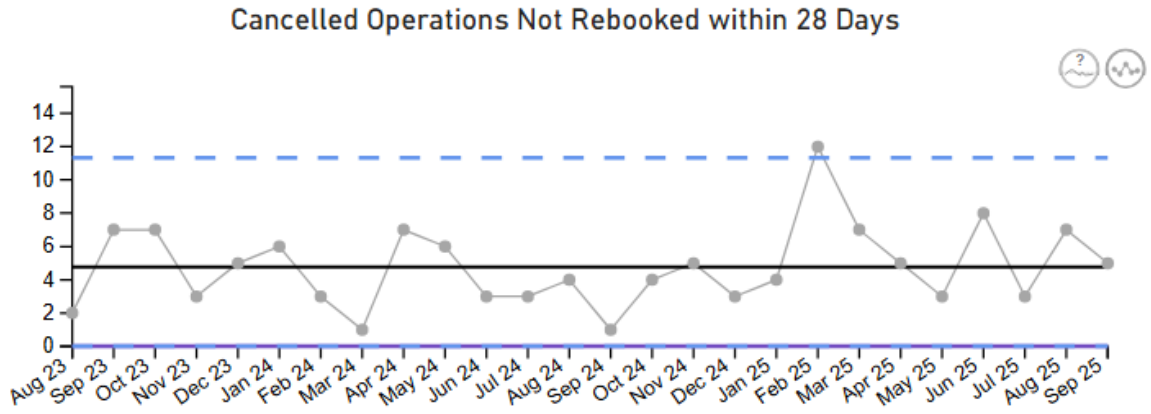




Assurance report

Cancelled operations not rebooked within 28 days

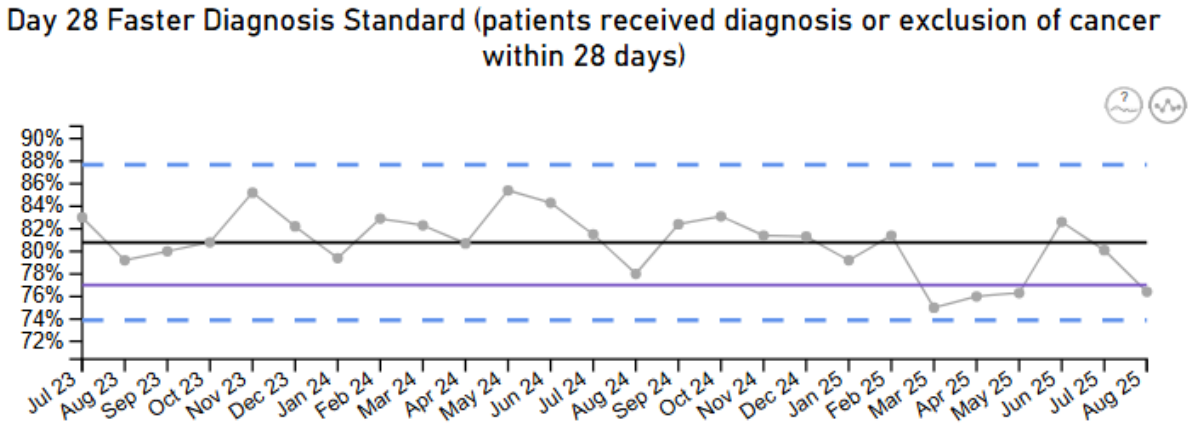
Summary of challenges & risks	There were **5 breaches** of the 28-day guarantee in September 2025. **Ophthalmology x 2** – surgeon sickness on the day of the rescheduled date within 28 days **T&O x 3** - 2 patients due to equipment issues, 1 patient due to HDU bed availability on the day Common variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Escalation process for on the day cancellations remains sporadic and further work is required within Division to fully embed the process and ensure oversight of re-booking within 28 days. There is a risk of continued breaches until this occurs.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care

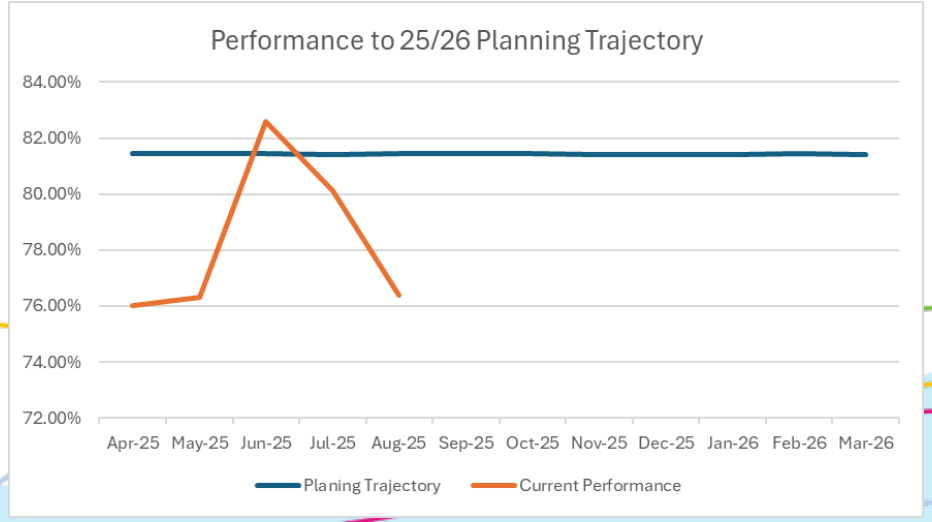


Assurance report

28 days from urgent referral to definitive cancer / not cancer diagnosis

Summary of challenges & risks	In August 2025, 76.4% of patients were with the **Cancer 28 day Faster Diagnosis Standard** against the trajectory of 81.5%. Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between the process limits
Actions to address risks, issues and emerging concerns relating to performance and forecast	In August, referrals for urgent suspected cancer were 417 (27.3%) above the plan of 1525. This increase has had a detrimental impact on 28 day FDS performance in a number of tumour sites and overall performance against the standard. The most significant impact at tumour site level has been seen in Breast (7.5%), LGI (5.4%), Prostate (7.1%), and Gynae (7.3%). Key actions to improve performance include: • Additional capacity in Breast and Prostate to address the backlog of referrals • Converting routine capacity in Gynaecology to urgent suspected cancer outpatient slots • Clinical oversight in the Gynaecology PTL meetings to improve PTL management and minimise delays following first outpatient appointment
Action timescales and assurance group or committee	Monthly trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	N/A

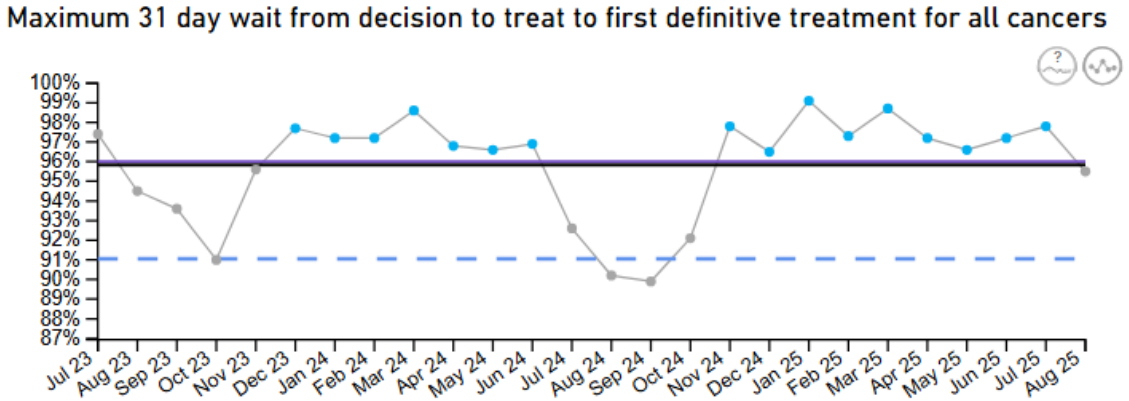


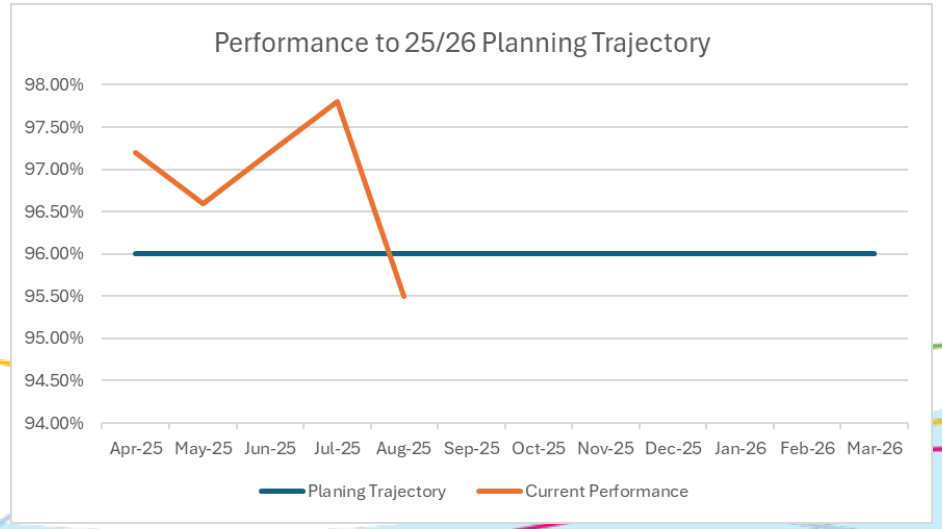


Assurance report

Maximum 31 day wait from decision to treat to first definitive treatment

Summary of challenges & risks	In August 2025, 95.5% of patients had a maximum wait of 31 days from decision to treat to first definitive treatment for all cancers against the trajectory of 96.0%. There were 9 breaches in month: 2 x Breast x 2, both patients had more complex pathways with high comorbidities 7 x skin x 7, due to a shortfall in treatment capacity and histology delays Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between the process limits
Actions to address risks, issues and emerging concerns relating to performance and forecast	Key actions to improve performance include: • Improvement plan in place to improvement histology delays, with oversight at the Pathology Partnership Board • Capacity and demand planning in Dermatology
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	N/A

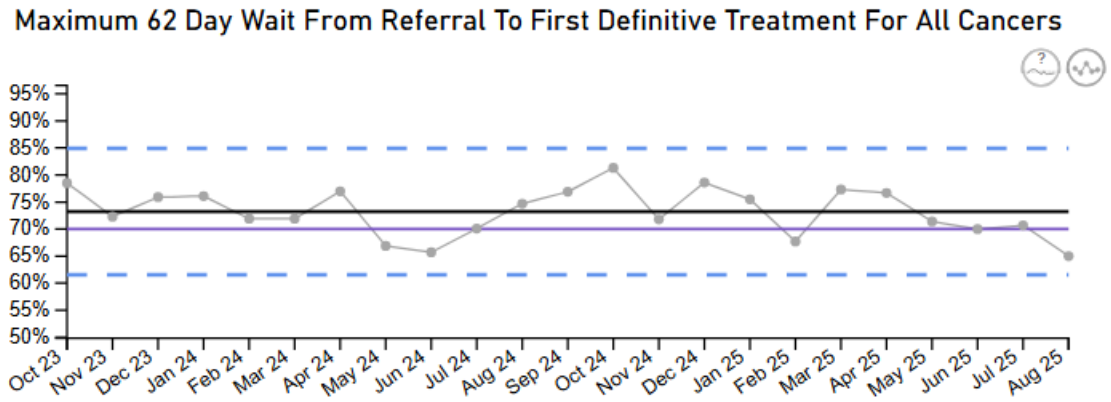


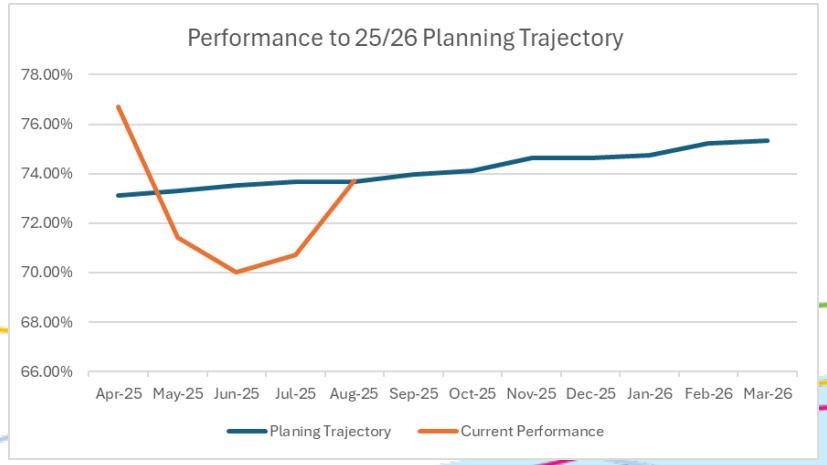


Assurance report

62 days urgent GP referral to first cancer treatment

Summary of challenges & risks	In August 2025, 65.0% of patients had a maximum wait of 62 days from referral to first definitive treatment for all cancers against the trajectory of 73.7%.206 patients were treated in total, of which 134 patients were treated within 62 days and 72 patients breached the standard. The tumour sites driving the overall underperformance were Lung (26.5%), Urology (58.4%) and Lower GI (66.7%) Common cause variation, **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Key factors causing the underperformance include: • Diagnostic and staging capacity pressures, in particular for those patients required tertiary centre input • Outpatient capacity Key actions to improve performance include: • Review of the LGI straight to test pathway • Improved PTL management and escalation process
Action timescales and assurance group or committee	Monthly trajectory in place. Monthly reporting to the Finance and Performance Committee.
Risk register	N/A

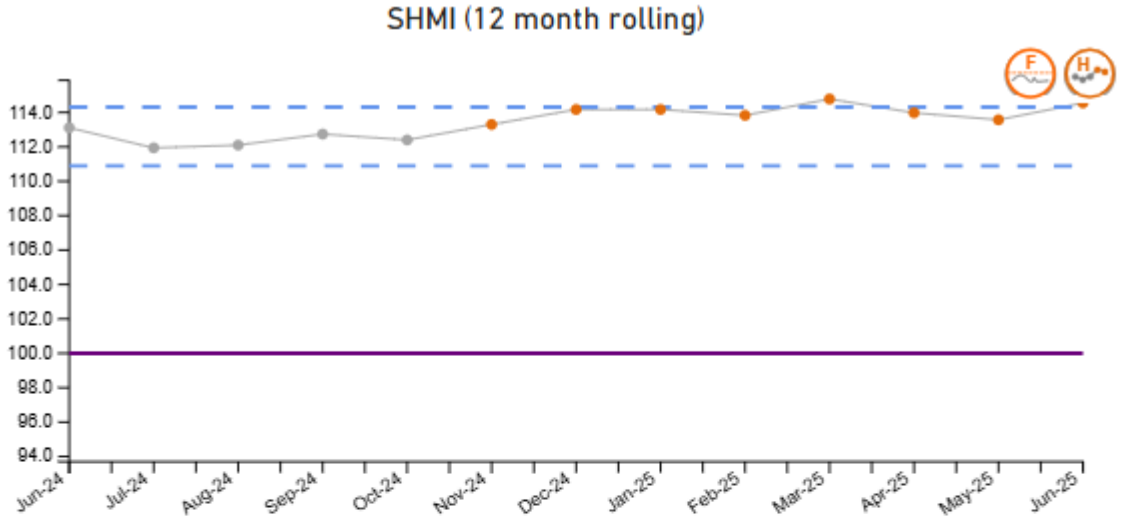


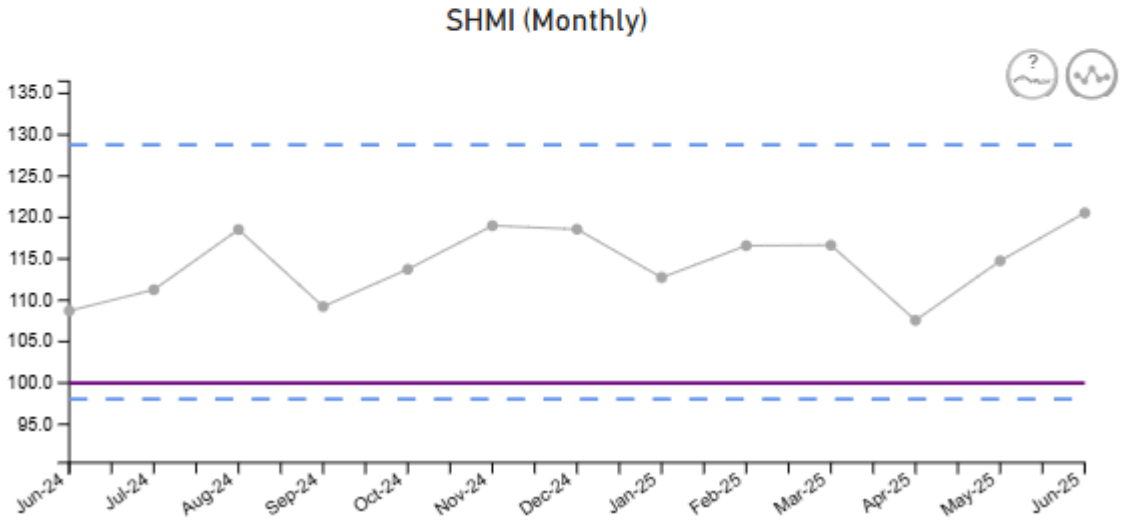


Assurance report

SHMI

Summary of challenges & risks	The 12 month rolling SHMI in June 2025 was 114.6. Monthly SHMI in June 2025 was 120.6. **<u>SHMI (12 month rolling)</u>** Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. **<u>SHMI (Monthly)</u>** Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Standard Indicator Set: Mortality Review / Trust Performance / Benchmarking Indicator / Current / Previous / Change / Peer / National / Position SHMI (12 mth rolling) — HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025) — 114.55 (Jul 2024 - Jun 2025) — 113.57 (Jun 2024 - May 2025) — 0.98 ↑ — 96.09 — 100.54 — Within expected range SHMI (monthly) — HES Inpatients, HES-ONS Linked Mortality Datasets (Sep 2025) — 120.56 (Jun 2025) — 115.75 (May 2025) — 4.81 ↑ — 94.98 — 99.77 — Within expected range HED data shows the Trust continues to remain within expected range in terms of number of deaths. Work continues on the action plans to ensure recovery measures are embedded, and the clinical coding and depth of coding improvement work is showing significant benefits. Additional medical colleagues have expressed an interest in training to undertake Structured Judgement Reviews, which will increase scrutiny and learning from deaths.
Action timescales and assurance group or committee	Mortality performance is monitored via the Mortality Governance Group and reported to Effective Committee and Quality Committee
Risk register	

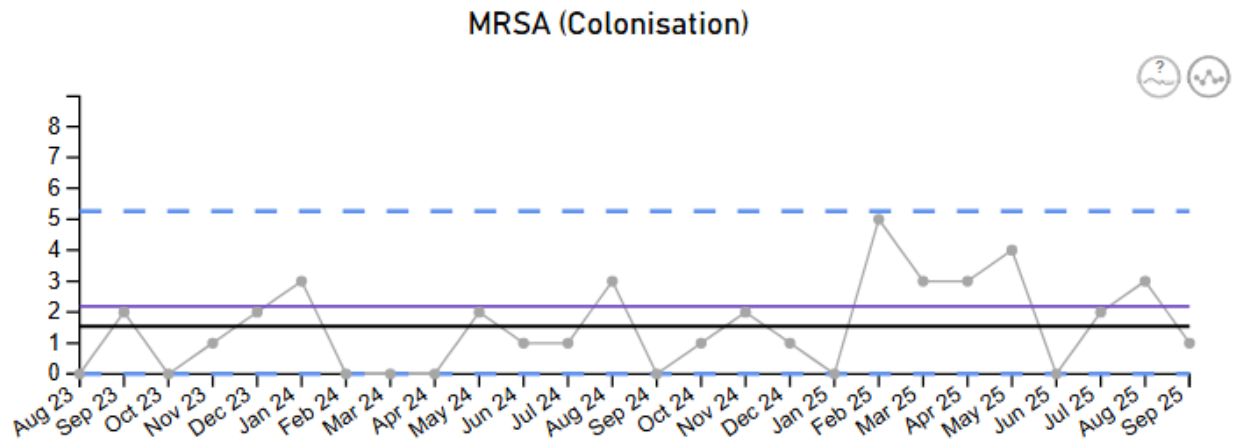


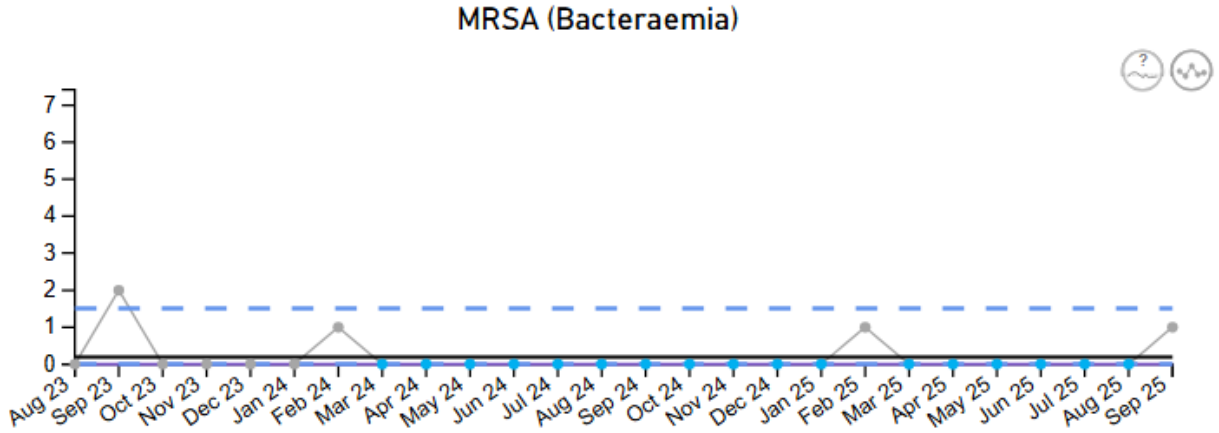


Assurance report

Hospital acquired MRSA cases reported in month

Summary of challenges & risks	In September 2025 there was 1 case of Hospital Acquired MRSA – Colonisation and 1 case of Hospital Acquired MRSA - Bacteraemia reported in Month Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Bacteraemia likely a contaminant caused by incorrect blood culture sampling techniques. Review of case with clinical team DIPC to write to relevant Divisional Directors where contaminant is identified in more than one set of blood cultures, this is to support learning and assessment of competence. Concerns identified regarding VIP score and cannula care, poor documentation. To be discussed at speciality clinical governance meetings and audit to be undertaken by IPC team and provide feedback to clinical area. Patient identified as difficult to cannulate and required multiple attempts and ultra sound guided insertion – consideration for PICC line, and education. **Training with medical staff on blood culture taking – this is currently ad hoc. There is no formal training included for clinical skills for medical staff.**
Action timescales and assurance group or committee	All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group Routine actions are ongoing business as usual. Training for medical staff on blood culture taking to be escalated to PSAG.
Risk register	N/A



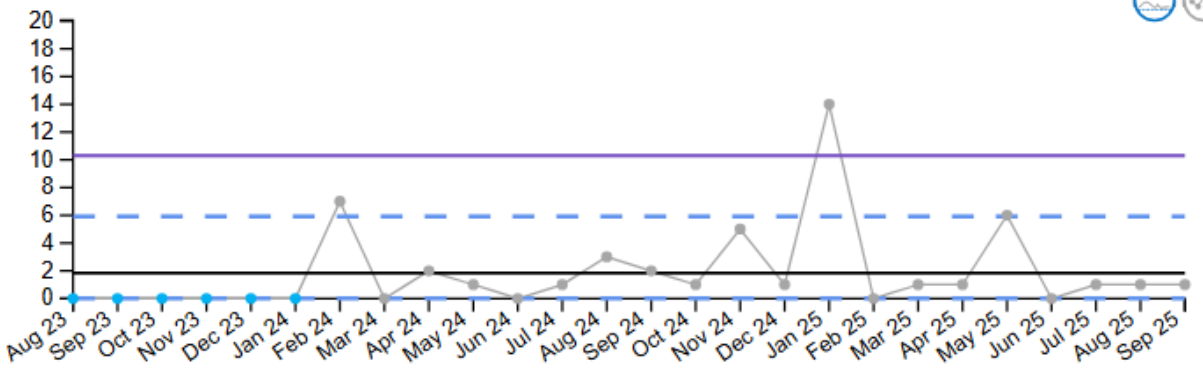


Assurance report

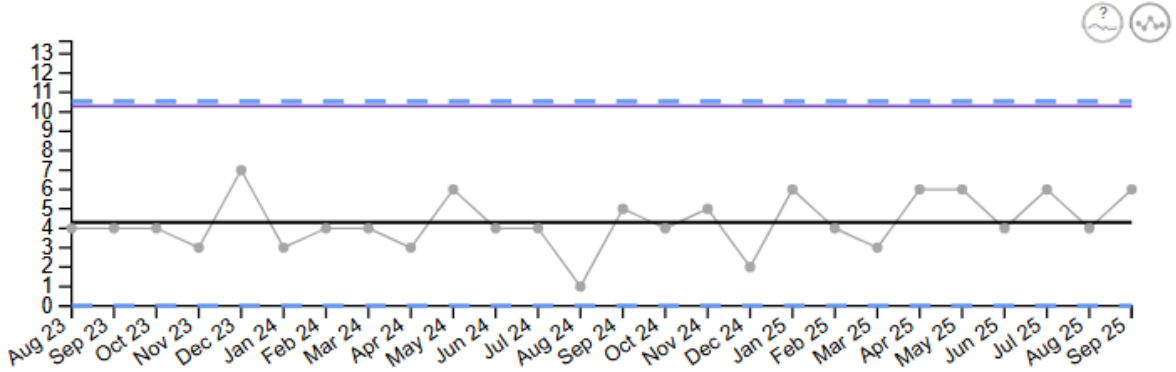
Number of C.Diff cases in month

Summary of challenges & risks	In September 2025 there were 7 cases of Hospital or Community Onset Healthcare associated C.Diff cases **COHA** Common cause variation. **NO SIGNIFICANT CHANGE.** This process is capable and will consistently PASS the target if nothing changes. **HOHA** Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Ongoing project to identify CDI carriers via stool sampling for early detection and reduced contamination. No recent cross-infection except 2 cases, earlier in year DIPC will alert clinical leads of known clusters. Initiatives underway to improve stewardship and narrow antibiotic use. Community care home review of antibiotic prescriptions and sensitivities to support AMS. Routine IPC measures and hand hygiene education continue. Weekly case reviews by DIPC/DDIPC for learning and feedback through governance; AMS audits and surveillance ongoing.
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	Risk ID 3517

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



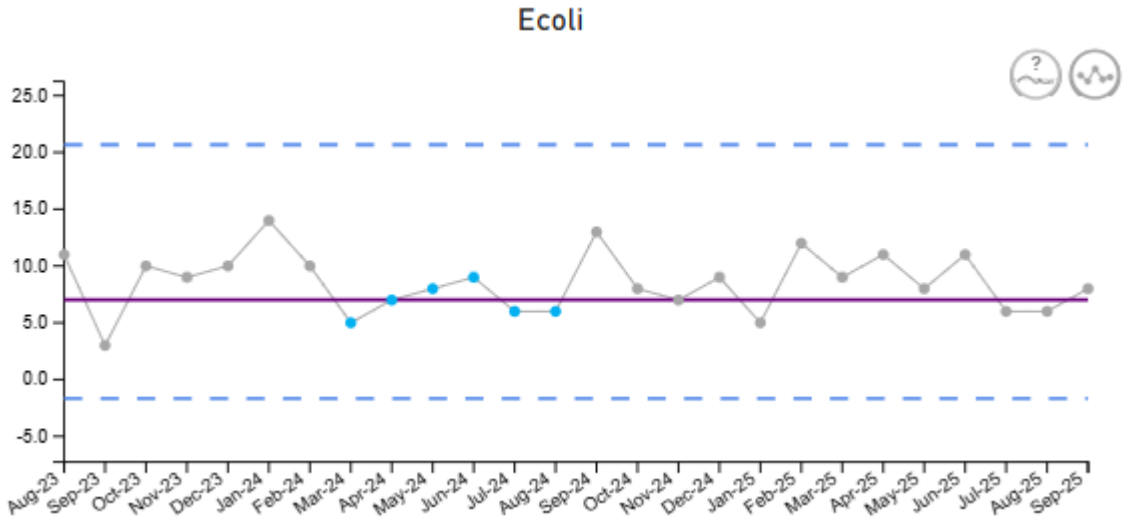
Number of Hospital Onset Healthcare associated (HOHA) C.Diff cases in month



Assurance report

E.Coli

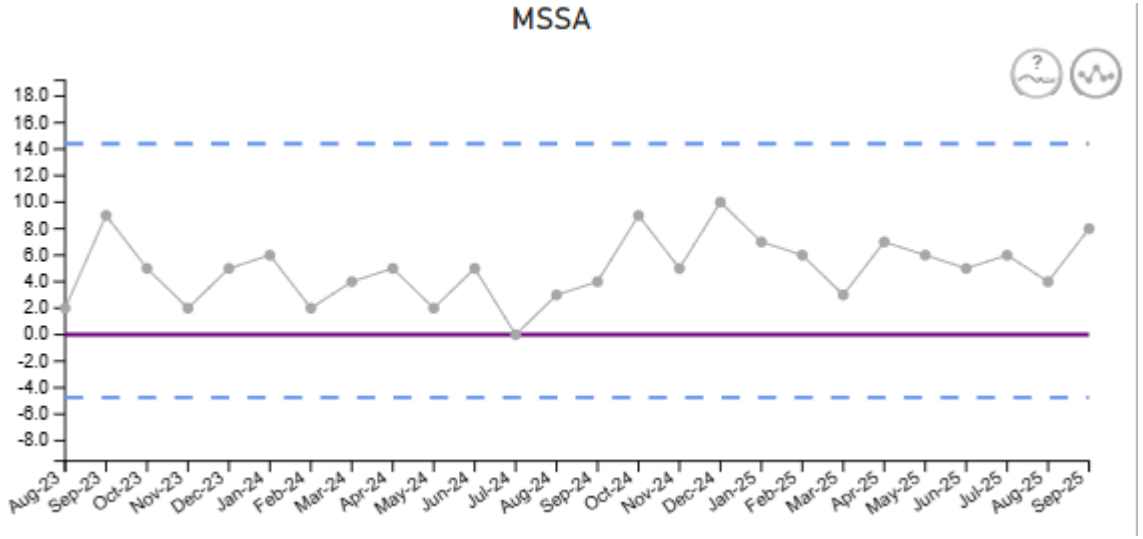
Summary of challenges & risks	In September 2025 there were 8 cases of E.Coli. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	All gram negative blood stream infections are rising nationally. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepuncture. Ongoing education, monitoring and surveillance of IPC interventions followed by feedback. Promotion of good hydration in inpatients and in care home residents and acute trust Education and promotion of good catheter care External urine management device trial to move to another ward Hand hygiene promotion, observation and feedback Procurement are reviewing urinary catheter products that prevent back flow to minimise risk of infection.
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

MSSA

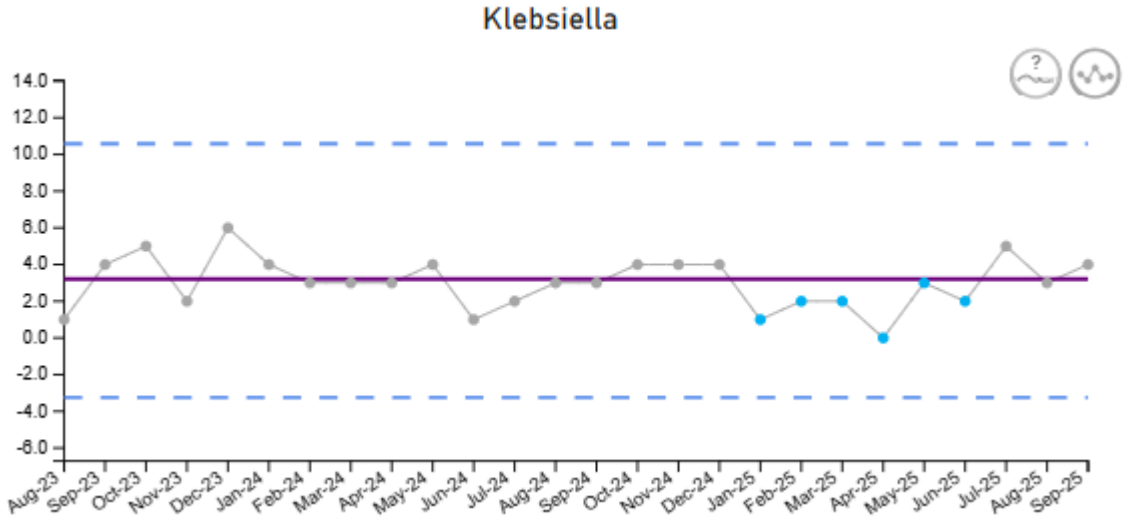
Summary of challenges & risks	In September 2025 there were 8 cases of MSSA. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	MSSA is carried on the skin of third of the population as normal bacteria. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepuncture. Hand hygiene promotion, audit and feedback Extensive work underway in ED and AMU DRI in relation to blood culture taking, volumes, diagnostic stewardship, time to analyser. Specific QI project within Renal – screening and decolonisation of patients who have invasive lines. – reduction in line infections – measures being reviewed to implement in other areas New Chlorhexidine dressings used. Screening in Renal Ongoing education and surveillance in relation to VIP scoring/line care across the organisation.
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

Klebsiella

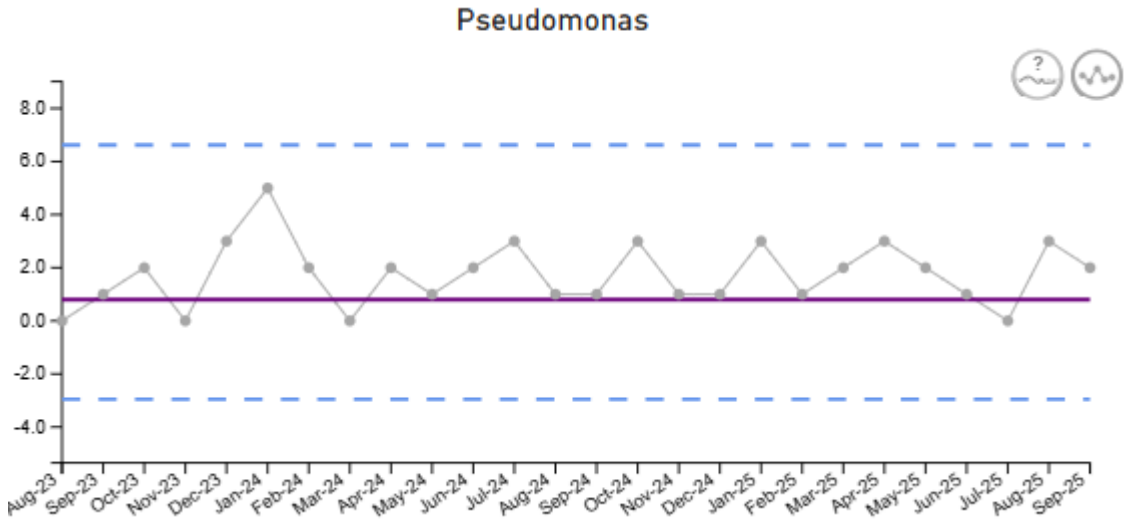
Summary of challenges & risks	In September 2025 there were 4 cases of Klebsiella. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	All gram negative blood stream infections are rising nationally. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepuncture. Ongoing education, monitoring and surveillance of IPC interventions followed by feedback. Promotion of good hydration in inpatients and in care home residents Education and promotion of good catheter care External urine management device trial underway Hand hygiene promotion, observation and feedback Procurement are reviewing urinary catheter products that prevent back flow to minimise risk of infection.
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

Pseudomonas

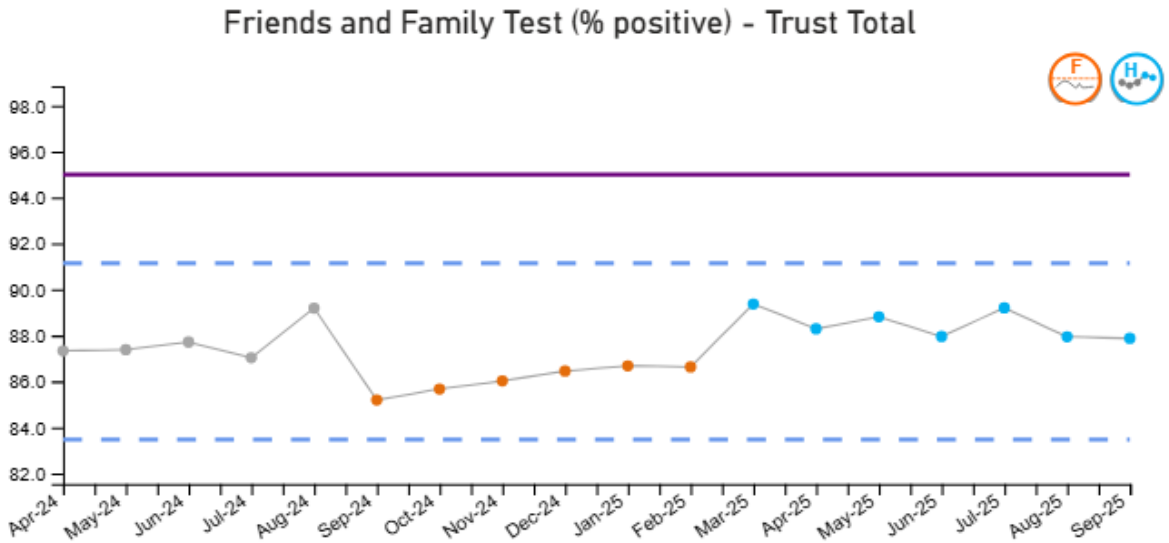
Summary of challenges & risks	In September 2025 there were 2 cases of Pseudomonas. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	All gram negative blood stream infections are rising nationally. Principles of IPC practice minimise the risk of transmission – skin decontamination prior to line insertion or venepuncture. Ongoing education, monitoring and surveillance of IPC interventions followed by feedback. Promotion of good hydration in inpatients and in care home residents and acute trust. Education and promotion of good catheter care External urine management device trial to move to another ward Hand hygiene promotion, observation and feedback Procurement are reviewing urinary catheter products that prevent back flow to minimise risk of infection. Water outlets present a risk. Water testing is completed regularly. Estates act on results quickly, using filters, working on pipework etc. New DCC will be waterlite – sinks moved away from bedside. New equipment is being trialled – this has the capacity to decontaminate drains easily as part of deep cleaning. Business case to be written and presented for approval once trial is complete (Nov 2025).
Action timescales and assurance group or committee	All measures are ongoing throughout All cases feedback through divisional governance and through Infection control operational group and Trust wide infection prevention and control group
Risk register	N/A



Assurance report

Friends & Family Positive Response Score - Trust

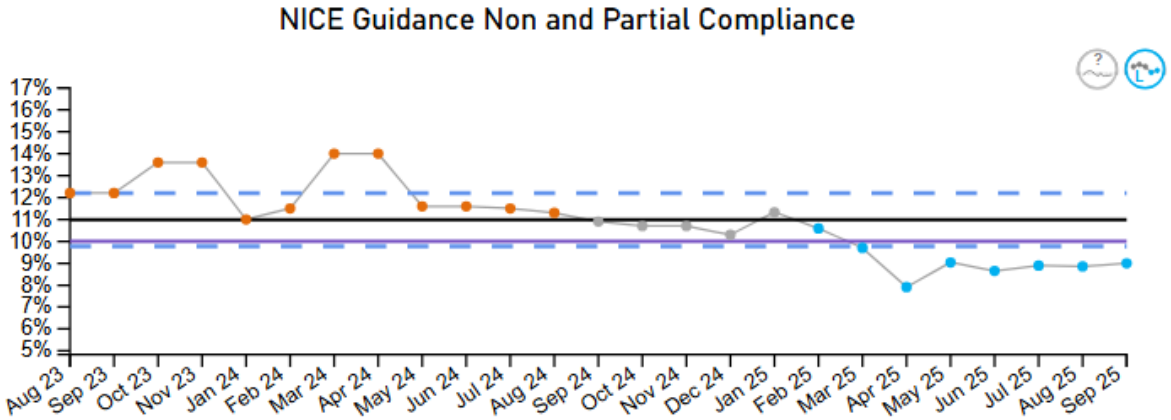
Summary of challenges & risks	The Trust position was 87.9% for September 2025. Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER.** This process is not capable and will consistently **FALL BELOW** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Year on Year improvement inpatient, UEC and Maternity response rate however reduced return rate noted in September 2025. Negative responses for Inpatient areas low – focus on day surgery / short stay units areas and ED where negative returns slightly higher than other areas. OPD areas positivity rating 87%, focus on areas with lower positivity ratings and increasing response rate within OPD areas. • Continued focus on reducing returned forms (improved Sept 2025). • Focus on increasing overall response rates in inpatient, day surgery and UEC areas, including progression with patient experience volunteers for 2026.
Action timescales and assurance group or committee	Continue to monitor response rates and positivity rating via Divisional Clinical Governance processes, Patient Experience and Involvement Operation Group and Caring Committee, benchmarking against local providers and national average.
Risk register	No



Assurance report

NICE Guidance % non & partial compliance (for monitoring only)

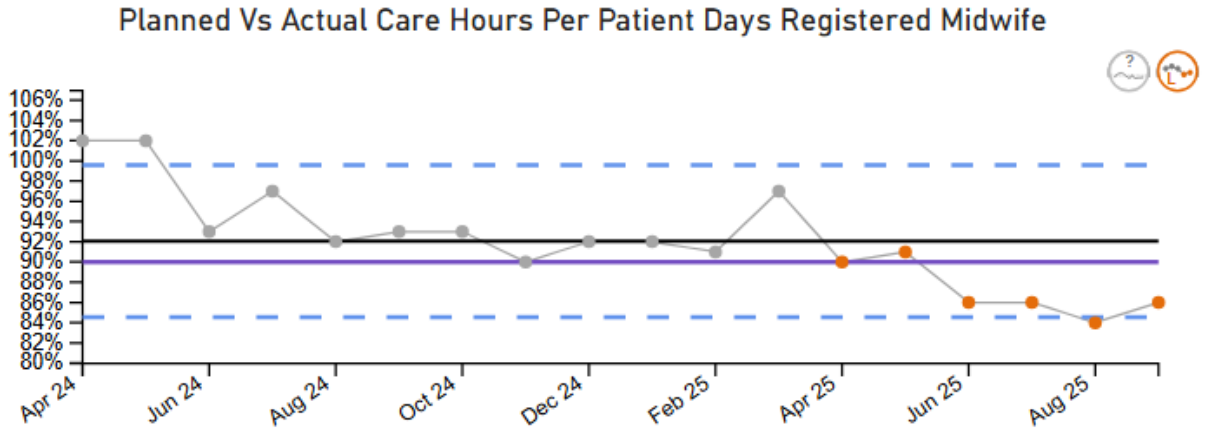
Summary of challenges & risks	For September 2025, the Trust achieved 9.0%. Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER** The process will not consistently **HIT OR MISS** the target as the target lies between the process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• **Performance** tracked via Monday.com with actions aligned to audit schedules and timescales. • **Divisions must justify** non-adoption of guidance; NICE guidance not applicable at specialty level will be removed with clear rationale. • **Compliance snapshot**: 427 NICE guidance identified; 38 non/partially compliant; 9 unlikely to adopt due to service scope.I • **Impact:** Removing non-applicable guidance improves Trust compliance position.
Action timescales and assurance group or committee	• Monitored/reported to the Audit and Effectiveness Committee by the DQACs • Compliance reported to Effective Committee in a divisional highlight report • Reports to Audit and Risk Committee for oversight and assurance
Risk register	



Assurance report

Planned Vs Actual CHPPD - Midwife

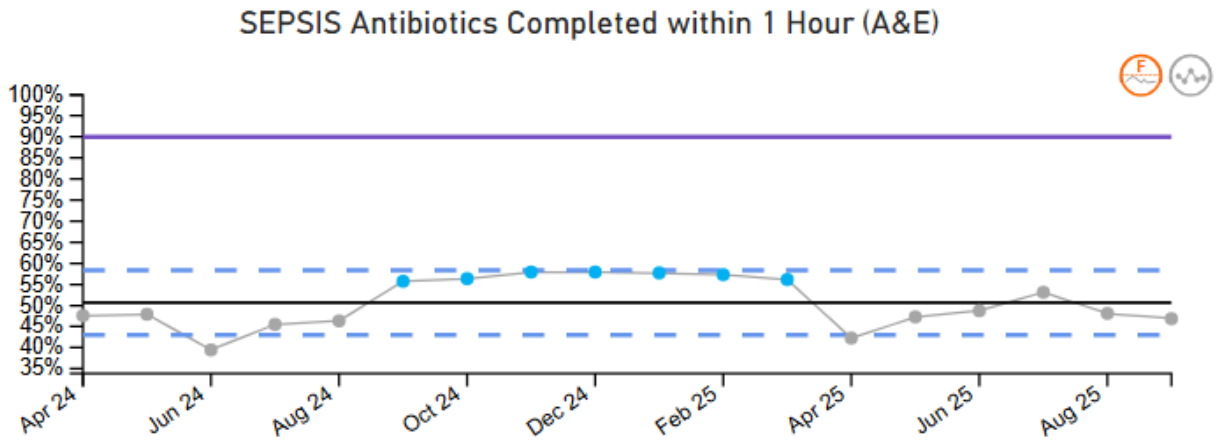
Summary of challenges & risks	In September 2025 Planned Vs Actual CHPPD for Registered Midwifes was 85.6%. Special cause variation of a concerning nature where the measure is significantly lower. The process will not consistently HIT or MISS the target as the target lies between process limits
Actions to address risks, issues and emerging concerns relating to performance and forecast	High sickness rates – support from HR to improve. All vacant shift offered on NHSP – variable uptake. Twice daily huddles recommenced to manage staffing. A manager of the day to organise workload & staffing operationally. Senior manager on call over night to support . Escalation processes in house and within the LMNS to manage the workload. Registered nurses and band 2 CSW now offered shift where appropriate to enhance support to RMs only. 27 WTE newly qualified midwives to commence Oct (majority) to Jan 2026, this will bring the service to fully recruited.
Action timescales and assurance group or committee	All actions above in place. All newly qualified midwives will be in place by Jan 2026 Sickness consistently managed. Raised at DLT and MNSQG meetings.
Risk register	On risk register

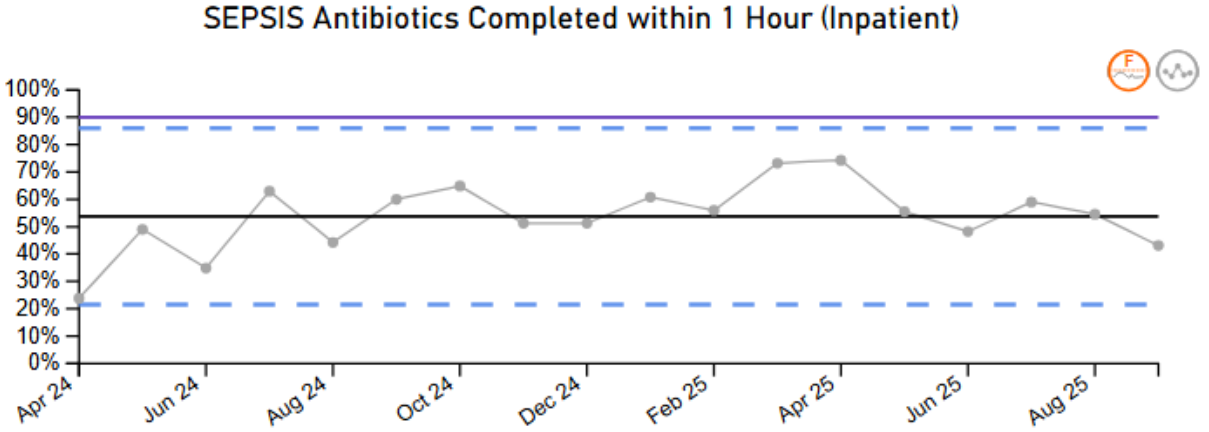


Assurance report

Sepsis antibiotics completed within 1 hour

Summary of challenges & risks	For September 2025, the Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis in A&E was 46.9% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign. For September 2025, the proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis as an Inpatient was 43.1% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Sepsis strategy recently launched which includes ongoing education and training in the following: • Mandatory sepsis screening – trust wide • Sepsis alerts in acute medicine tracker and ED sepsis tracker – real time monitoring of sepsis six compliance • Integration with symphony and nervecentre – now live • Standardised and streamlined care pathways • IPOCs in place • Treatment and investigation bundles on ICE • Education and awareness – ongoing training for staff and raising awareness for patients • Ongoing clinical audit/feedback for continuous improvement
Action timescales and assurance group or committee	Delivery of sepsis actions reported to Sepsis Action Group
Risk register	

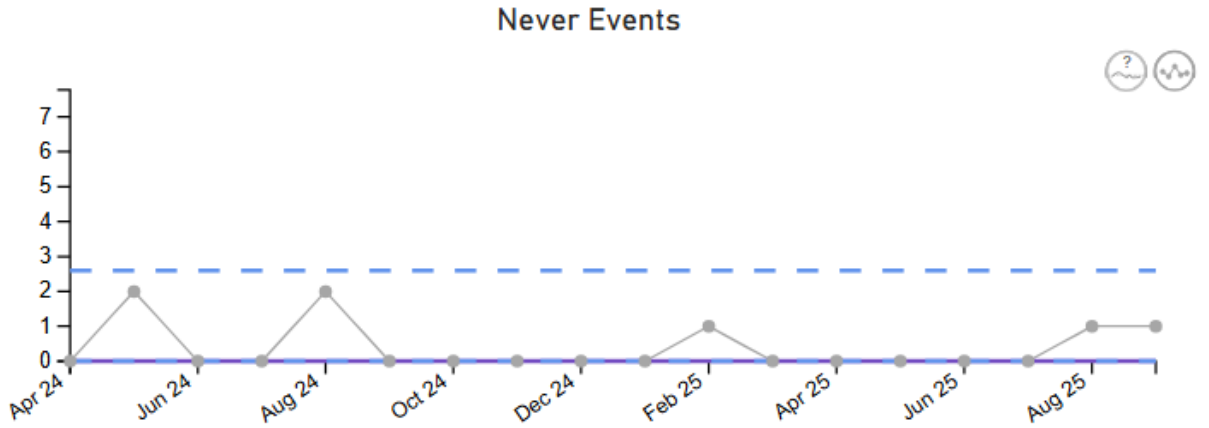




Assurance report

Never events reported in month

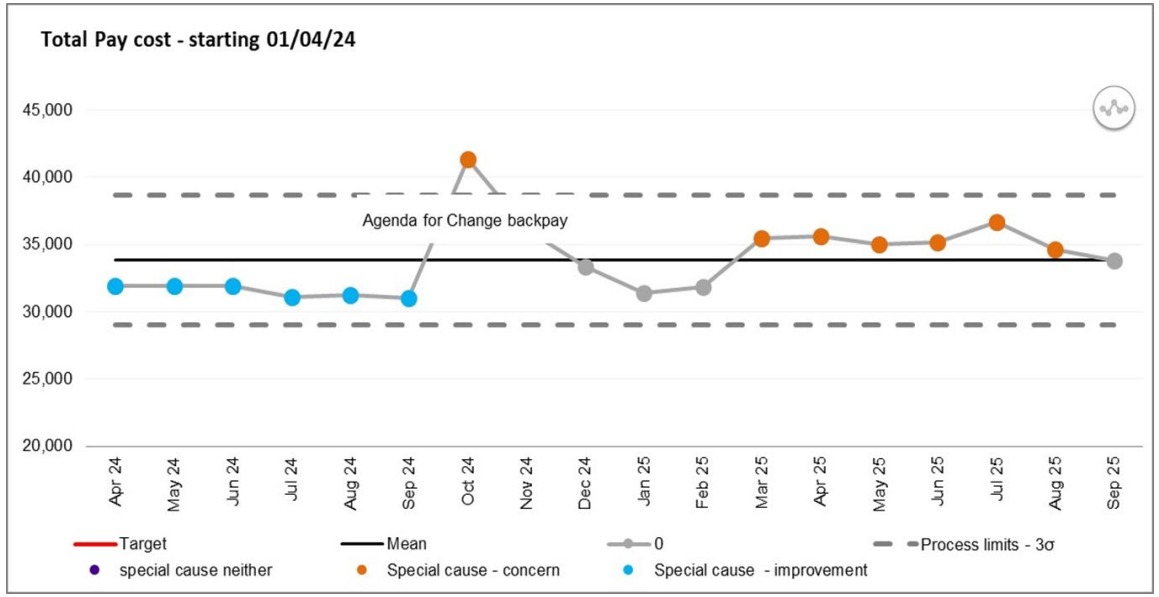
Summary of challenges & risks	In September 2025 there was 1 never event reported. Common cause variation. **NO SIGNIFICANT CHANGE.** This process will not consistently **HIT OR MISS** the target as the target lies between process limits.
Actions to address risks, issues and emerging concerns relating to performance and forecast	**Immediate safety actions/ learning:** Prior to insertion stent theatre staff to confirm with operating surgeon and consent form which side the stent is being inserted. Ensure x-ray request from is completed prior to surgery for all cases.
Action timescales and assurance group or committee	Patient Safety Incident Investigation commissioned. Timeframe 4 months. Patient Safety assurance group have oversight.
Risk register	No



Assurance report

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

Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,034	6,105	71	A	(209)	F
Ambulance staff	-	-	-			
Apprenticeship Levy	131	124	(7)	F	(33)	F
Allied health professionals	3,033	2,968	(65)	F	(313)	F
Healthcare science staff	21	16	(5)	F	(34)	F
Medical and dental	10,504	11,248	744	A	6,153	A
Nursing & midwifery	12,878	13,423	545	A	1,383	A
Comprising:	-	-	-			
Registered nursing	9,476	9,748	272	A	(462)	F
Unregistered nursing	3,402	3,675	273	A	1,845	A
Scientific, therapeutic and tech	861	822	(39)	F	216	A
Reserves & Technical Adjustments	577	(882)	(1,459)	F	(1,457)	F
Total Trust	**34,038**	**33,823**	**-215**	F	**5,707**	A



Assurance report

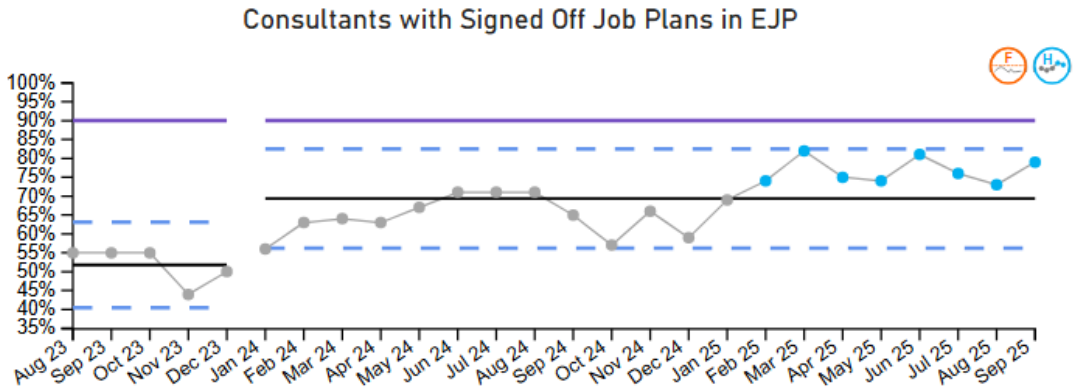
Pay spend against plan including substantive, additional sessions, bank and agency

Summary of	Pay is overspent by £5.7m YTD
Actions to address	**A. CIP Pay Efficiency Workstream** in place for 25/26. Within the workstream there are x5 key projects supporting the reduction of agency and bank volumes and price:- (1) Medical Recruitment - Review recruitment activity and provide support through a series of initiatives to have more substantive colleagues in post and reduce reliance on temporary workers. This will include visibility that vacant roles are proactively recruited to, and plans are in place. (2) Medical Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. Identifying and managing escalation rates and out of policy bookings should be done through grip and control meetings. This should also include a review of the current controls in place e.g. sign off thresholds and that they are effective and proportionate. (3) Nursing, Midwifery & AHP Agency & Bank - Review rates paid for agency and bank workers with the aim of reducing these holistically. This includes a review of the current controls in place e.g. G&C, sign off thresholds and that they are effective and proportionate. (4) Sickness Absence - Support the reduction in sickness across the Trust through identification of hotspots and ensuring plans are in place to support increased attendance, monitor compliance with policies and through the wider health and wellbeing agenda. A recent PIR on the Sickness Policy has identified additional areas that will be built in to improve current help and support to colleagues. (5) Effective Rostering - Ensure our people are deployed as effectively as possible by monitoring compliance with rostering best practice e.g. roster sign off period, compliance with Annual Leave and Sick Leave thresholds, use of "additional bricks" and owed hours. Recent initiatives include:- - Regular KPI reporting has been rolled out to members of the Workforce Education Group - Nursing bank requests are now subject to a 2 tier sign off process for NHSP which should impact favourably on the volume of bank bookings - Newly qualified recruitment success - starting Oct/Nov expecting impact on bank spend as nearer full establishment - Self rostering pilot - as we get nearer to full establishment self rostering should improve bank demand as well as maximising retention Alongside these enabler projects the working groups are capturing divisional initiatives to reduce reliance on premium staff by reviewing long standing agency staff and feedback for the VCF panel to recruit substantive posts.
	B. Additional Session funding is held centrally in reserves and only allocated once the COO has approved the sessions to be undertaken, this is considerable step change to previous years where funding was within divisional budgets with limited challenge. Productivity improvements within the Theatres and Outpatient Workstreams have been recognised as CIP associated with a reduction in additional sessions undertaken with regard to clinical activity compared to last year. Locally the UEC Division has undertaken a rota review, the change was effective from August 25, this has resulted in a reduction in additional sessions required to fill rota gaps.
	C. CIP Workforce Planning Workstream in place for 25/26. Within the workstream there are x3 key projects plus a number of ad hoc findings supporting the reduction of medical spend:- (1) Unpredictable on call emergency diary exercise - In line with the Consultant contract and recommendations from NHS Employers and BMA, during 2025/2026 the Medical Director's office are planning to review the demands of unpredictable emergency work for those teams of senior medical staff who participate in an on-call rota. To date Medicine data is ready for review, W&S and CSS returns are being collated and Surgery are yet to start. This data will be analysed by the MD Office and findings will be discussed initially with DDs and recommendations for any appropriate change put forward to the Medical Director to approve prior to enacting. (2) Sessional Delivery Tracking - The aim of the sessional delivery tracking is to ensure that as far as possible clinical activity is being delivered as planned, for 25/26 the focus will be Outpatient and Theatres activity only. Most specialties have now been reviewed and meetings held with divisional colleagues to sense check initial outputs. Further amendments have been highlighted and outputs are being revised. The Medical Director is yet to send formal comms out to GMs/DDs re guidance on how to address colleagues in excess of the +/-20% tolerance set. This guidance is required to ensure consistency in approach and clearly evidence reclaim decisions / actions which will feed into the CIP plan. (3) Standardisation of Travel Time in Job Plans (4) Ad Hoc - RRP payments, review of annual and bank holiday entitlements for part time staff
Action timescale	Sessional delivery - guidance required from MD Office re procedure for reclaiming lost sessions - expected Oct 25 Divisional action plans to address the pay overspends are being discussed at PRMS / Finance Confirm & Challenge Meetings / Grip & Control Meetings and overall plans to 6.1% escalated to DBTHI Executive Accountability Meetings Review of long term locums to reduce reliance on premium rate capacity DBTHi Executive Accountability Meetings reviewing CIP progress commenced 22/7/25 and run monthly Detailed cash flow monitoring in place and being reviewed Detailed I&E forecasts including impact of efficiency plans discussed at PRMS

Assurance report

Consultants with signed off job plans in EJP

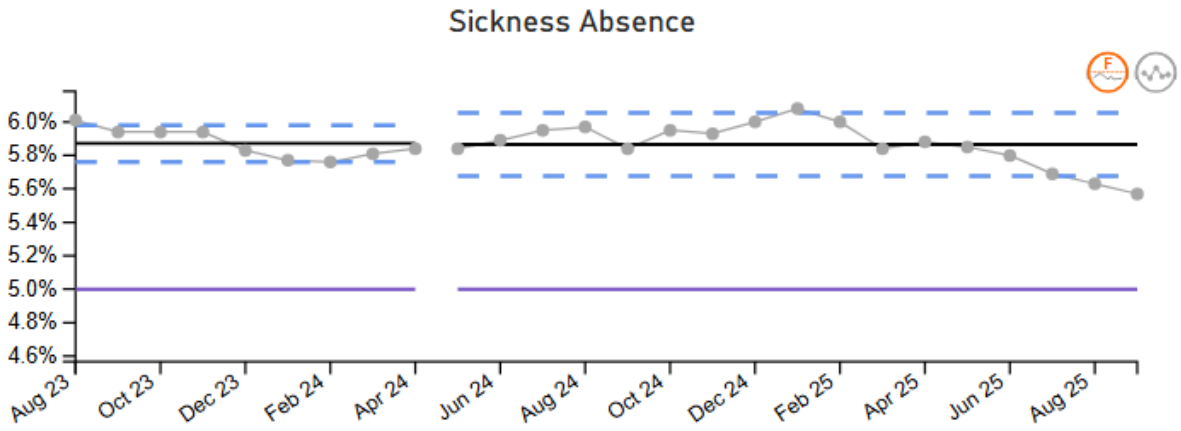
Summary of challenges & risks	For September 2025 79.0% of Consultants had a signed off job plan Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **FALL BELOW** the target if nothing changes. Re-basing has taken place December 2023 as job planning completion was linked to CEA programme
Actions to address risks, issues and emerging concerns relating to performance and forecast	Job plan sign off rates fluctuate between the balance of those which become due and those signed off each month, with peaks in variation during August and April. Overall an improving position with 3 specialties to finalise job plan templates and sign off. Ongoing issues with eJP software are causing delays specifically within surgical job planning. Contractual and service delivery discussions are taking place with the software supplier. Job Plan Policy developed, currently progressing through approval process.
Action timescales and assurance group or committee	Performance monitored and reported to Job Planning Consistency Committee and Effective Committee
Risk register	



Assurance report

Sickness absence

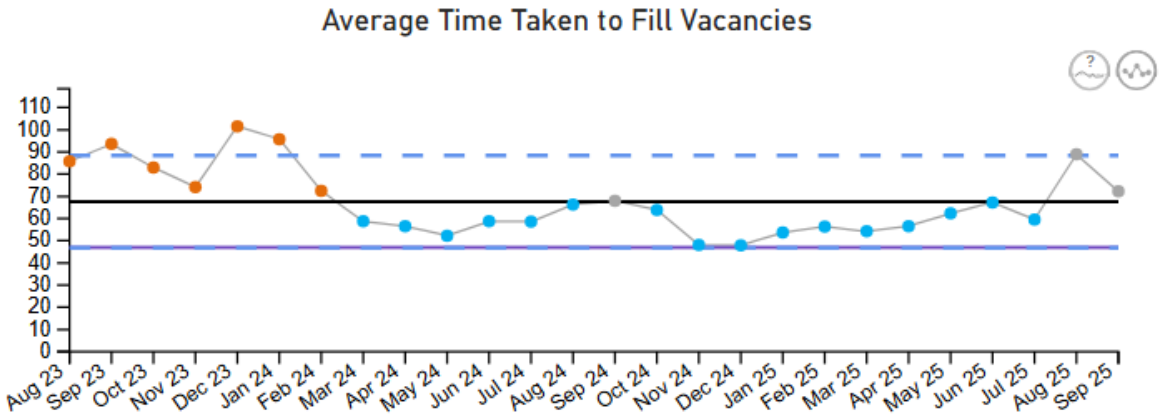
Summary of challenges & risks	In September 2025 the overall sickness was 5.6% Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FALL BELOW** the target without process redesign.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Managing Attendance at Work policy drafted, revised and refocused following policy implementation and learning from elsewhere. Discussions with Staff Side commenced and draft policy to be presented to Policy Formulation Group in Q3. • Offer of additional support and training from the People Business Partner teams ongoing • Identification of patterns of absence and appropriate actions that can be taken in line with the policy • Improvement work ongoing supporting absence management for medical colleagues with feedback, input and support from Clinical Directors
Action timescales and assurance group or committee	• All actions in relation to improving attendance and sickness absence management are tracked on Monday.com and monitored through the Pay Efficiency workstream with monthly steering group meetings, chaired by the CPO • Actions have timeframes and deadlines throughout 2025/26
Risk register	2554



Assurance report

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

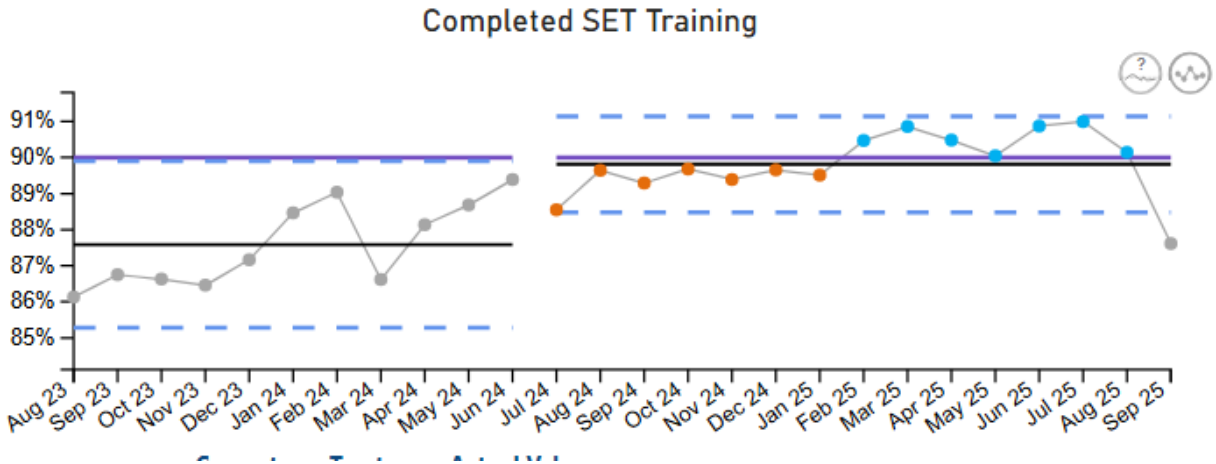
Summary of challenges & risks	The Trusts time to hire is 72.2 days for September 2025 Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Plan to pilot the internal transfer process for clinical admin and clerical roles delayed, to be reviewed in Q3 – anticipated to have a positive impact on reduction of number of vacancies • Collaborative work with system trusts on improving time to hire continues, including reviewing processes for pre-employment checks • Recruitment administrative model to be reconsidered in 2025/26. Pilot area to be considered
Action timescales and assurance group or committee	• Support actions and recruitment training offer are ongoing • Collaborative work is ongoing throughout 2025/26 • Workforce & Education Group reports (bi-annual) • People Committee bi-annual reports (bi-annual) • Internal transfer for admin and clerical posts expected to pilot Q3/4
Risk register	



Assurance report

Completed SET training

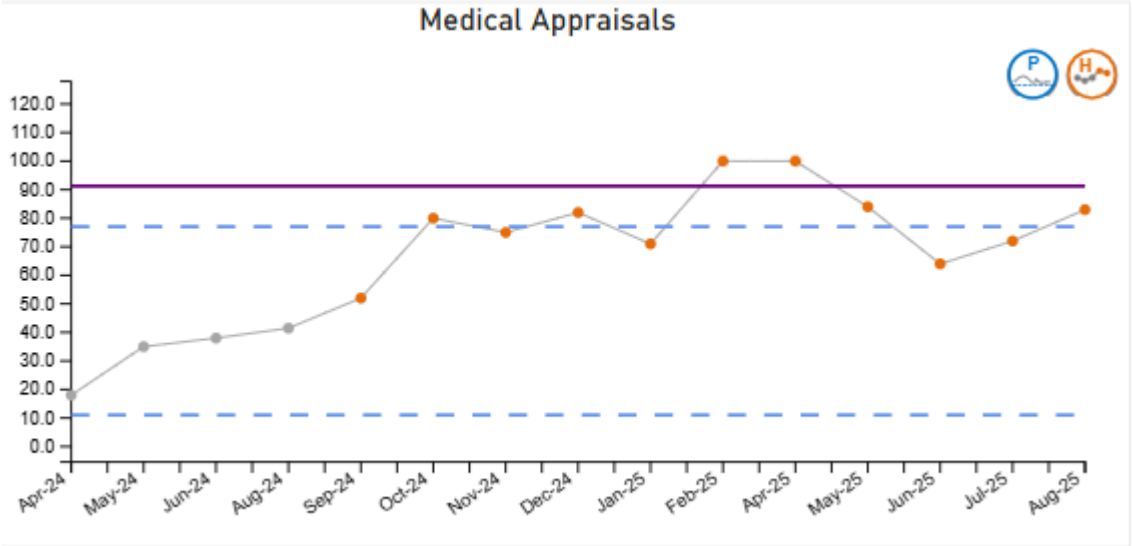
Summary of challenges & risks	In September 2025 SET training compliance was 87.8% Common cause variation, **NO SIGNIFICANT CHANGE** This process is capable and will consistently **HIT OR MISS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Work against the NHSE national statutory and mandatory training project continues and is on track • Local approval panel for addition of topics to Role Specific Training (ReST) being reviewed, in line with national guidance. The Trust had a local process in place, prior to this being recommended as part of the national project • Data analysis undertaken by professional group, to support identification of focused actions • Workplan in place alongside SY acute trusts, as part of the Acute Federation Plan for People, seeking opportunities to collaborate on training
Action timescales and assurance group or committee	• NHSE project work in line with national timescales during 2025/26. Progress reports to Workforce & Education Group • People Committee reports – every meeting
Risk register	



Assurance report

Medical appraisals completed

Summary of challenges & risks	Medical appraisals completed for September 2025 was 83%. Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER** This process is capable and will consistently **PASS** the target if nothing changes.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Medical appraisals are scheduled quarterly through the year and performance monitored by the Associate Medical Director for Professional Standards. Unlike other professional groups within the organisation, medical colleagues do not have a set appraisal season, with the expectation that their appraisal is undertaken annually within the appraisal year. Annual appraisal performance is taken at 31 March each year, validated and reported through the governance framework, signed off by the Chief Executive Officer and submitted to NHS England. The NHS England year end performance metric for medical appraisals is 90%
Action timescales and assurance group or committee	Good progress has been made in the first 2 quarters of the year and performance is on track to achieve/surpass the NHS England standard.
Risk register	



Metrics in development

- Medical Appraisals completed – *Back dated forms not yet completed.*
- Duty of Candour (failure to undertake in its entirety) - *Awaiting changes to be made in Datix.*
- Vacancies (specific staff groups) – *Additional data required in extracts provided. This is being investigated.*
- Turnover – *logic agreed, reports being updated.*
- Severe harm falls per 1000 bed days – *Quality Dashboard to be re-built starting in November so this work will be picked up during that development.*

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

2511 - E2 FINANCIAL & ACTIVITY REPORT - MONTH 6

Discussion Item

Sam Wilde, Chief Finance Officer & Denise Smith, Chief Operating Officer

10 minutes

REFERENCES

Only PDFs are attached

E2 - Finance and Activity Report - Month 6.pdf

E2 - Appendix 1 - Finance and Activity Report Month 6.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Finance and Activity Report - Month 6**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer Denise Smith, Chief Operating Officer			
Authors:	Yasmin Ahmed, Deputy Director of Finance Suzanne Stubbs, Deputy Chief Operating Officer			
Appendices:	Appendix 1 – Finance and Activity Report September 2025			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	BAF5 - If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term			

Executive Summary – Key messages and Issues

The Trust delivered a £2.9m surplus in month, in line with plan. This brings the year-to-date (YTD) position to a £1.2m surplus, also in line with plan. £1.6m of non-recurrent technical benefits have been made earlier than planned to support the year-to-date position (an improvement of £0.3m over the level last month).

The level of net risk (after mitigations) to delivery of the committed financial plan remains at 0, but £6.4m (of gross risks remain (up from £5.6m last month). Failure to secure additional income in respect of ERF overperformance has been added as a new risk. To mitigate this, system discussions are taking place to ensure the Trust receives the additional income required to tackle the remaining over 65-week waiters. The increased maturity of the efficiency scheme plans has resulted in a £3.8m reduction in gross efficiency scheme risk this month. At present we are not including the risk associated with loss of planned Deficit Support Funding, in line with instructions from South Yorkshire ICB who are holding that risk on behalf of the entire Integrated Care System.

The estimated underlying deficit exiting 2025/26 has increased from £33.5m last month to £35.5m this month but remains better than both the £37.2m level planned and the £41.2m 2024/25 exit rate. The deterioration since last month's estimate is driven by a reduction in the forecast of recurrent full year effect savings.

Activity in the month of September 2025 for elective, new outpatients and daycases exceeded plan, however outpatients follow ups were slightly behind plan. Year to date all points of delivery have exceeded plan.

Pay costs were below plan in-month but remain above plan in the year-to-date. The funded establishment has reduced by 23.2 Whole Time Equivalents (WTE) in the last month driven by efficiency schemes and skill mixing. Based on the number of contracted staff, there is a 'vacancy' rate of 9% gross or 4% net of temporary staffing. These figures are inflated by a number of roles being 'held' rather than actively recruited to, in order to support efficiency savings.

The latest published figures show that DBTH implied productivity has improved by 4.9% in M3 2025/26 YTD compared to M3 YTD 2024/25. This is driven primarily by a reduction in real-term costs. It represents a better performance than the 3.4% regional average. However, DBTH implied productivity still remains 10.7% below pre-COVID (2019/20) levels.

Efficiency schemes implemented in the year to date will yield recurrent full year savings of £19.3m (up from £17.5m last month). This is forecast to rise to £24.0m by the end of the year. In-year savings (which include non-recurrent efficiencies) are in line with plan in-month (£3.4m), year to date (£16.2m) and forecast full year (£31.4m).

The cash balance is £15.7m against a plan of £15.8m. Cash projections for the rest of the year have been included under best, most likely and worse case scenarios. These indicate the revenue cash balance is expected to drop below the level at which cash support would be required during quarter 4.

Year to date capital expenditure of £6.4m is £14.7m below plan (an improvement from £15.5m last month). Analysis of business case approval levels has been added to the pack this month.

Recommendations
The Board is asked to **NOTE** the financial and activity performance at month 6.

Healthier together – delivering exceptional care for all	
Patients	
People	
Partnerships	
Pounds	Paper outlines the financial and activity performance of the Trust
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	

Assurance Route	
Previously considered by - including date:	Finance and Performance Committee on 23rd October 2025
Any outcomes/next steps / time scales	
Is this in line with Current risk appetite? **NO**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Summary Finance And Activity Report

September 2025

Contents

Executive Summary

In month and YTD surplus/deficit (September 2025)

The Trust delivered a £2.9m surplus in month, in line with plan. The £1.2m year-to-date surplus is also in line with plan. £1.6m of non-recurrent technical benefits have been made earlier than planned to support the year-to-date position (an improvement of £0.3m over the position last month).

Annual Forecast Outturn (FOT)

FOT remains at breakeven in line with plan.

Activity

Activity in the month of September 2025 for elective, outpatient news and daycases exceeded plan, however outpatients follow ups were slightly behind plan. Year to date all points of delivery have exceeded plan.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust M06 September 2025 Income and Expenditure vs. Budget									
Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		YTD Budget	YTD Actual	Variance to budget	
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Income	(626,894)	(52,149)	(52,222)	(73)	F	(313,784)	(315,057)	(1,273)	F
Pay	411,567	34,038	33,823	(215)	F	205,183	210,890	5,707	A
Non Pay	206,159	14,468	15,071	603	A	102,848	100,276	(2,571)	F
Financing Costs	9,660	805	521	(284)	F	4,830	3,147	(1,683)	F
(Surplus)/Deficit for the period	**492**	**(2,839)**	**(2,807)**	**32**	**A**	**(923)**	**(743)**	**180**	**A**
Donated Asset Adjustment	(492)	(41)	(83)	(42)	F	(246)	(439)	(193)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**0**	**(2,880)**	**(2,890)**	**(10)**	**F**	**(1,169)**	**(1,182)**	**(13)**	**F**

Income: Over-achieved F; Under-achieved A

Expenditure: Underspent F; Overspent A

Key

F = Favourable **A** = Adverse

Efficiencies

Schemes implemented in the year to date will yield a recurrent full year effect of £19.3m (up from £17.5m last month). This is forecast to rise to £24.0m by the end of the year.

In-year savings are in line with plan, in-month (£3.4m), year to date (£16.2m) and forecast full year (£31.4m). Non recurrent savings are supporting the in-year delivery.

Cash

The cash balance is £15.7m just below the plan of £15.8m.

Capital

Year to date expenditure of £6.4m is £14.7m below plan with business cases being developed to deliver the full-year programme.

Key Risks and Mitigations

Key Risks	Risks (R)				
	25/26 Plan	M4	M5	M6	(Increase) Decrease
	£'000	£'000	£'000	£'000	£'000
Additional cost risk	(2,000)	(2,000)	(0)	0	0
Additional cost risk (inflation)	(6,178)	(2,500)	0	0	0
Efficiency risk	(22,817)	(7,322)	(5,621)	(1,834)	3,787
Industrial action loss of income	0	(700)	0	0	0
Income risk	(1,000)	0	0	(4,600)	(4,600)
Total	**(31,995)**	**(12,522)**	**(5,621)**	**(6,434)**	**(813)**

Key Mitigations	Mitigations (M)				
	25/26 Plan	M4	M5	M6	Increase (Decrease)
	£'000	£'000	£'000	£'000	£'000
Additional cost control	2,000	500	0	0	0
Additional income	6,178	2,100	0	4,600	4,600
Efficiency mitigation	2,322	3,661	5,621	1,834	(3,787)
Industrial action mitigation	0	700	0	0	0
Contract negotiations	1,000	0	0	0	0
Total	**11,500**	**6,961**	**5,621**	**6,434**	**813**

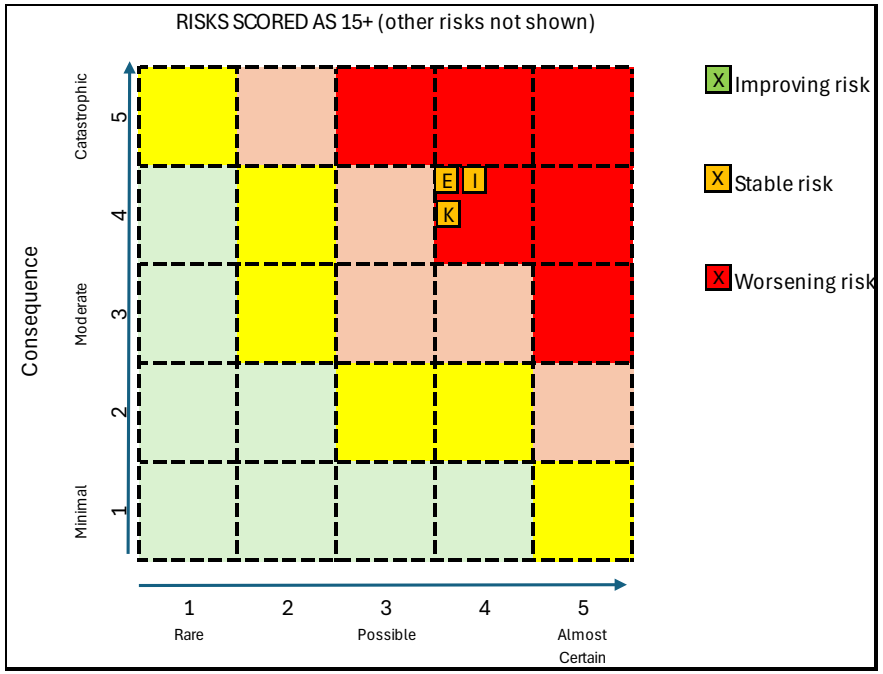
Net (R/M)	(Increase) Decrease
£'000	£'000
0	0
4,600	4,600
0	0
0	0
(4,600)	(4,600)
0	**0**

- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.
- ERF overperformance has been added as a new risk, with system discussions taking place to ensure the Trust receives the additional income to treat patients waiting over 65 weeks.
- The increased maturity of the efficiency scheme plans has resulted in a £3.8m reduction in gross efficiency scheme risk this month.
- There is a risk to the Trust if SYICB are unable to receive the deficit support funding. NB this has not been included in the above table as it is being reported by the ICB.

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

Worsening Risks
- Failure to deliver 25/26 Capital Programme including inability to meet Trust's needs for capital investment (H – increased due to pending confirmation of funding for constitutional standards and development of business cases)

Actions
- DBTHi team reviewing CIP plans and progress to ensure fully developed plans in place
- Detailed cash monitoring and forecasting on monthly basis
- ERF overperformance – Reviewed at system
- Capital cases being developed and funding confirmation from NHSE awaited



Surplus/Deficit – Graphs M6

In month/YTD

- In month £2.9m surplus, in line with plan.
- Year to date a £1.2m surplus in line with plan. £1.6m of non-recurrent technical benefits have been made earlier than planned to support the position.

Income

- Income is £0.1m favourable to budget in month due to ERF over performance.

Pay

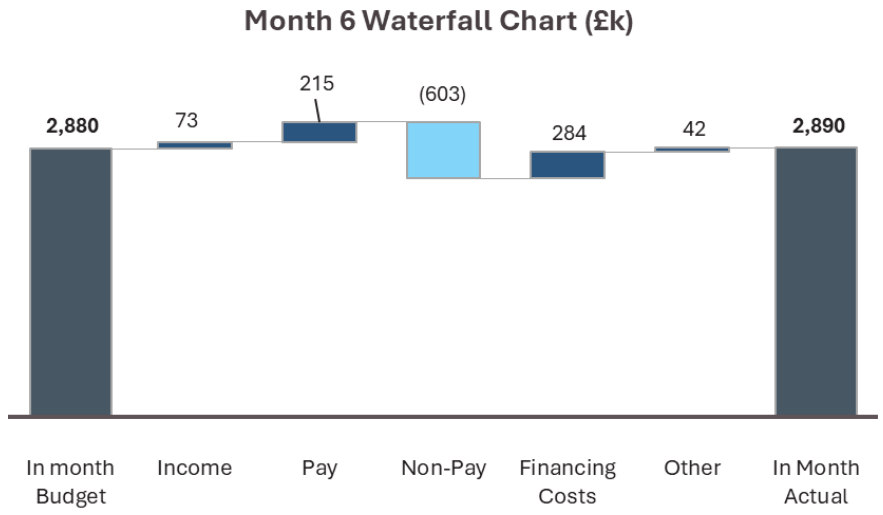
- Pay is £0.2m favourable to budget in month mainly due to non recurrent benefits and £5.7m adverse YTD due to CIP delivery, industrial action costs, operational pressures and premium costs.
- Bank/agency and additional medical sessions spend in month is £3.5m due to operational pressures, cover for vacant posts and sickness cover.

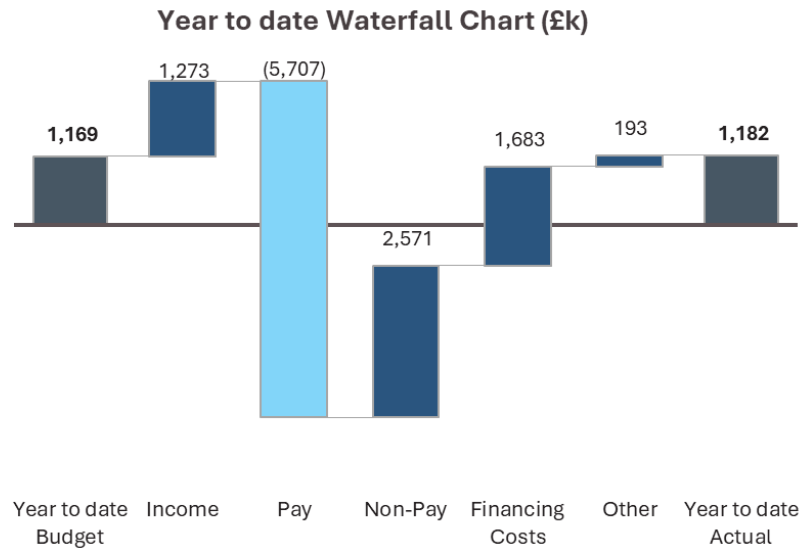
Non-Pay

- Non pay is £0.6m adverse to budget in month and £2.6m favourable YTD mainly due to non recurrent technical benefits.

Financing Costs

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





Underlying Deficit

	Income	Pay	Non Pay	Financing income/(costs)	Surplus/(Deficit)	Month 5	Movement
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
25/26 Forecast	638,614	(425,597)	(206,624)	(6,393)	-	-	-
25/26 FOT NR Efficiencies	(937)	(4,019)	(5,795)		**(10,751)**	**(6,408)**	**(4,343)**
25/26 Deficit Support Funding	(17,000)				**(17,000)**	**(17,000)**	-
25/26 Full year effect FOT recurring efficiencies	16	1,940	1,365		**3,321**	**2,638**	**683**
Donated asset movements	(39)		660	(621)	-	-	-
Non Recurrent ICB Income	(6,877)	-	(3,109)	-	**(9,986)**	**(9,986)**	-
Non Recurrent Benefits	(2,483)	(300)	(774)	-	**(3,557)**	**(5,288)**	**1,731**
Vacancies - assumed recurrent	-	2,500	-	-	**2,500**	**2,500**	-
Underlying Surplus/(Deficit)	**611,294**	**(425,476)**	**(214,277)**	**(7,014)**	**(35,473)**	**(33,544)**	**(1,929)**

The estimated underlying deficit exiting 2025/26 is £35.5m as at Month 6, compared to £33.5m reported in Month 5. The deterioration is as a result of a decrease in the forecast of recurrent FYE efficiency savings by the end of the year (£27.6M last month, £24.0M this month).

However, the latest estimate of the exit underlying deficit still represents an improvement over the £37.2m exit underlying deficit estimated within the final 2025/26 planning submission.

Financial Performance – Income

Clinical Income Position Month 6

	Plan - M6 YTD	Actuals - M6 YTD	Variance
	£'000	£'000	£'000
ICB			
NHS South Yorkshire ICB	(197,637)	(197,439)	199
NHS Nottingham and Nottinghamshire ICB	(55,195)	(55,187)	8
NHS Humber and North Yorkshire ICB	(4,168)	(4,166)	2
NHS Derby and Derbyshire ICB	(3,031)	(3,031)	0
NHS West Yorkshire ICB	(2,029)	(2,030)	(1)
NHS Lincolnshire ICB	(1,155)	(1,155)	(0)
LVA	(622)	(625)	(3)
ERF	0	(1,825)	(1,825)
API variable	(38)	(38)	0
ICB sub total	**(263,876)**	**(265,496)**	**(1,620)**
NHS England			
Specialised Commissioning	0	0	0
Public Health	(2,279)	(2,341)	(62)
Offender Health	(829)	(828)	0
Drugs and Devices	(5,648)	(5,648)	0
NHSE sub total	**(8,756)**	**(8,818)**	**(61)**
CDC	(4,948)	(3,739)	1,209
Clinical Income - misc	(855)	(1,607)	(753)
RTAs, PPs, OSV, CIP target	(2,640)	(2,635)	5
ERF Provision	0	160	160
Reported Position	(281,075)	(282,135)	(1,060)

In Month

The Clinical Income position in month 6 is in line with plan (M5 £0.3m - adverse). The ERF over performance in month 6 improved slightly from the previous month. The CDC performance in month deteriorated by £0.2m against the plan. Other income is in line with plan.

Year to Date

The Clinical Income position is showing a favourable position YTD of £1.1m and other income is in line with plan. The main driver of the year-to-date favourable clinical income performance is ERF performance at £1.8m (baseline ERF income is included in the ICB income categories) partially offset by lower CDC activity of £1.2m. A provision £0.2m for non-payment of ERF has been made for Audiology, no contract challenge has been raised on this activity, but this is prudent provision.

ERF Performance

The activity has not yet been fully coded and includes estimates. MEOC, Ophthalmology and Urology specialties are the main over performers as at month 6. Below is a table showing the ERF position at Month 6 by Commissioner.

Commissioner	ERF Baseline in Contract	Plan YTD M6	Actual YTD M6	Variance
NHS Derby and Derbyshire ICB	(953)	(474)	(615)	(141)
NHS Humber and North Yorkshire ICB	(1,850)	(921)	(1,092)	(171)
NHS Lincolnshire ICB	(746)	(372)	(295)	77
NHS Nottingham and Nottinghamshire ICB	(27,106)	(13,499)	(14,759)	(1,260)
NHS West Yorkshire ICB	(752)	(375)	(353)	21
NHS South Yorkshire ICB	(88,486)	(44,067)	(44,600)	(533)
NHS England - Offender Health & Armed Forces	(544)	(271)	(283)	(12)
NHS England - Specialised Commissioning	(1,903)	(948)	(753)	195
Grand Total	(122,339)	(60,926)	(62,751)	(1,825)

Activity Against Plan 25/26

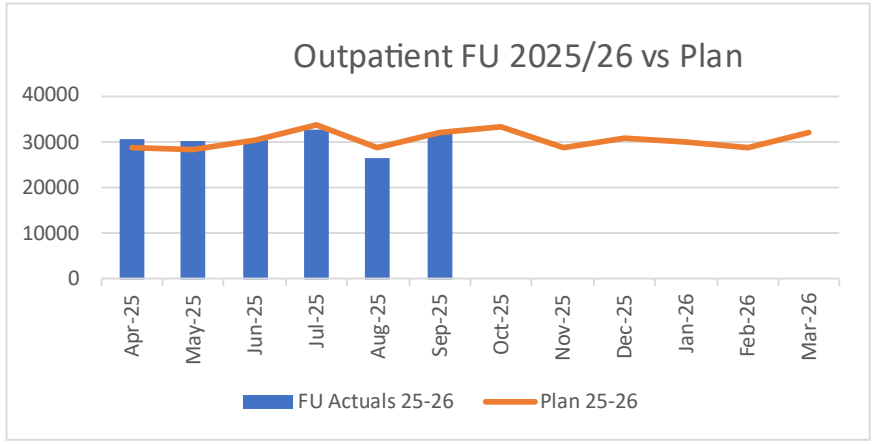
Point of Delivery	Activity vs Plan (September 2025)
Outpatients New	102.2%
Outpatient Follow up	99.4%
Daycase, excluding MEOC	104.3%
Elective, excluding MEOC	105.3%

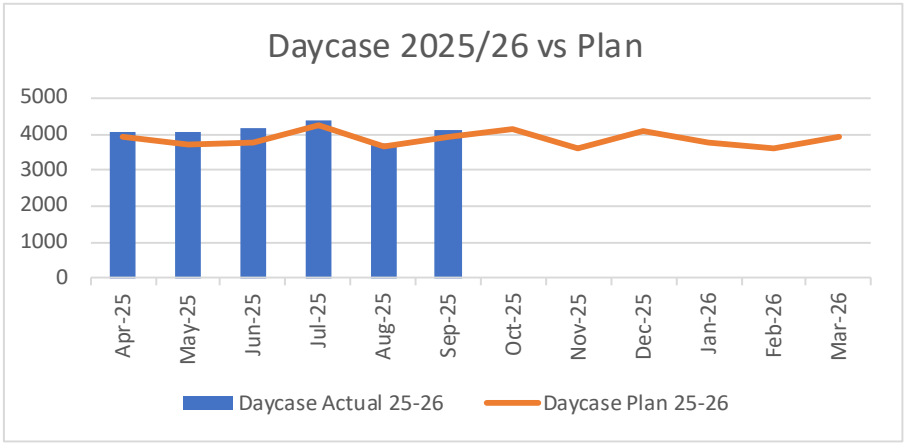
Outpatient New: 331 above plan in month and is 2,459 above plan YTD (102.8%)

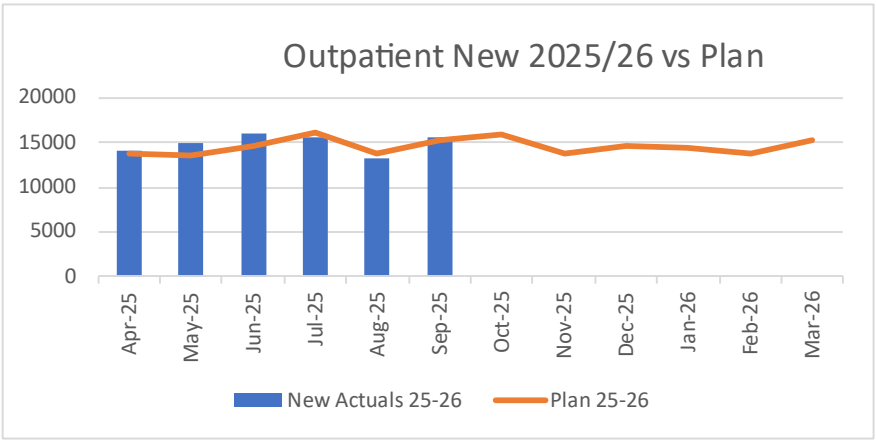
Outpatient Follow Up: 190 behind plan in month and is 1473 (100.8%) above plan YTD

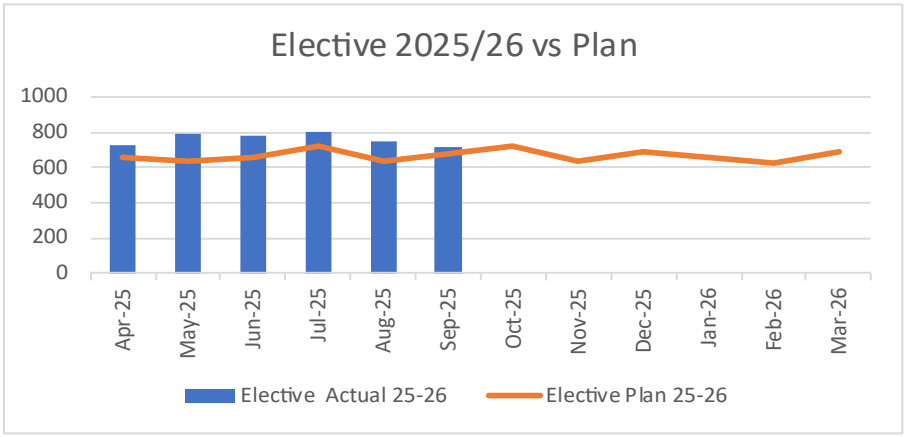
Daycase: 169 cases above plan in month and 1,331 cases above plan YTD (105.7%) Ophthalmology, Rheumatology, Respiratory, Endocrinology, Gynaecology and Urology are above plan in month and YTD. General Surgery, Oral Surgery and Trauma & Orthopaedics are below plan in month and YTD.

Elective: 36 cases above plan in month and 579 cases above plan YTD (114.5%). Trauma and Orthopaedics, ENT and Urology are above plan in month and YTD







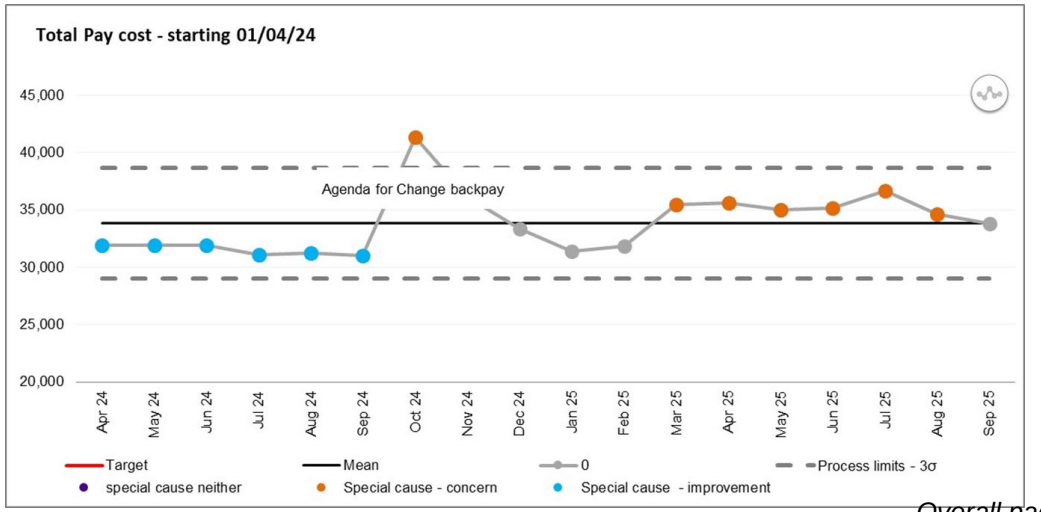


Financial Performance - Pay

In Month - £0.2m favourable to budget
Year to date - £5.7m adverse to budget

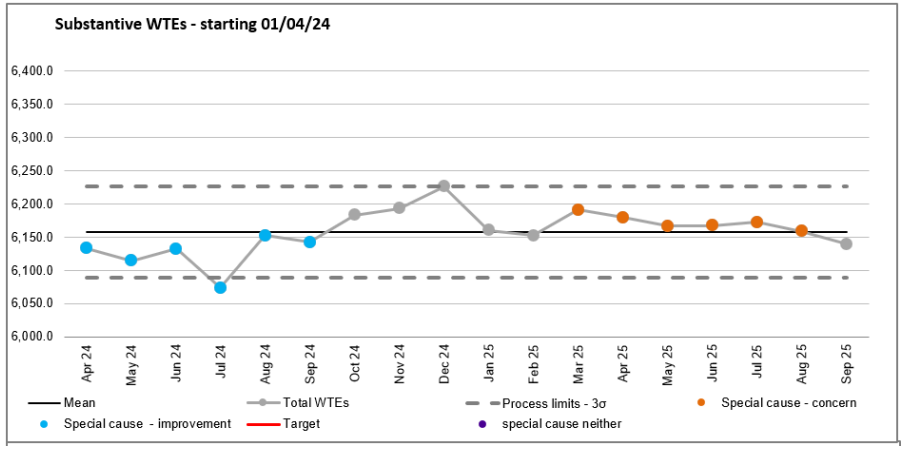
- Pay expenditure in month reduced by £0.8m mainly due to reductions in premium costs and recharges from other Trusts.
- Agency spend reduced by £0.1m in month
- Bank spend reduced by £0.1m in month
- Additional sessions reduced by £0.4m in month.
- Total Agency/Bank/Additional sessions spend in month was £3.5m.
- The adverse variance in the year to date is driven by unachieved CIP, industrial action costs, operational pressures and premium costs of medics.

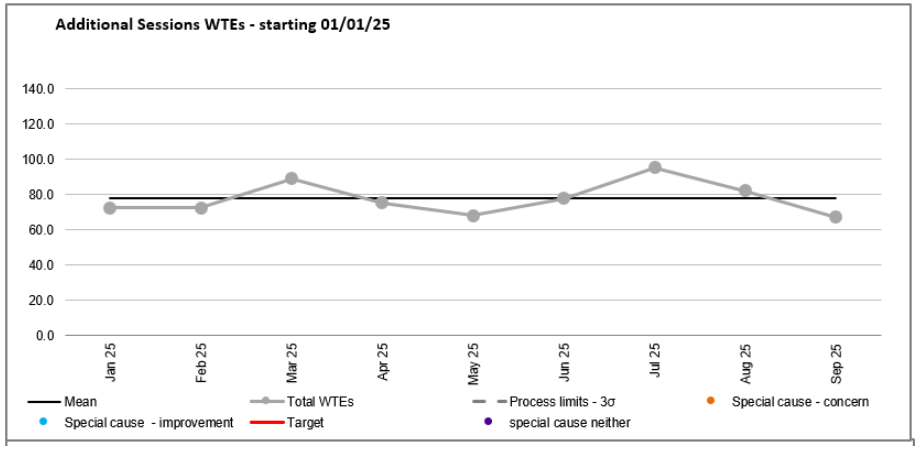
Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,034	6,105	71	A	(209)	F
Ambulance staff	-	-	-			
Apprenticeship Levy	131	124	(7)	F	(33)	F
Allied health professionals	3,033	2,968	(65)	F	(313)	F
Healthcare science staff	21	16	(5)	F	(34)	F
Medical and dental	10,504	11,248	744	A	6,153	A
Nursing & midwifery	12,878	13,423	545	A	1,383	A
Comprising:	-	-	-			
Registered nursing	9,476	9,748	272	A	(462)	F
Unregistered nursing	3,402	3,675	273	A	1,845	A
Scientific, therapeutic and tech	861	822	(39)	F	216	A
Reserves & Technical Adjustments	577	(882)	(1,459)	F	(1,457)	F
Total Trust	**34,038**	**33,823**	**-215**	**F**	**5,707**	**A**

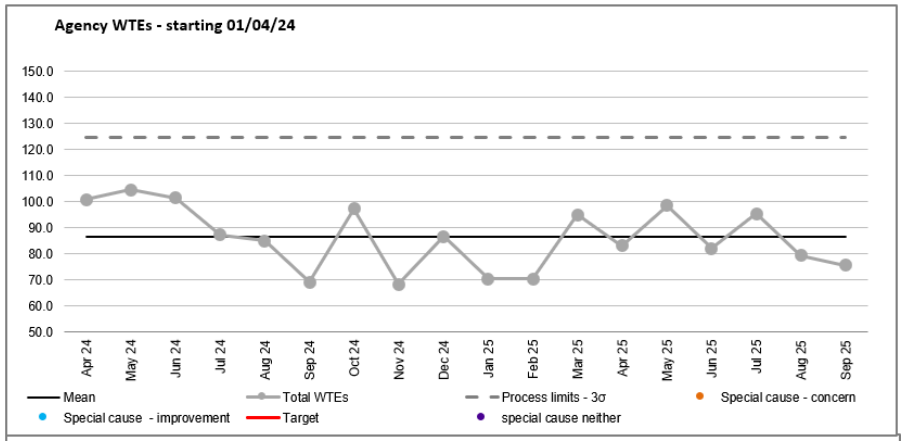


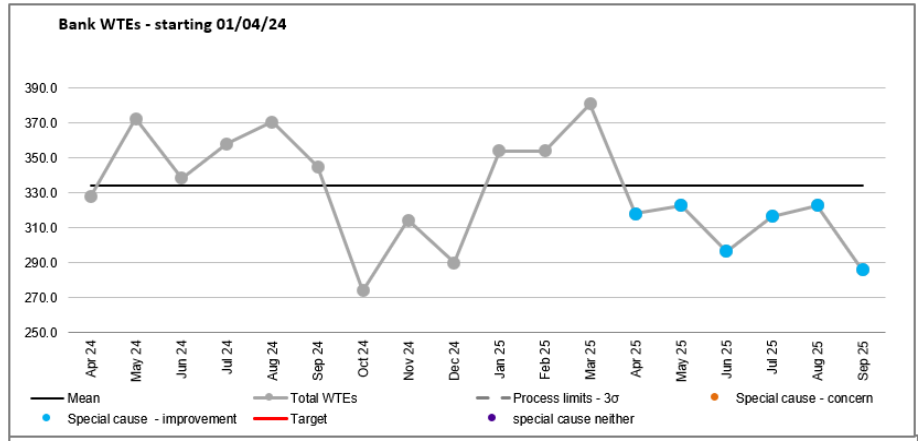
Financial Performance – Worked WTE

Workforce								
	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Additional Sessions	Total Temporary WTE	Total Worked WTE	Variance
Current Month	6,888.6	6,139.6	286.0	75.6	67.08	428.7	6,568.3	-320.3
Previous Month	6,911.8	6,158.9	323.0	79.4	82.24	484.6	6,643.5	-268.3
Movement	-23.2	-19.3	-37.0	-3.8	-15.2	-55.9	-75.2	-51.9









The WTE's reported are worked WTE which are derived from the actual hours paid and worked.

Prior to Jan 25, Additional Sessions WTEs were not reported and therefore this chart starts in Jan 2025.

Substantive staff continue to reduce from March.

The statistically significant deterioration in substantive WTE numbers from March to August 2025 has now ended.

Bank WTE worked shows statistically significant improvement from April 2025 onwards .

Financial Performance – Non-Pay

In Month - £0.6m adverse to budget

Year to date - £2.6m favourable to budget

The main reasons for the favourable variance YTD is due to:

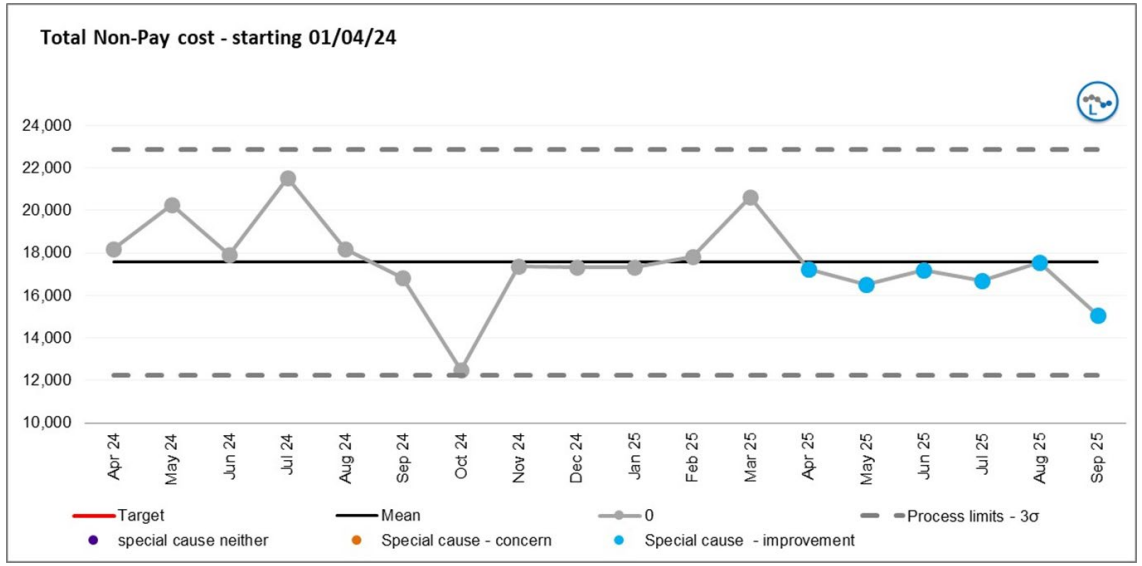
- Non-recurrent technical benefits made earlier than planned to support the position

Offset by:

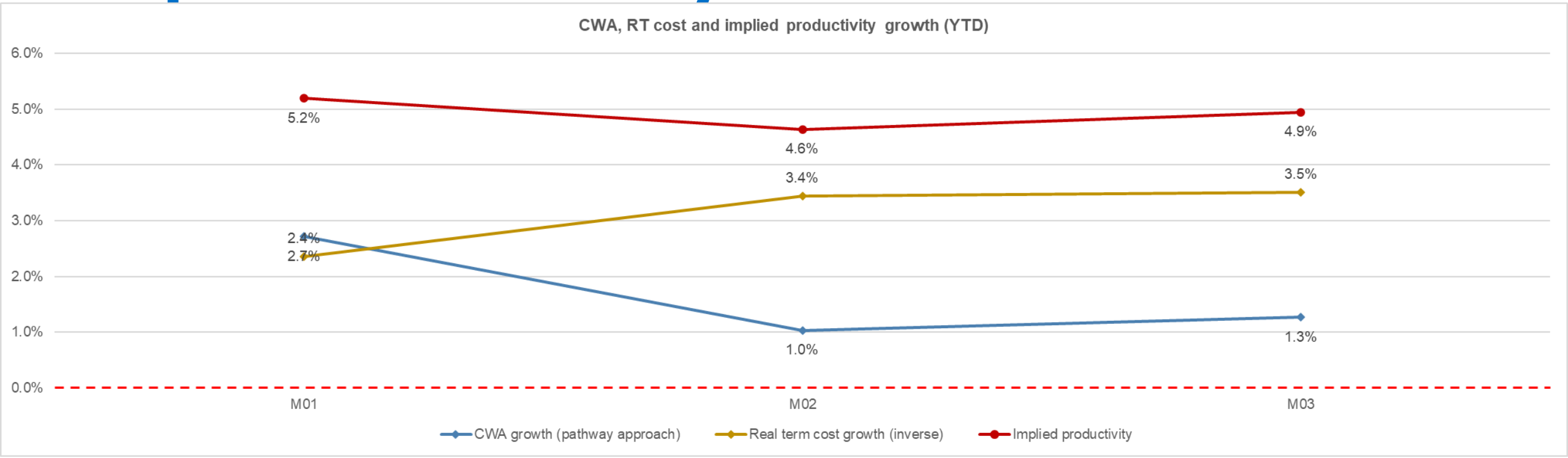
- Clinical supplies and services, mainly relating to CSS x-ray maintenance contracts for equipment
- Other costs (mainly unachieved CIP)

In month actual is £2.5m lower than the prior month as a result of the non-recurrent benefits released in month and CIP.

Non-pay trend by subjective	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Drugs (excluding non-PBR drugs)	1,304	1,179	(125)	F	(450)	F
Drugs (non PBR)	2,657	2,394	(264)	F	(106)	F
Clinical Supplies and Services	2,795	2,705	(90)	F	158	A
Other costs	6,973	7,502	529	A	704	A
Non-Executive Directors	16	15	(1)	F	(9)	F
Depreciation	1,595	1,623	28	A	42	A
Reserves & Technical Adjustments	(2,461)	(1,940)	521	A	(2,923)	F
Recharges	1,554	1,554	-	A	-	A
Parkhill	34	40	6	A	12	A
Total Trust	**14,468**	**15,071**	**603**	A	**(2,571)**	F



Implied Productivity



Implied Productivity is one of the suite of metrics which form part of the new national oversight framework and contribute towards the recently published league table of NHS provider organisations. The metric is published by NHS England 3 months in arrears.

The most recently published data shows a 4.9% improvement in implied productivity for DBTH for month 3 year-to-date 2025/56 (in comparison to M3 YTD 2024/25). This is more than the 3.4% average improvement seen across the North-East and Yorkshire region as a whole.

The majority of the 4.9% DBTH improvement is driven by a 3.5% reduction in real term costs with the remainder driven by a 1.3% increase in (cost weighted) activity.

Efficiency Programme

In terms of recurrent full year effect:

- Savings beyond £12.7m will start to eat into the Trust's underlying deficit, planned delivery was £16.7m.
- Schemes implemented in the year to date will yield a recurrent full year effect of £19.3m (up from £17.5m last month).
- Forecast delivery by the end of the year is £24.0m which would exceed plan and address £11.3m of the Trust's underlying deficit.
- The risk adjusted forecast stands at £20.9m, which would exceed plan and address £8.3m of the Trust's underlying deficit. The main reason for the reduction is due to the Flow & LOS Workstream. Bed closures have now been agreed and financially assessed following a review of the bed modelling. Further work is ongoing reviewing bedday costs and non elective length of stay benchmarking opportunities.
- The committed plan is to reduce recurrent establishment by 252.1 WTE recurrently. At the end of month 6 we have delivered a recurrent reduction of 50.6 WTE, this is forecast to rise to 65.8 WTE by the end of the year. This has reduced from 230.0 WTE in month 5 due to the re-forecasting of the Flow & LOS Workstream.

In terms of 2025/26 in-year impact:

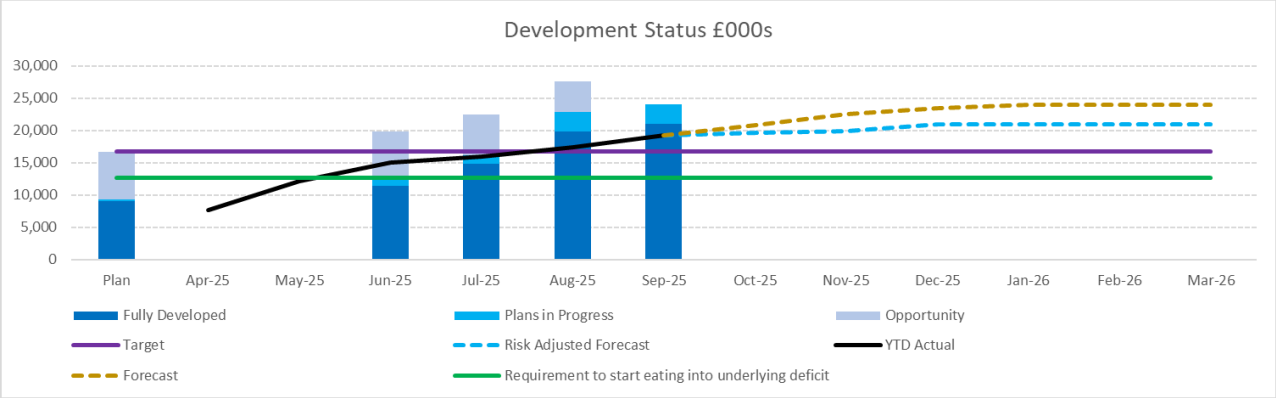
- In month 6 the Trust delivered £3.4m of savings in line with plan, bringing year to date delivery to £16.2m, also in line with plan. This includes non-recurrent savings.
- Further progress has been made in de-risking the plan with high-risk schemes falling from £2.7m to £0m in month.
- Forecast in-year savings are £31.4m in line with plan, the risk adjusted forecast now stands at £29.6m (up from £24.5m last month).
- The committed plan is to reduce by 252.1 WTE on average across the year. The average WTE reduction in the year to date is 75.0 WTE, this is forecast to rise to an average reduction of 84.1 WTE across the full year.

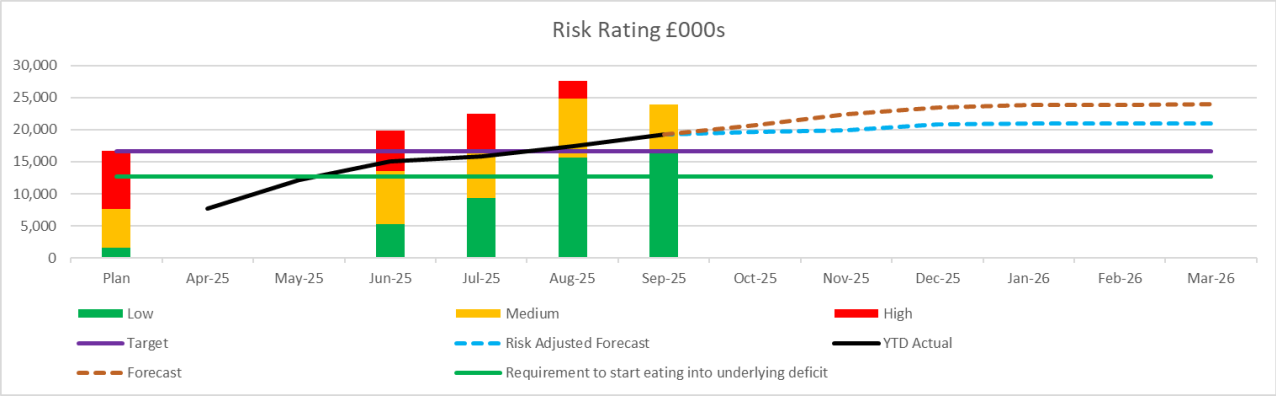
Efficiency Schemes – Recurrent FYE (£)

Recurrent FYE £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
Fully Developed	9,008	19,846	20,938	1,092
Plans in Progress	278	3,045	3,030	(15)
Opportunity	7,402	4,736	0	(4,736)
Unidentified	0	0	0	0
Total	**16,688**	**27,627**	**23,967**	**(3,660)**

Recurrent FYE £000's	April Plan Submission	Month 5	Month 6	Increase (Decrease)
High	9,083	2,718	0	(2,718)
Medium	5,973	9,200	7,622	(1,579)
Low	1,632	15,709	16,346	637
Total	**16,688**	**27,627**	**23,967**	**(3,660)**

The NHSE recurrent Plan (53% of the total target) is £16.7m. At the end of month 6 we have delivered a recurrent FYE of £19.3m and are forecasting delivery of £24.0m by the end of the year. The risk adjusted forecast is £20.9m (up from £19.8m last month)





Workstream / Scheme	Movement from prior month FYE	Value £000's	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(2,360)	High	n/a	Plan in Progress	n/a
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(2,000)	Medium	n/a	Plan in Progress	n/a
Local	x5 new recurrent schemes added in month including UEC revised rota, Surgery Breast Prosthesis	833	n/a	Low	n/a	Fully Developed
Corporate Services	Drop in FYE across a number of Digital and E&F schemes which have been offset in month with non recurrent additions	(133)	Low	n/a	Fully Developed	n/a
TOTAL		(3,660)				

Workstream / Scheme	Additional FYE expected in next month	Value £000's
Energy & Estates Management	Utilities scheme	279
Flow & LOS	Bed Closures - W&C	61
Procurement	KPMG Initiatives	347
Diagnostics	CT AI and MRI DNAs	33
Corporate Services	Digital & DNS schemes	194
Local	Multiple Divisional schemes	586
TOTAL		1,500

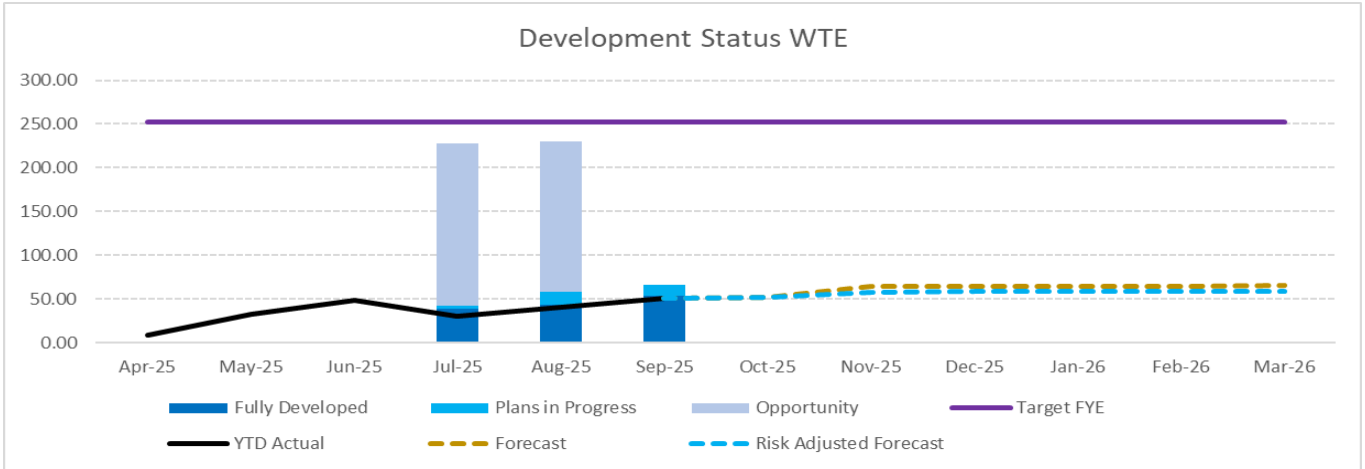
Efficiency Schemes – Recurrent FYE (WTE reduction)

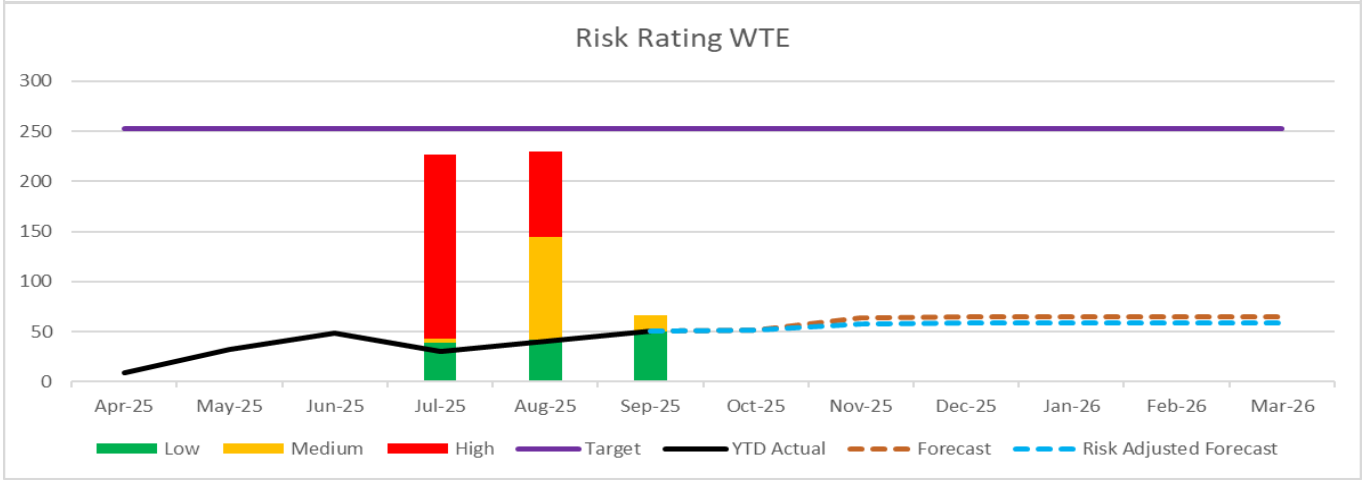
Our committed plan is to reduce by 252.1 WTE recurrently in the year. Tracking started in earnest in month 4. At the end of month 6 we have delivered a recurrent FYE WTE of 50.6 and are forecasting delivery of 65.8wte by the end of the year.

WTE - FYE	April Plan Submission	Month 4	Month 5	Month 6	Increase (Decrease)
Fully Developed	0.0	39.0	43.2	53.5	10.4
Plans in Progress	0.0	3.7	14.7	12.3	(2.3)
Opportunity	114.7	184.5	172.2	0.0	(172.2)
Unidentified	137.3	0.0	0.0	0.0	0.0
Total	**252.1**	**227.2**	**230.0**	**65.8**	**(164.2)**

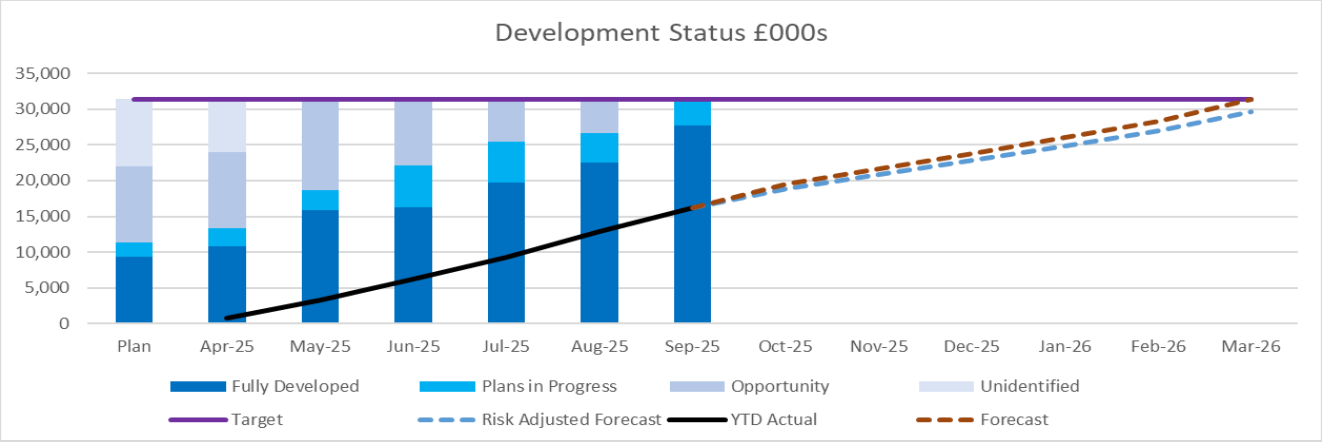
WTE - FYE	April Plan Submission	Month 4	Month 5	Month 6	Increase (Decrease)
High	252.1	184.5	85.4	0.0	(85.4)
Medium	0.0	3.5	102.6	16.2	(86.4)
Low	0.0	39.1	42.0	49.6	7.6
Total	**252.1**	**227.2**	**230.0**	**65.8**	**(164.2)**

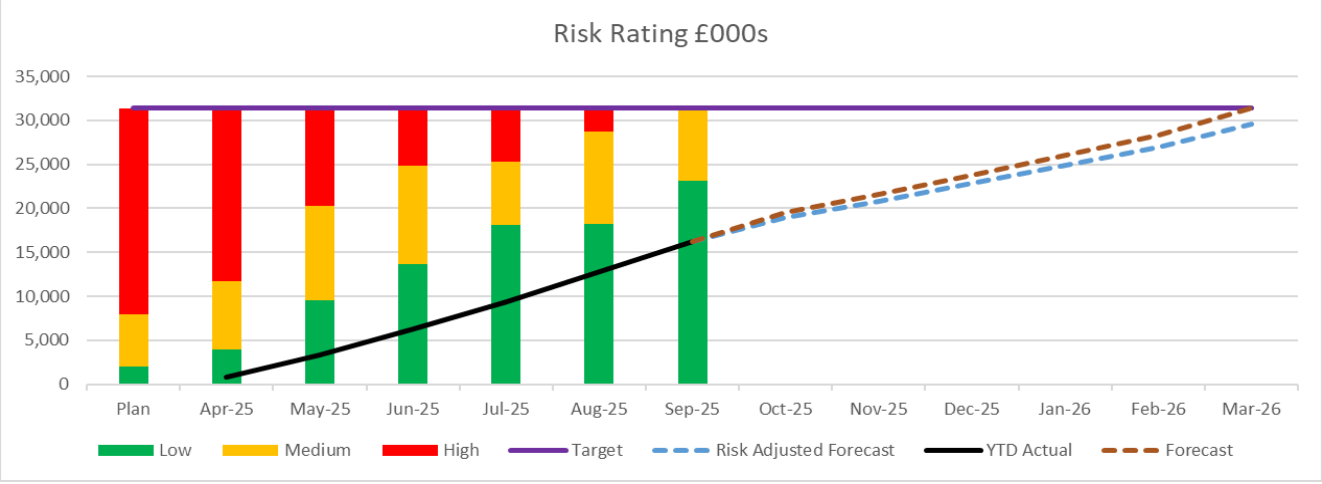
Workstream / Scheme	Movement	WTE	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(168.7)	High/Med	n/a	Opportunity	n/a
Local	x2 UEC schemes added in month	5.9	n/a	Low	n/a	Fully Developed





Efficiency Schemes – 2025/26 In Year Savings (£)





Efficiency Plan Status £000's	April Plan Submission	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Increase (Decrease)
Fully Developed	9,350	10,835	15,935	16,301	19,762	22,515	27,730	5,215
Plans in Progress	2,051	2,578	2,732	5,872	5,616	4,164	3,667	(497)
Opportunity	10,528	10,527	12,730	9,224	6,019	4,718	0	(4,718)
Unidentified	9,468	7,457	0	0	0	0	0	0
Total	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**0**

Efficiency Plan Risk £000's	April Plan Submission	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Increase (Decrease)
High	23,450	19,739	11,104	6,512	6,089	2,718	0	(2,718)
Medium	5,968	7,674	10,707	11,257	7,203	10,407	8,223	(2,184)
Low	1,979	3,984	9,586	13,628	18,105	18,272	23,174	4,902
Total	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**0**

The committed plan is to deliver £31.4m of in-year savings during 2025/26. At the half way point in the year we have delivered £16.2m of savings (52% of the full year plan). This is in line with plan and includes non-recurrent savings. Forecast delivery for the full year is £31.4m and the risk adjusted forecast is £29.6m.

The table to the right highlights the key changes in month 6 to the risk and status of planned schemes.

Workstream / Scheme	Movement	Value £000's	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(2,522)	High	n/a	Plan in Progress	n/a
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(2,000)	Medium	n/a	Plan in Progress	n/a
Local	Non Recurrent Reserve Releases	3,249	n/a	Low	n/a	Fully Developed
Local	x12 new schemes added in month including UEC revised rota, Surgery Breast Prosthesis, Corporate Pay Underspends	919	n/a	Low	n/a	Fully Developed
Corporate Services	x6 new schemes added from the E&F Directorate	500	n/a	Low	n/a	Fully Developed

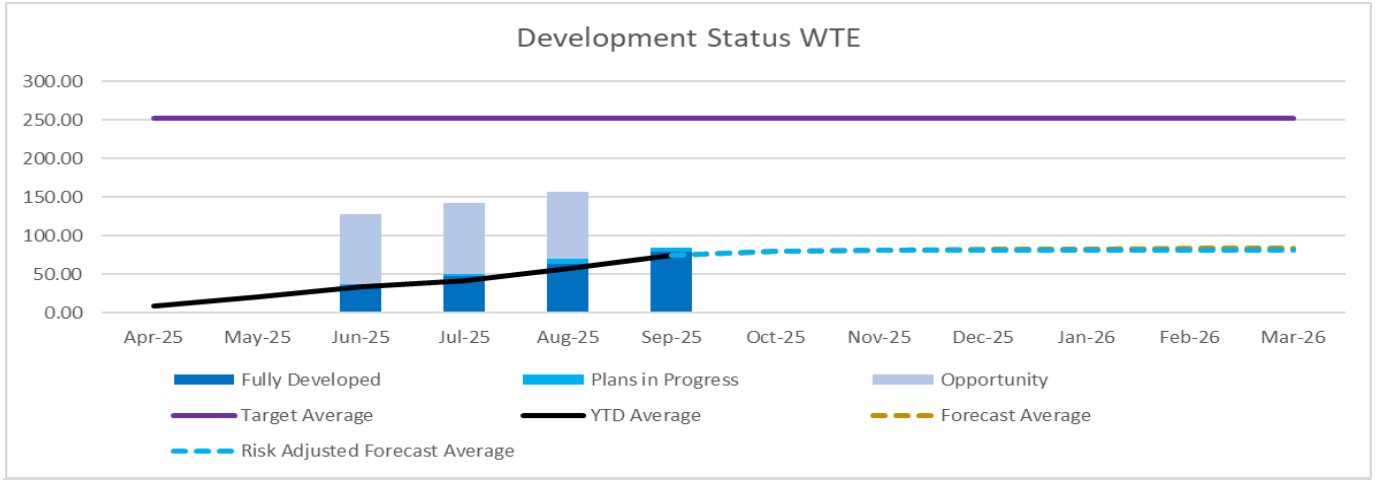
Efficiency Schemes – 2025/26 In-Year (WTE reduction)

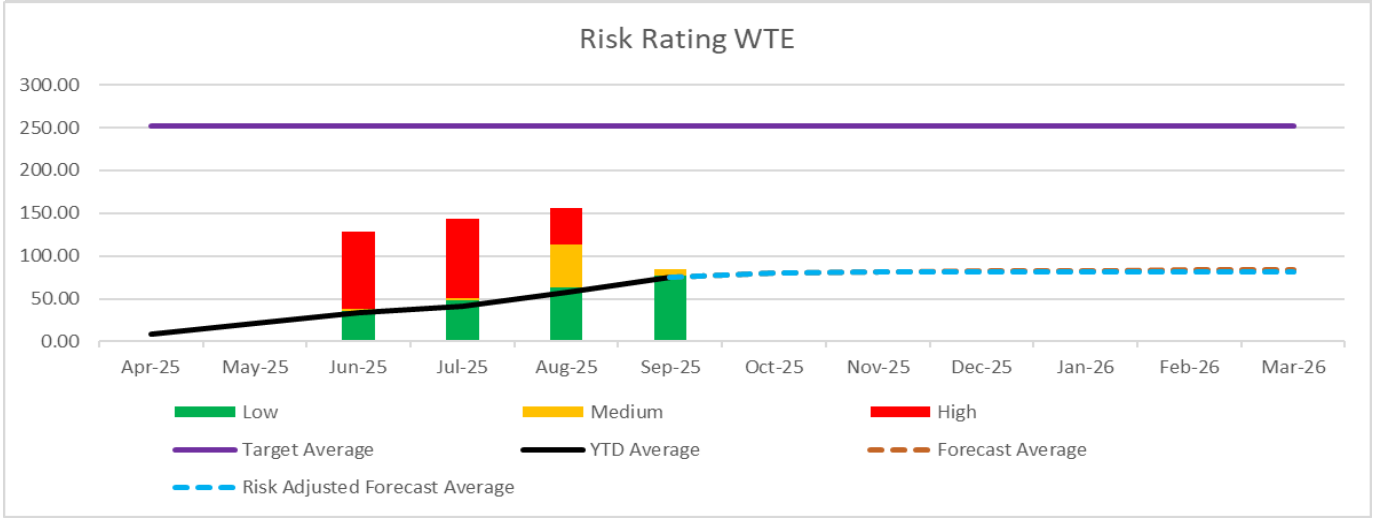
Our committed plan is to reduce by 252.1 WTE on average across the year. Tracking started in earnest in month 4. The average WTE reduction in the year to date is 75.0 WTE and the forecast average reduction across the full year is currently 84.1 WTE.

WTE - in year	April Plan Submission	Month 4	Month 5	Month 6	Increase (Decrease)	FOT
Fully Developed	-	48.0	63.8	78.9	15.1	53.5
Plans in Progress	-	2.4	6.5	5.1	(1.4)	12.3
Opportunity	114.7	92.4	86.1	-	(86.1)	0.0
Unidentified	137.3	-	-	-	0.0	0.0
Total	**252.1**	**142.8**	**156.4**	**84.1**	**(72.3)**	**65.8**

WTE - in year	April Plan Submission	Month 4	Month 5	Month 6	Increase (Decrease)	FOT
High	252.1	92.4	42.7	0.0	(42.7)	0.0
Medium	0.0	2.3	50.7	7.7	(43.0)	16.2
Low	0.0	48.1	63.0	76.4	13.4	49.6
Total	**252.1**	**142.8**	**156.4**	**84.1**	**(72.3)**	**65.8**

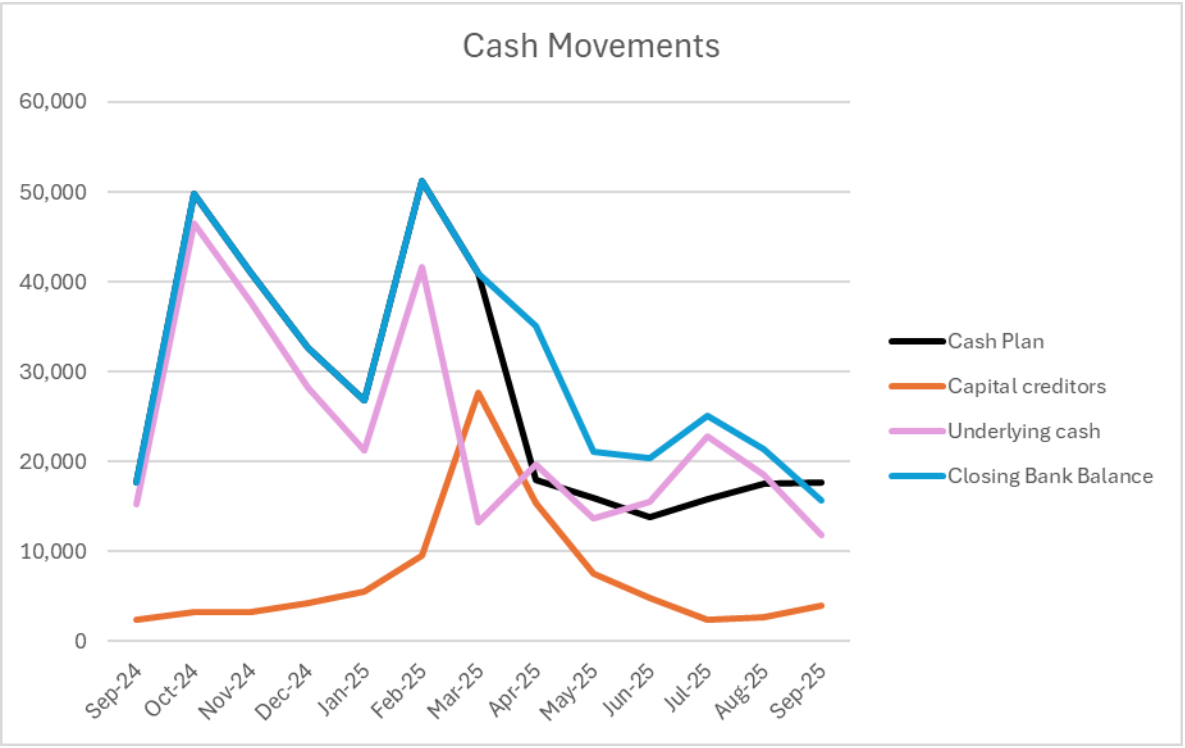
Workstream / Scheme	Movement	WTE	Risk as per Month 5	Risk as per Month 6	Status as per Month 5	Status as per Month 6
Flow & LOS	Re-forecast in month of LIVE bed reduction schemes	(83.6)	High/Med	n/a	Opportunity	n/a
Corporate Services	x3 E&F schemes added in month	4.5	n/a	Low	n/a	Fully Developed
Local	x3 UEC schemes added in month	6.3	n/a	Low	n/a	Fully Developed





Cash, Receivables and Payables

Cash reduced by £5.9m in the month to £15.7m and has fallen just below plan. The reduction in month is mainly the 6 monthly PDC payment (£2.8m), timing of Education monies (£2m) and underlying deficit. Better Payment Practice Code overall performance has improved slightly in the month as SBS problems affected August performance.



Invoice Turnaround

Average days	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
Between date of invoice and date available on system	27	13.9	20.3	14.7	11.8	13.9	16.9
Between being available on system and approval	7	8.4	7.3	6.5	8.7	12.1	8.3
Between approved date and payment date	22.4	22.2	21	21.9	45.8	32.8	27.7
Total	56.4	44.5	48.6	43.1	66.3	58.8	52.9
Total that the Trust has control over	**29.4**	**30.6**	**28.3**	**28.4**	**54.5**	**44.9**	**36**
Number of invoices	*10,397*	*7,327*	*7,807*	*9,005*	*8,373*	*9,002*	*8,652*

Better Payment Practice Code (In month)

Average days	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
NHS - %age based on invoice count	91.79%	86.34%	88.46%	85.94%	82.87%	90.82%	87.70%
NHS - %age based on invoice value	89.85%	90.10%	81.84%	88.51%	87.41%	85.59%	87.22%
Non NHS - %age based on invoice count	40.63%	36.93%	39.12%	37.65%	33.89%	39.87%	38.02%
Non NHS - %age based on invoice value	77.48%	72.66%	79.27%	80.17%	74.75%	79.27%	77.27%
Overall - %age based on invoice count	42.10%	38.00%	40.43%	39.26%	35.27%	41.50%	39.43%
Overall - %age based on invoice value	74.69%	74.31%	79.54%	81.27%	76.04%	80.00%	77.64%

Cash Projections

The graph shows a scenario analysis of cash movements between the end of Month 6 and Month 12.

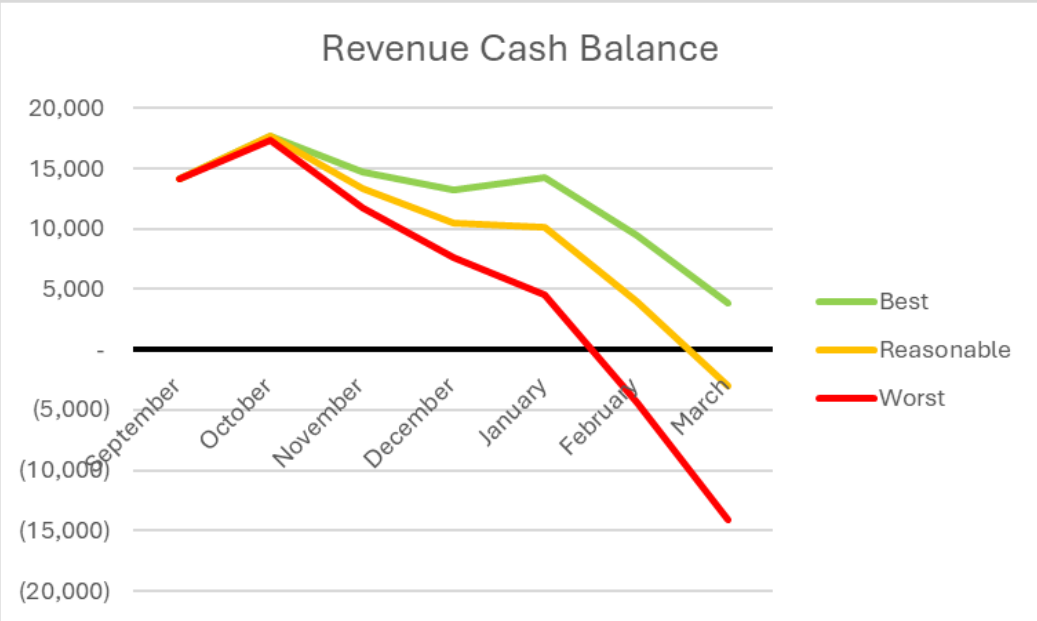
An explanation of the key differences in each scenario is shown in the table.

The *revenue* cash balance is forecast to drop below £5m at the following month ends:
Best Case Scenario – March 2026
Reasonable Case Scenario – February 2026
Worse Case Scenario – January 2026

Due to the high levels of capital spend, the split between *capital* and *revenue* cash is important and caution needs to be exercised in using the overall cash level.

These forecast timings are consistent with last month's report.

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



Key variations in models	Best	Likely	Worse
Risks/Mitigations (See Slide 4)	Efficiency mitigations of £1.8m	Total efficiency risks of £1.8m, less efficiency mitigations of £1.8m Total risk £0m	Total efficiency risks of £1.8m
Deficit Support Funding	Trust to continue receiving funding steadily through the year	Trust to continue receiving funding steadily through the year	Trust not to achieve Q4 funding Total risk £4.25m
Cash Management pressures	Extension of creditor payment terms by £5m	No change	Tightening of creditor payment terms by £5m

Capital

Capital spend in month is £2.6m, an overspend of £0.7m. However, the year to date underspend is £14.7m

	In Month Budget (£'000)	In Month Spend (£'000)	In Month Variance (£'000)	YTD Budget (£'000)	YTD Spend (£'000)	YTD Budget Variance (£'000)	Revised Annual Plan (£'000)
Estates Projects	1,154	2,252	1,098	11,891	3,698	(8,194)	31,780
Medical Equipment	141	220	79	2,450	1,950	(500)	4,758
Digital Transformation Projects	320	172	(149)	2,170	820	(1,350)	21,712
Central Capital	251	(11)	(262)	4,044	(3)	(4,048)	3,006
IFRS16 Leases	31	0	(31)	654	0	(654)	964
Total Capital Spend	**1,896**	**2,632**	**736**	**21,210**	**6,465**	**(14,745)**	**62,221**
Charitable Funds/Donated Assets	0	0	0	0	(18)	(18)	0
Total Capital Spend inc Charitable Funds/Donated Assets	**1,896**	**2,632**	**736**	**21,210**	**6,447**	**(14,763)**	**62,221**

The main areas of in month spend include SPECT CT, CT Scanner, Estates Safety (Inc Fire), Windows 11, Urology Camera Stack and Operating Table / Trolley.

A further capital allocation has been approved by the Executive Team on the 8th of October, providing a further allocation of £2m contingency to the Medical Equipment Group. It was also agreed that the VAT Recovery money received will be used to support the DCC cost pressure, following agreement of the GMP.

MOU received for DCC Critical Infrastructure Risk Scheme confirming availability of funding for 25/26.

A further MOU has been received for Cyber Security Funding awarded to the Trust for £47k, a business case is currently being developed.

The EPR business case has been through the FCR Gateway review and is currently going through NHSE detailed review process, finalisation expected by the 17th October.

Capital – Business Cases

To date 60 Capital Business Cases have been approved by CIG

To date 60 business cases have been approved through CIG, with a number of schemes in progress and orders being placed.

There is still a number of capital business cases outstanding, specifically around Digital and Medical Equipment. Work is continuing with the sub-groups to identify timeframes for completion ensuring deliverability within the financial year to ensure the Capital plan is delivered.

NHSE approval is outstanding for the following:

- UEC
- MRI Refurbishment
- Physiological Science

The Trust are currently completing the following National business cases

- Planned Care
- Echocardiogram

Business Cases Status £	Estates	Medical Equipment	Digital Transformation	Central	Total
Approved	£ 27,179,773	£ 2,354,295	£ 2,265,597	£ 100,000	**£ 31,899,665**
Awaiting Approval	£ 2,403,680	£ 2,547,689	£ 19,499,407	£ 4,906,491	**£ 29,357,267**
IFRS16 Leases	£ -	£ -	£ -	£ 964,068	**£ 964,068**
Total	**£ 29,583,453**	**£ 4,901,984**	**£ 21,765,004**	**£ 5,970,559**	**£ 62,221,000**

Business Cases Status Volume	Estates	Medical Equipment	Digital Transformation	Central	Total
Approved	21	25	13	1	**60**
Awaiting Approval	4	31	26	2	**63**
IFRS16 Leases	-	-	-	1	**1**
Total	**25**	**56**	**39**	**4**	**124**

2511 - E3 DELIVERY OF 2025/26 STRATEGIC SUCCESS MEASURES

Discussion Item | Zara Jones, Deputy Chief Executive | 13:20

10 minutes

REFERENCES

Only PDFs are attached

- E3 - Delivery of 2025-26 Strategic Success Measures.pdf
- E3 - Appendix - Strategic Ambitions and Success Measures Progress Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		Meeting Date:	4 November 2025
Report Title/ Ref:	**Delivery of 2025/26 Strategic Success Measures**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and governance James Tabor, Associate Director Planning and Performance			
Appendices:	Appendix 1: Trust Strategic Ambitions & Success Measures Progress Report			
Purpose of the report	**Assurance**	~~Decision~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**All BAF risks**: The strategic direction of the Trust risks are outlined in all the BAF Risks 1-7			

Executive Summary – Key messages and Issues

Purpose of the report

This paper presents the progress made on the Trusts Strategy and agreed strategic priorities

Background

The Board has agreed on the 4P's framework, Patients, People, Pounds, and Partnerships. We have used these to frame the discussions with our key stakeholders including governors, partners, and colleagues, on what should be the Trusts ambitions over the next 1-3 years which have been agreed as:

- **Tackling Health inequalities**, to include how decisions are made through the lens of health inequalities and how we capture this information about our patients and population, supporting services to intervene earlier and moving to a preventative approach to healthcare. This aligns to the national priority.

- Becoming a **digitally enabled and digitally mature** organisation, including the implementation of an electronic patient record system, and all of the additional workstreams that will be required in order to maximise the benefit of digital for patients and our people. This aligns to the national priority.

- Improving the Trusts estate to provide the **best care environment** for our patients and people, including the ability to deliver healthcare where it is most needed, which is not always within a specialist hospital setting, but in community locations away from the hospital site. This aligns to the national priority.

- Developing our **education and research** offer to become a centre of excellence, aligned to progressing with our ambition to become a university teaching hospital, which supports the wider people plan of attracting and retaining the best people and embedding a learning culture within the Trust.

The delivery of these ambitions is supported by enabling workstreams that are also reported as part of this update. This includes areas around strengthening the governance and internal risk reporting mechanisms of the Trust to build resilience and identify issues and risks at the earliest possible time to support a timely remedy.

Progress update framework Appendix 1

The management and monitoring of the strategic ambitions is presented in Appendix 1 and provides the progress framework that will be used throughout 25/26. This follows a similar pattern of reporting as in 24/25, with changes to the content that aligns more explicitly to the strategic ambitions and the outcomes that have so far been achieved by this.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board of Directors is asked to:
Take assurance on the progress made to date on the delivery of the strategic ambitions for 2025/26.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>These documents support the Board to be assured around the delivery of safe and effective patient care</td></tr>
<tr><td>People</td><td>These documents support the Board to be assured about delivery of the people aspects of the strategy and the impact on patient care</td></tr>
<tr><td>Partnerships</td><td>These documents support the Board to be assured around the partnership and collaboration activities taking place across the Trust and system that align to our strategic priorities</td></tr>
<tr><td>Pounds</td><td>These documents support the Board to be assured around the financial position, control and management of the Trust finances, in delivery of the strategy</td></tr>
<tr><td>Health Inequalities</td><td>These documents support the work to deliver the strategic objective of tackling health inequalities.</td></tr>
<tr><td>Legal/ Regulation:</td><td>It is a regulatory requirement for the Board of Directors to set the strategic direction of the organisation and review on a regular basis</td></tr>
<tr><td>Partner ICB strategies</td><td>These documents align to ICB and partner strategies</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td></td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Progress will continue to be monitored through the executive team.</td></tr>
<tr><td>In line with Current risk appetite

YES</td><td>Risk Appetite levels: - highlight if this report is outside of Board Assessment
<table>
<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
</table></td></tr>
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NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Trust Strategic Ambitions and Success Measures Progress Report

September 2025

Strategic Ambitions

Progress Update – Key Highlights

Tackling Health Inequalities

- Innovative equity index developed to highlight areas of priority for the Trust.
- Health inequalities self-assessment has been completed with the Board sub-group.
- Health inequalities and planning teams have worked jointly to commence a review of priorities
- Continued rollout of Health Inequalities Advocate, Change Initiators and Practitioner training.
- Health inequality impact assessment embedded

Leading Centre for Education and Research

- Positive informal feedback received from Medical School quality visit, awaiting report
- Focused approach being taken in response to GMC results with specialty-level action plans being developed and central oversight
- Opening of the Clinical Research Hub at DRI in September
- Progress on Research & Innovation enabling plan presented at July Board

Digitally Enabled and Digitally Mature Organisation

- Network upgrades and Wi-Fi upgrades at Montagu
- Implementation of Radiology Information System
- Implementation of Audiology system
- Business case creation and planning for maternity system upgrade (due to start early 2026)
- Commencement of implementation of Inpatients and RTT Federated Data Platform modules
- Launch of Digital and Data Academy
- Creation of Digital Enabling Plan 2025 – 2029 (subject to Board approval in November 2025)
- Implementation of the Yorkshire and Humber Care Record
- Read access to the Nottinghamshire Care Record

Improved Estate and the Best Care Environment

- Refreshed Green Plan
- Green Flag Awards achieved for Mexborough and retained for Doncaster and Bassetlaw
- Delivery of Estates capital programme – DCC out of the ground, SDEC's, Discharge Lounge, CT Scanner
- Development of Outline Business Case for East Ward Block
- Bronze award for 'Best Clinical Waste Reduction of the Year'
- Construction Excellence Awards and Building Better Healthcare Award nominations for BEV and CDC
- RoSPA gold award recognising improvements in Health & Safety

Success Measures

Delivery of year 3 of the People Strategy

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Next Steps
• Anti-racism work with Doncaster partners shortlisted for a national award in September. Allyship video featuring DBTH and other colleagues launched, shared amongst partners. • Data triangulation process established, with representatives from People & OD and Patient Safety teams reviewing people and patient metrics. Process agreed for escalation to Executive Team. • Second Leadership Conference held in April, and planning commenced for the third in April 2026. • Launch of 2025 staff survey in September and live until November, with supporting communications and engagement plan. Response rate currently in line with same time last year (62% in 2024). Reverted to paper surveys for Estates & Facilities colleagues, in response to feedback last year. • Appraisal season 2025 achieved a 93.28% completion rate (against 90% target). • Resources from IGLOO research study into management of long-term sickness received and considered as part of review of sickness absence policy and processes. • Positive informal feedback received from Medical School quality visit, awaiting report. Focused approach being taken in response to GMC results with specialty-level action plans being developed and central oversight.	• Sustained commitment from all partners to Doncaster Anti-racism partnership work, with refreshed approach to the working groups from October: two groups - Recruitment & Progression, Education. Areas of focus identified by the Steering Group, which is chaired by DBTH CPO. • Launch of inclusive recruitment practices e-learning in Q3. • Confirm speakers and workshops for 2026 Leadership Conference in Q3. • Further develop the emerging management competencies series of workshops in Q3/4, designed to enhance leadership knowledge and skills. • Continued year-round of engagement in Q3/4, aligned with staff survey cycle. • Revised Supporting Attendance at Work policy drafted and to go through usual approval channels in Q3/4, incorporating stakeholder feedback and learning from other trusts. Sickness absence rates declining in 2025/25 which is a positive trend, however, remains above target (5.6% v 5%). • NHSE Education Senior Leader Engagement quality visit planned in November. • Review of national report on agile working and actions to improve data quality in recording of flexible working requests.

• New factsheets, resources and posters developed to promote flexible working and support both managers and individuals. Webinars and drop-in sessions held during Work Life week in October. • New approach to DBTH Welcome (corporate induction) implemented in April with positive feedback from attendees. • Well-attended We Care into the Future events held in Doncaster and Worksop in July. • E-rostering roadmap designed and rolled-out from September.	• Review exit conversation themes at Workforce & Education Group in Q3/4 following launch of new MS form in September. • Involvement in South Yorkshire Pathways to Work programme, with further employer engagement is expected in Q3/4. • Continued roll-out of Healthrota e-rostering for medics, plan continues throughout 2025/26. • Continue to support relevant aspects of 10-point plan for improving working lives of resident doctors. • Further testing of HR chatbot, which has been developed by a member of the People & OD team.

Delivery of year 2 of Research & Innovation strategy

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Next Steps
• Successful opening of the Clinical Research Hub at DRI in September, providing treatment chairs and consultation room. • Strategic proposal developed in relation to the funding model to support the Research & Innovation enabling plan and future achievement of University Hospital status. Currently being reviewed. • Successful Innovation Expedition held, externally facilitated and designed to support an understanding of innovation through teams developing practical ideas. • Active study delivery in all key specialty areas identified in R&I strategy (Cancer, Cardiology, Respiratory, Maternal & Child Health) with at least one active study in each area.	• Review usage of Clinical Research Hub in Q3/4 and progress external capital bid outcomes to extend clinical research facilities. • Progress the next steps in the review of the strategic proposal through appropriate channels. • Applications for external research funding planned in Q4. • Recruitment plans for open studies to continue in Q3/4. • Further development of standard operating procedures to strengthen consistency in governance systems. • Increase research engagement activities with DBTH teams, once recruitment to roles in the Research team has been completed e.g. Curiosity Café.

Success Measures

Delivery of the national priorities as set out in our 25/26 operational plan

Denise Smith, Chief Operating Officer

Lead Director Progress Update	Next Steps
• Strong opening position for DBTH in the NHS Oversight Framework league tables at 51st of 134 acute trusts. • Improvements seen in 4- and 12-hour performance within ED with further work to do to return to achievement of the Trust Trajectory for 25/26. • Improvements seen in Ambulance Handovers with the Trust ahead of trajectory to deliver the required 20-minute average by March with current handovers averaging around 16 minutes. • Progress on 18-week elective performance with waits to first appointment ahead of trajectory but further focus required on wait to treatment. • Focus on eliminating 52-week waits has yielded results with the Trust on trajectory to achieve 1% by March 2026. • Continued focus on cancer standards is required in order to meet national standards for diagnosis and treatment.	• Continuing our programme of UEC improvements focussing on optimising utilisation of the Urgent Treatment Centre at Doncaster, maximising same day emergency care and reducing longer lengths of stay. • Improving elective care with the support of the NHS Elective Care Improvement Support Team. Completion of demand and capacity modelling for ENT and Orthopaedics in November 2025. • Delivery of productivity improvements in Outpatients, Theatres and Diagnostics workstreams and the associated improvement metrics • Addressing diagnostic and staging capacity pressures to improve cancer diagnosis and return to the trajectory to meet 82% by March 2026. Targeted improvements in Breast, Gynaecology, Haematology, Head and Neck, Lung and Urology to meet treatment trajectory.

Success Measures

Delivery of the 3 Quality priorities:

1. Reduction of Hospital Acquired Pneumonia
2. Antimicrobial Prescribing
3. Compliance with Mental Capacity Act

Karen Jessop, Chief Nurse & Nick Mallaband, Acting Executive Medical Director

1. Reduction of Hospital Acquired Pneumonia • Mouth Care Quality Indicators 'how well is mouth care being delivered' is now on nerve centre • QI project in place for equipment availability. • Train the trainer model on the QI project wards, involving wider MDT **2. Antimicrobial Prescribing** • Audit tool for antimicrobial stewardship (AMS) updated and quarterly antibiotic audit in place. • Established process for timely blood culture samples from ED to lab • AMS walk rounds commenced • AMS QI project commenced on AMU	• Establishing medical lead and metrics for ongoing monitoring. • Continue audit process and cascade results • Review of training in relation to blood culture sampling

3. **Compliance with Mental Capacity Act** • Nerve Centre MCA1 + 2 now incorporated. The daily assessment on nerve centre reviewed to prompt decision specific and more formal assessment and DOLS explore the benefits of the daily assessment outcome triggering a flag to indicate the patient lacks capacity (if that is the outcome) • Contribution to shaping the consent audit with a view on the Consent form 4 forms outcomes to assess if any form 4 that are part of the audit can evidence prior decision specific MCA and best interest. • MCA Trust training improvement is currently 84.37% (Q1 was 81 %) • Q3 audit will be repeating the same sample areas that were audited in Q2 so we can consider if this demonstrates any more consistency in results.	

Success Measures

Completion of the three-year plan for maternity and neonatal services

Karen Jessop, Chief Nurse

Lead Director Progress Update	Next Steps
• All elements of the single delivery are on plan to be completed by March 2026. • Theme 1: Listening to and working with women and families with compassion & Theme 3: Developing and sustaining a culture of safety, learning and support 3 - requirements are met (rated green) • Theme 2: Growing, retaining and supporting our workforce & Theme 4: Standards and structures that underpin safer, personalised and equitable care - work is underway towards meeting the requirements (rated amber)	• Theme 2 – Birthrate Plus® report awaited, expected October 2025. BAPM medical workforce business case due for completion by 15 October 2025 (to the next agreed Corporate Investment Group), labour Ward coordinators preceptorship package nearly completed and will be implemented with new recruits • Theme 4 – Saving Babies Lives Care Bundle V3.2 – 94% compliant (improving position)

Success Measures

Ensure clinically and operationally effective services by delivering strong performance aligned to GIRFT, national standards and benchmarks

Nick Mallaband, Acting Executive Medical Director & Denise Smith, Chief Operating Officer

• GIRFT governance structure in place: - 6 monthly divisional meetings and 6 monthly specialty level meetings in place focusing on further faster priorities • Reporting mechanisms in place: - Monthly reporting to National GIRFT team - Bi-monthly reports to Effective Committee and Finance & Performance Committee - National GIRFT reports published, benchmarking the organisation against national standards and other Trusts' performance • GIRFT principles embedded into Outpatients, Theatres and Pre-Op Assessment improvement workstreams • Focus on medical job planning to ensure team and individual job plans are aligned to capacity and demand modelling. Monitoring planned versus delivered activity at individual level Job Planning Consistency Committee established reviewing clinical admin / admin time allocation proportional to clinic / theatre sessions	• Continue to monitor and report performance against national standards and benchmarks • Review and refine the report structure so that quality and productivity metrics are displayed in a clear, comparable format against previous baseline data and show compliance with GIRFT recommendations • Understand barriers to achievement and support needed to overcome • Continue to ensure job plans are standardised and reflect best practice in terms of PA per session, including outpatients, pre-op time, post-op rounds, admin etc. • Support divisions/specialty teams with aligning job plans to capacity and demand plans

Success Measures

Deliver the boards Health Inequalities commitments for 25/26

Zara Jones, Deputy Chief Executive

Lead Director Progress Update	Next Steps
An equity index has been developed in-house that highlights the biggest opportunities to address inequalities using Trust data. • This has determined the areas of focus for the current year, fair waiting lists, reducing Did Not Attends for target groups, and equity focussed approaches to improving access to Women and Children's services. • The health inequalities self-assessment has been completed with the Board sub-group to establish the baseline for improvement and identify priority areas of focus, e.g. data and analytics. • Health inequalities and planning teams have worked jointly to commence a review of priorities and gaps from the 25/26 planning exercise which has now moved into phase 2. • Continued rollout of Health Inequalities Advocate, Change Initiators and Practitioner training. • Health inequality impact assessment embedded as part of trust executive and board reporting. • Board member pledges exercise completed.	• Complete the review of the 25/26 planning exercise health inequality priorities and gaps to be completed November 2025. • Targeted DNA reductions with an equity focussed approach linked into the DBTHi outpatients programme initially throughout the remainder of 25/26. • Completion of the Equity Index development by January 2026. • Implementation of the fair waiting list approach using the Coventry and Warwickshire HEARTT tool. • Health inequalities self-assessment tool to be repeated in April 2026 to measure organisational progress. • Trial of Health Inequalities case study and patient experience for a public Board meeting planned for Q3-4 • Further development of the communications plan linked to the Trust strategy to continue to raise the profile of the programme

Success Measures

Embed improved trust governance and risk management at Board and committee level to support robust leadership and decision making

Zara Jones, Deputy Chief Executive

Lead Director Progress Update	Next Steps
The Trust ambition is to ensure ward to board insight on the core standards and national metrics which DBTH are expected to deliver and to improve the consistency of this information flow across the trust. In delivering this the first step is to apply a consistent approach with standard templates to support the divisions. The principles outlined in the NHS Insightful Provider board Guidance. These actions are structured around ensuring the Trust becomes more aware of the issues it needs to know, in a timely manner and in a way that can manage risks and issues at the earliest possible point of intervention. Performance Review Meetings monthly now with consistent approach, agenda items and reporting principles to all divisions • Completed governance baseline for all divisions in August / September 2025 to inform next steps • Compliance with the Trust Risk Management policy with BAF and Risk register at every committee and board meeting and process reported at the Audit and Risk Committee • Risk annual report showing the progress on risk plans across the Trust and reported at the Audit and Risk Committee biannually.	• Corporate Performance Review Meetings to commence with consistent approach to performance (December 2025) • To commence work on DBTH Governance Manual, which will articulate the corporate governance arrangements in the first phase (January 2026) • Review recommendations from the external well-led assessment to align implementation (January 2026)

Success Measures

Investment into digital platforms for improvements to care, and delivery of the Electronic Patient Record business case deliverables for 25/26

Sam Wilde, Chief Finance Officer

Lead Director Progress Update	Next Steps
• Trust Board approval of the Electronic Patient Record Full Business Case (FBC) • Preparatory work on the Memorandum of Understanding, Change Control Notice, Commercial aspects ahead of FBC approval by NHSE, expected in November 2025 • Upgrades to CaMIS (Patient Administration System) and Nervecentre • Optimisation of Digital Paging System • Progress on the Windows 11 and Office 365 upgrades • Device Refresh Programme underway • Assessment against the NHS Digital Maturity Assessment in summer 2025 • 'Standards Met' assessment against the Data Security and Protection Toolkit	• EPR FBC to be approved by NHSE in November 2025 and by Cabinet Office, thereafter • Implementation of the Oracle Health EPR to commence on 16 February 2026 and conclude in late 2027 • Oracle Health Change Control Notice to be signed • Mobilisation of colleagues to support EPR implementation • Clinical Subject Matter Experts to be recruited across DBTH • Implementation of Single Cancer Management System to commence

Success Measures

Delivery of the 25/26 financial plan and improvement in the underlying financial sustainability

Sam Wilde, Chief Finance Officer

Lead Director Progress Update	Next Steps
• £1.2M year-to- date surplus delivered in H1 in line with financial plan • Net risk to delivery of 2025/26 financial plan eliminated from £20.5M by the end of month 5. Gross risk reduced from £32.0M in planning submission to £6.4M at the end of H1. • Recurrent efficiency schemes implemented in H1 will yield annual savings of £19.3M every year going forward. This exceeds the full year plan of £16.7M. • In-year efficiency savings (including non-recurrent) delivered in H1 total £16.2M (52% of the full year plan). • £15.7M cash balance at the end of H1 is just below £15.8M planned level. • £6.4M H1 capital expenditure is £14.7M below plan. • Estimated underlying deficit exiting 2025/26 improved to £35.5M from £41.2M exiting 2024/25. This is better than the £37.2M estimate of 2025/26 exit rate in the planning submission. • Latest figures show DBTH implied productivity has improved by 4.9% between M3 YTD 2024/25 and M3 YTD 2025/26. This compares favourably with the 3.4% regional average and is driven mainly by reduction in real-term costs. However, DBTH implied productivity remains 10.7% below pre-COVID levels.	• Continue to deliver all aspects of the 2025/26 financial plan throughout the remainder of the year. • Latest forecast suggests recurrent efficiency schemes implemented across the whole year will deliver annual savings of £24.0M by the end of the year. • Seek cash support from system and/or NHSE if and when required. Latest projections show revenue cash balance dropping below £5M in March 2026 (best case), February 2026 (reasonable case) and January 2026 (worst case) • Develop medium term financial plan (including detailed plan for 2026/27) during H2 in line with national timetable.

2511 - E4 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

Decision Item | Zara Jones, Deputy Chief Executive | 13:30

Executive Directors
10 minutes

REFERENCES

Only PDFs are attached

E4 - Board Assurance Framework including Trust Risk Register (1).pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Board Assurance Framework Compliance and Risk Register**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance Tracy Evans-Philips, Trust Risk Manager			
Appendices:	Appendix 1: Risk Report and Trust Risk Register Appendix 2: BAF Risk 1 - 7			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	Compliance to the Risk Policy and Board Assurance Framework impacts the effectiveness of the Board to monitor the Trusts Strategic risks			

Executive Summary – Key messages and Issues

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

Background and Summary

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

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

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

The BAF reflects the ongoing changes and updates to the strategic risks of the organisation. These are updated by the lead executive and monitored through the responsible committees. All risks and action plans are discussed in line with the risk policy.

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

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

To note the Partnership and collaboration risk is usually discussed within the board development sessions, however this was not possible in October and so will be discussed within the confidential board in November and presented to the public board in January. A deep dive of Risk 4 (estates) will also take place in December's board development session, and facilitate the ongoing discussions around the highest risks, and their management for DBTH.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board of Directors are asked to:
Receive the report.
Approve the current BAF risk content and take assurance this enables the Board to fulfil its duty to monitor its highest strategic risks.
Note that the BAF and Trust Risk Register is a live document, which will be reviewed and updated regularly throughout the year.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>Regular review and assessment of the risks to patient care support the delivery of safe and effective services.</td></tr>
<tr><td>People</td><td>Regular review and assessment of strategic risks, support our people to deliver safe and effective care.</td></tr>
<tr><td>Partnerships</td><td>This paper has no positive or negative impact on partnerships, however, may identify areas of risk as part of a triangulated approach to risk management.</td></tr>
<tr><td>Pounds</td><td>Regular review and assessment of the financial risks, support delivery of the strategic priority to be sustainable and spend money wisely. Regular review may identify areas of financial or resource risk as part of a triangulated approach to risk management.</td></tr>
<tr><td>Health Inequalities</td><td>All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities</td></tr>
<tr><td>Legal/ Regulation</td><td>It is a regulatory requirement as part of the NHS Code of Governance for the Board of Directors to have mechanisms in place to manage and address risk throughout the organisation.</td></tr>
<tr><td>Partner ICB strategies</td><td>These documents have no positive or negative impact on ICB Strategies</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Quality Committee
People Committee
Finance and Performance Committee</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>To be reviewed and updated in subsequent committees of the Board</td></tr>
<tr><td>In line with Current risk appetite

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

Board Assurance Framework and Trust Risk Register Review

BAF Summary of Changes:

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

Trust Risk Register (Appendix 1)

Summary of data extracted from Datix Risk Management System 13 October 2025
Author: Tracy Evans-Phillips, Trust Risk Manager.

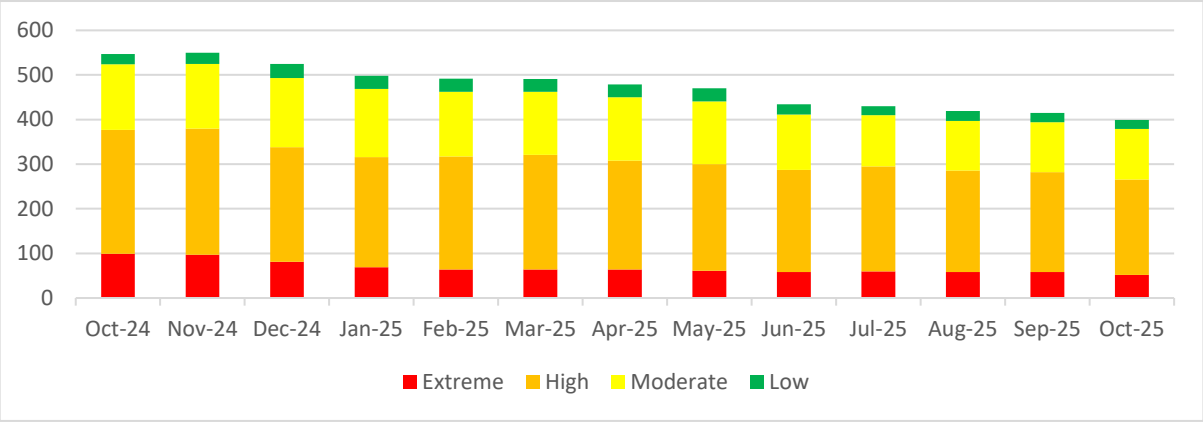
Introduction

This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the continued efforts of the Risk Management Group to assess and moderate risks, including escalations to the Trust Leadership Team and any new developments in risk management practices.

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

Risk Activity September to October 2025

Between August and October 2025, the total count of risks recorded on the register fell from 419 to 399, representing a net decrease of 20 risks, or approximately 4.7%. This positive change is attributed to proactive management of risks, whereby risks have been closed or reclassified as controls have strengthened, and issues have been addressed. The Trust's overall risk landscape is improving, evidenced by a lower number of open risks compared to the previous reporting period. This downward trend reflects the effectiveness of ongoing risk controls and mitigation measures, as well as the active upkeep of the risk register. The decline in risk numbers is the outcome of several contributing factors, including the resolution and archiving of certain risks, alongside others being downgraded due to completion of risk action plans.



Overview of Risk Numbers and Changes

- Risks archived: 30
- New risks added: 10
- Risks escalated (risk rating increased): 5

- Risks downgraded (risk rating decreased): 23
- Risks with no change in rating: 361

Between August and October, the Trust saw meaningful movement across the risk register. This pattern supports a positive trend in risk management at DBTH. The high number of downgrades compared to escalations suggests that existing controls are working effectively. The addition of new risks shows that the system is responsive to change, and the archiving of resolved risks helps keep the register current and focused. Together, these movements reflect a maturing risk process that balances vigilance with proactive management.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	**4**	
Moderate	**9**	
High	**13**	
Extreme	**4**	Overarching EPRR* Risk, converted into separate domain risks Maternity mental health risk, merged into the Trust mental health risk Two Audiology risks with multiple themes closed one new risk opened
Total	**30**	

*EPRR – Emergency Preparedness, Resilience and Response

The majority of archived risks were moderate or high, indicating active management and resolution of significant issues. The Extreme risks included a broad EPRR* risk which was split into separate domain-specific risks for better oversight. A maternity mental health risk was merged into the wider Trust mental health risk, and two complex Audiology risks were closed with one new risk opened to reflect the key theme relating to waiting lists. This targeted consolidation and closure of risks supports a more streamlined and focused approach to risk management, helping the Trust maintain clarity and control over its active risk profile.

Risk Management Group (RMG) Update

The RMG's recent work shows a strong commitment to improving risk management, with deep dives and moderation helping to address complex and longstanding risks. The move towards more frequent reviews, better action plan compliance, and clearer reporting supports a more resilient and responsive risk process. These efforts provide assurance that risks are being managed proactively and transparently.

Moderation and deep dives are a central part of the RMG's approach. In July, deep dives were conducted into Clinical Specialist Services and Chief Operating Officer risks, examining issues such as medicine shortages, outdated ICU layouts, and EPRR non-compliance. These sessions allowed for detailed scrutiny of root causes, mitigations, and future actions, supporting more informed decision-making and targeted improvements. In September, a finance deep dive was held, focusing on cash flow forecasting, cost improvement plans, and counter-fraud risks. These deep dives are important as they provide assurance that complex and high-impact risks are being actively managed and that mitigations are robust.

Longstanding risks have also been a focus. The group noted that a significant number of risks have been open for over 24 months, particularly in Estates and Facilities, which are reliant on capital expenditure for mitigation. The RMG discussed the need for realistic target ratings and agreed to trial propose changes to review periods for extreme and long-standing risks, aiming for annual reviews by exception (planned for November). This pilot

would test out the focus of value-adding activity in respect of the risk management framework, in an area that has already demonstrated its robust risk management processes via RoSPA Gold status.

Other salient points include improved action plan compliance, now at 80%, achieving the target, and a reduction in overdue risks. The group continues to transition away from overarching risks, splitting broad risks into more manageable themes for better oversight. Risk moderation is ongoing, with new risks regularly added and reviewed.

Risks escalated to Trust Leadership Team

There have been no escalations to the Trust Leadership Team.

SHIELD Risk Register

The Trust has implemented a new system to identify, record and monitor specialist resilience and hostile risk threats. The Security, Hazards, Incidents, Emergencies, and Localised Disruptions (SHIELD) Risk Register is a dedicated area within the Trust's risk management system and is maintained separately from the operational risks and aligns to the national framework. SHIELD risks are evaluated using a "reasonable worst-case scenario" and identify the effect to DBTH plus other potential targets within its operational footprint. This governance and assurance process provide effective oversight and continuous improvement and will be monitored by the EPRR Group, chaired by the Chief Operating Officer and Risk Management Group, chaired by the Deputy Chief Executive Officer. These risks will be identified and reported on within existing risk management and reporting structures from November 2025.

Appendix 1 Trust Risk Register

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

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

BAF	Risk ID	Risk Owner	Title	Review date	Regular Review	Rating (current)	Rating (Target)	Risk score requires review	Time at current risk rating (months)	Duration requires review	Number of Dependent Extreme Risks	Action Status
BAF 1	1517	Chief Pharmacist	Medicine shortages from supply chain issues delay treatment, risking harm, errors, and reduced patient safety and satisfaction	28/10/ 2025	✓	15	6	No	15 Months	RMG Deep Dive ✓	0	✓
BAF 1	3209	Chief Operating Officer	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	31/12/ 2025	✓	8	6	No	3 Months	No	0	✓
BAF 1	3246	Deputy Chief Nurse	There is a risk of regulatory action due to poor application of Mental Capacity Act and Deprivation of Liberty Safeguards	16/01/ 2026	✓	15	9	No	31 Months	RMG Deep Dive ✓	0	✓
BAF 1	3290	Chief Nurse	Risk of harm to patient, due to Registered / Unregistered Skill mix across Adult Inpatient areas not in line with guidance.	01/12/ 2025	✓	10	6	No	29 Months	RMG Deep Dive ✓	0	✓
BAF 1	3454	Executive Medical Director	Insufficient governance and service gaps risk failure to meet guidance, leading to harm, regulatory action, and reputational damage	31/12/ 2025	✓	16	8	No	19 Months	RMG Deep Dive ✓	3	✓
BAF 1	3678	Chief Operating Officer	Non-Compliance with National HAZMAT/CBRN Preparedness Standards Resulting in Regulatory, Operational, and Safety Risks	29/12/ 2025	✓	15	8	No	4 Months	No	0	✓
BAF 1	3769	Chief Operating Officer	Gaps in Emergency Response Frameworks may Impact EPRR Compliance and Incident Response (Domain 3)	28/11/ 2025	✓	15	6	No	3 Month	No	0	✓
BAF 1	3770	Chief Operating Officer	Limited Assurance Around On-Call Training May Impact Effective Incident Coordination and Compliance with EPRR Duties (Domain 4)	28/11/ 2025	✓	15	6	No	3 Month	No	0	✓

BAF 1	3771	Chief Operating Officer	Gaps in EPRR Training and Exercising May Limit Incident Response Effectiveness and Compliance with Statutory Duties (Domain 5)	28/11/2025	✓	15	6	No	3 Month	No	0	✓
BAF 1	3773	Chief Operating Officer	Potential Gaps in HAZMAT/CBRN Preparedness May Compromise Operational Safety and Assurance (Domain 10)	28/11/2025	✓	15	6	No	3 Month	No	0	✓
BAF 2	16	Chief People Officer	Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs	27/02/2026	✓	9	9	No	2 Month	No	2	✓
BAF 2	19	Chief People Officer	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	30/10/2025	✓	8	8	No	11 Months	No	0	✓
BAF 3	3434	Deputy Chief Operating Officer	Timely access to diagnostic services - Demand, Capacity & Flow	31/12/2025	✓	12	12	No	20 Months	Yes Jun 26	4	✓
BAF 3	3435	Deputy Chief Operating Officer	Timely access to elective care - Demand, Capacity & Flow	31/12/2025	✓	12	12	No	20 Months	Yes Jun 26	2	✓
BAF 3	3436	Head of Cancer Nursing	Timely access to cancer services - Demand, Capacity & Flow	31/12/2025	✓	12	12	No	16 Months	Yes Jun 26	0	✓
BAF 3	3437	Deputy Chief Operating Officer	Timely access to emergency care - Demand, Capacity & Flow	31/12/2025	✓	16	12	No	20 Months	Yes Jun 26	5	✓
BAF 4	12	Director of Infrastructure	Failure to ensure that estates infra-structure is adequately maintained and upgraded in line with current legislation	28/11/2025	✓	25	10	No	7 Months	RMG Deep Dive ✓	11	✓
BAF 4	1083	Operational Director of Estates and Facilities	Risk of electrical failure due to age and condition of HV/LV infrastructure	28/11/2025	✓	15	10	No	87 Months	Yes Apr 26	1	✓
BAF 4	1412	Deputy Director of Estates and Facilities	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the RRFSO	31/12/2025	✓	15	10	No	55 Months	Yes Apr 26	6	✓
BAF 4	1807	Operational Director of Estates and Facilities	Risk of Critical Lift Failure in a Number of Passenger Lifts Trust Wide	31/12/2025	✓	16	8	No	7 Months	RMG Deep Dive ✓	2	✓
BAF 4	3348	Executive Medical Director	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/04/2026	✓	12	10	No	12 Months	No	1	✓
BAF 5	3628	Head of Project Management Office (Finance)	25/26 PMO2 Financial services don't complete financial analysis of identified schemes within agreed timescales delaying schemes	14/01/2026	✓	6	6	No	7 Months	No	0	✓
BAF 5	3629	Chief Finance Officer	25/26 Risk of Fraud, Bribery and Corruption against the Trust through criminality by exploitation of control measures.	13/11/2025	✓	12	8	No	7 Months	RMG Deep Dive ✓	0	✓
BAF 5	3630	Head of Project Management Office (Finance)	25/26PMO1 Lack of engagement/capacity from operational services to deliver project objectives/CIP schemes not delivering savings	14/01/2026	✓	9	6	No	7 Months	No	0	✓
BAF 5	3631	Head of Project Management Office (Finance)	25/26 PMO3 - Monday.com system failure resulting in the loss of project information	14/01/2026	✓	10	10	No	7 Months	No	0	✓
BAF 5	3632	Chief Finance Officer	Failure to achieve compliance with financial performance and achieve 2025/26 financial plan	10/11/2025	✓	16	8	No	7 Months	RMG Deep Dive ✓	0	✓
BAF 5	3634	Deputy Director of Finance	Failure to deliver 25/26 Cost Improvement Plans impact on the Trust's deliver of financial targets	10/11/2025	✓	16	9	No	7 Months	RMG Deep Dive ✓	0	✓
BAF 5	3635	Deputy Director of Finance	Failure to deliver 25/26 Capital Programme including inability to meet Trust's needs for capital investment	13/11/2025	✓	9	6	No	7 Months	No	0	✓
BAF 5	3636	Deputy Director of Finance	Non-delivery of 25/26 activity targets impacting on levels of income received by the Trust	13/11/2025	✓	6	6	No	1 Month	No	0	✓
BAF 5	3637	Deputy Director of Finance	Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital	10/11/2025	✓	16	8	No	7 Months	RMG Deep Dive ✓	0	✓
BAF 5	3639	Deputy Director of Finance	Failure to capture all 25/26 NHS revenues may result in reduction in payments by commissioners	16/03/2026	✓	4	4	No	3 Months	No	0	✓
BAF 6	3507	Director of Education and Research	Failure to meet MHRA research inspection standards	20/10/2025	✓	12	4	No	16 Months	Yes Mar 26	0	✓

BAF 7	1410	Head of Digital Operations and Cyber Security	Failure to protect digital assets, risk of a cyber-attack which may result in the Trust being non-operational	30/04/2025	✓	10	10	No	4 Months	No	0	✓
BAF 7	1663	Chief Information Officer	Failure of the HSCN, Internet, or VOIP telephony external network connections	14/11/2025	✓	8	4	No	11 Months	No	0	✓
BAF 7	2727	Digital Infrastructure Manager	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	31/10/2025	✓	9	3	No	19 Months	Yes Nov 25	0	✓
BAF 7	2736	Head of Digital Operations and Cyber Security	Gaps in process, tech & config documentation, resulting in risk to operations, business continuity & DR	30/01/2026	✓	9	6	No	44 Months	Yes Nov 25	0	✓
BAF 7	3184	Chief Information Officer	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	28/11/2025	✓	8	4	No	21 Months	Yes Nov 25	0	✓
BAF 7	3384	Chief Information Officer	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	20/02/2025	✓	8	8	No	11 Months	No	2	✓

Appendix 2: Board Assurance Framework –

Strategic Risk 1	*If there is a failure to embed the learning from incidents or listening to patients, Patients could experience avoidable harm, resulting in poor patient outcomes and possible regulatory action for DBTH.*						**Strategic Objective: Patients**	**We deliver safe, exceptional, person-centred care**
Lead Committee	Quality Committee	Risk Rating	Current Exposure	Tolerable	Target (March 26)	Risk Type	Strategic/ reputational	Links to Significant Risks on Risk Register
Executive Lead	Chief Nurse / Executive Medical Director	Likelihood	4		4	Risk Appetite	Quality: Cautious Regulatory: Cautious	3209; 3454; 3449; 3290; 1517, 3769,3770, 3771, 3773
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Last reviewed (by on behalf of Lead Directors)	October 2025	Risk Rating	**16**		**12**			
Last Changed (By Lead Committee)	December 2024	Inherent Score	5x4=20					

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC**	**Sources of Assurance relating to effectiveness of the controls and dates (Evidence that the controls/ systems which we are placing reliance on are effective)**	**Gaps in Assurance (Insufficient evidence as to effectiveness of the controls or negative assurance) GA**	**Current Assurance Level Assigned, (including where actions are in place to address gaps)**
Chief Nurse Oversight Framework – which includes ongoing monitoring of quality metrics, peer reviews, expert reviews, and the ward accreditation process.	**GC1** Quality Dashboard remains under development, ongoing issues with data quality and roll out of metrics	Divisional performance monitored at Performance Review Meetings with Exec oversight, (monthly) (1) CQC Quarterly Engagement Meetings (3) CARE Accreditation Process review oversight update to QC (Aug 25) (1) Maternity, Neonatal Quality and safety Group (1) IQPR (2) CQC Action plan completion assurance paper (October 25) (2) Safeguarding Annual Report at board (September 2025) (2) Annual Director of Infection Prevention and Control Report at board (September 2025) (2) Section 11 Safeguarding return provided to Safeguarding Partnership board (Notts March 2024 and Doncaster October 2024) (3) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3)		**Significant Assurance**
Compliance with Developing workforce safeguards including use of Safer Nursing Care Tool and biannual workforce reviews (BR+ for Midwifery) Establishment changes via Chief Nurse approval.	**GC2** Nursing skill mix of RN/Non-RN is not in line with national guidance **GC3** Limited national guidance/decision support tools and reporting for Allied Health Professionals	Biannual establishment review reporting for Nursing to People Committee (Feb 25) (2) Trust wide safe staffing meetings (1) Established use of safe care (1) Evidence of escalation in incident reporting (1) Monthly compliance with safe staffing care hours per patient day reporting via unify (2) AHP Biannual workforce report presented to People Committee (Jun 25) (2) Biannual Midwifery Workforce report to Trust Board of Directors (Jul 25) (2) Skill mix improvement business case to CIG approved (2)		**Significant Assurance** **Significant Assurance** **Significant Assurance**
Clinical Audit Programme and monitoring.		Report to Quality Committee June 2025 (2) Monday.com dashboards reports into Audit and effectiveness forum (1)	**GA2** Clinical Audit oversight not consistent across all areas.	**Significant Assurance**

Learning from deaths review process	**GC4** Insufficient structured judgement reviews (SJRs) completed to contribute to Learning from Deaths **GC5** No substantive Learning from Deaths manager in post	Mortality (and DQ) report to Quality Committee (2) Compliance with Quarterly reporting of perinatal mortality review tool outcomes (2) SANDS review of bereavement care (3)		**Significant Assurance**
Clinical policies, processes and clinical guidelines Risk Management Policy,	**GC7** Inconsistent use of complaints handling Policy **GC8** Application of the MCA not consistently applied across the Trust **GC9** High numbers of Clinical policies are out of date **GC10**: Antimicrobial Stewardship Procedures not consistently applied in all areas	Internal Audit Complaints Handling Policy (Oct 24) (3) (Moderate **Assurance)** Infection Prevention Control Steering Group (1) Internal Audit- Medicines Management **(Significant Assurance)** Risk Management Group (1) Actions completed and reported through to Audit and Risk committee (July 25)(**2)** Risk Management Group assesses and moderates significant risks and presence of valid action plans monthly (2)	**GA3** Lack of visibility of resuscitation activity and RESPECT compliance **GA4:** Implementation of recommendations for medicines management Internal Audit	**Moderate Assurance** **Significant Assurance** **Moderate Assurance**
Patient safety incident response plan	**GC11** Trust wide safety improvement plans under development and not embedded	Never event and PSII tracker at internal meetings (1) Patient experience Annual reports to Trust Board (sept 24) (2) Never Event Exception report to QC (Oct 24) (2) Divisional and Trust LFPSE panels (1) Trust Executive Patient Safety Oversight Group (2) Patient Safety report to QC (Oct 25) (2) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3)		**Significant Assurance**
Clinical Negligence Scheme for Trusts monitoring and oversight (maternity and neonates)		LMNS-Local maternity and neonatal Annual system check & challenge, feedback received and shared at QC (Jun 25) (3) CNST divisional oversight group highlight reports (1) Maternity, Neonatal Quality and safety committee (2) Maternity safety champions visits and meeting (2) Received confirmation of achievement of Year 6 CNST from the Maternity incentive scheme (Jun 25) (3) Maternity and Neonatal report to QC		**Significant Assurance**

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

Actions	Timescale	Lead	Progress update
GA2) Effectiveness Group receive divisional clinical audit highlight reports to check compliance with actions for clinical governance recommendations	March 26	EMD	All activities monitored through Monday.com and standardised templates for reporting through local governance, audit and effectiveness forum, and Effective Group. Report due to Quality Committee in October to provide assurance on progress of actions for compliance. Reporting on clinical audit remains on the Quality Committee work plan for assurance oversight.
GA3) Education Team working with EMD office to establish baseline for understanding required actions for RESPECT and resuscitation.	December 25	EMD	Audit review will come to Quality Committee once completed with next steps to address the gaps. Will be a priority area of focus in 2025/26, The Audit has been done at ward and service level. It was not possible to do through Tendable so will be done through Survey Monkey. Once the data capture form has been checked and signed off by the resus lead, it will be launched across the trust. An update to this is included in the resuscitation report that will go to PSRG in October 25 and will come to Quality Committee in December 25 to provide evidence that this assurance gap has been closed
GA4) Medicines management Implementation of Internal Audit 2 moderate recommendations.	October 2025	CN	Plans are in place to complete the recommendations; progress towards completion will be reported to Trust leadership team.
GC1) Quality dashboard implemented with phase 1 & 2 development complete overseen by IT (information services) Phase 3 development is underway. Further iterations included in annual plan for consideration in business planning processes.	September 25	CFO	Team met to review and adjust relevant metrics and issues with the timing of data capture inaccurately impacting on compliance.

GC4) SJR plan in place to address current gaps	December 25	EMD	Phase 3 is now ongoing training following identification of consultants once they come forward to be involved in the SJR process. A report is presented to Quality Committee for October 25 to demonstrate progress on the SJR process, with an additional 9 medics added to the cohort available for these. This will start to take affect from November 25.
GC5) Recruitment to Learning From Deaths Manager	December 25	EMD	October 25 update: The learning from deaths function to be combined into a new role with the Head of Clinical Audit and Effectiveness. This change is in progress and is following the internal process of job evaluation and banding prior to recruitment commencing. The previous interim arrangements remain in place until this is completed.
GC8) MCA steering group established with associated work plan	September 25	CN	Reported via Strategic Safeguarding Group, MCA advisor posts now recruited to
GC9) Implement and embed processes to ensure Trust wide clinical policies are reviewed in a timely fashion	September 25	DCEO	Process established for all policies on Monday.com for monitoring. Reports are shared with executives monthly to review and prioritise getting policies reviewed, Currently no policy support in place so reviewing a more sustainable and resilient option for the Trust for all policy management.
GC10) Continue with ongoing processes of antimicrobial ward rounds, embed role of antimicrobial stewardship nurse	September 25	CN	Role recently recruited to, plan to undergo induction and review of workplan utilising fresh eyes.

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

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) **RC**	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) **GC**	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) **GA**	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
The People Strategy Delivery Plans IA Bank and Agency processes	**GC1:** Additional actions identified to support return to work and reduce sickness absence.	Chief People Officer Senior Leadership meeting (1) Reports assurance at People Committee (2) IA Pay and expenditure (3) **Significant Assurance** IQPR to Board (2)		**Significant Assurance** **Significant Assurance** **Significant Assurance**
HR policies and support resources including Health and wellbeing resources.	**GC2:** Identified gap of capturing information from exit interviews.	Policy Formulation Group (1) Operational Delivery Groups (1) Reports to People Committee (2) Internal Audit eRostering (3) Moderate/Limited *Internal Audit Absence Management 2025 – 26 Audit plan (3)*		**Significant Assurance**
Equality Diversity & Inclusion Improvement Plans		EDI Forum reports bimonthly (1) People Committee Biannually (2) WRES and WDES data reporting to Board (3) Diversity and Inclusion 2025-*26 Audit Plan (3 *Internal Audit Strategy 2023-2027 Equality*)	**GA4:** Internal Audit Equality, Diversity & Inclusion. Significant Assurance - one recommendation	**Significant Assurance**
Education Quality Framework		Operational Delivery Groups and Networks (1) People Committee reports (2) External Quality Visits (Various annual) (3) Learner Feedback and Surveys (various ongoing) (3)		**Significant Assurance**
People Engagement Strategic Approach		People Committee reports (2) Annual Staff Survey (3)		**Significant Assurance**
Speaking Up Process and Partnering Activities	**GC3:** Not all Staff Networks currently running as awaiting new volunteer Chair appointments.	Staff Networks (1) Operational Delivery Groups (1) Reports to EDI Forum (1) Reports to People Committee and Board (2)		**Significant Assurance**

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

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

Actions	**Timescale**	**Lead**	**Progress update**
GA4: Implementation of Internal Audit Equality, Diversity & Inclusion recommendation	December 2025	Chief People Officer	On track to complete within suggested timeframe.
GC1: The Workforce workstream reviewing identified actions for improvements, reporting Executive team	March 26	Chief People Officer	Policy implementation review of refreshed sickness absence policy completed. The recommendations and learning from this and benchmarking with another trust have now been collated and improvements agreed for implementation. All actions are managed internally on Monday.com and monitored at steering group meetings. The draft revised Managing Attendance at Work policy will go through usual Trust review and approval processes in Q3.
GC2: Learning from Leavers Project in place to capture information from and ensure consistency of approach to the exit interviews process	March 26	Chief People Officer	New MS Teams form for exit conversations launched in Q2. Workforce & Education Group to receive updates on themes arising from exit conversations in Q3/4.
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	Date identified for third annual Leadership Conference in April 2026. The Organisational Development annual report, including an overview of the leadership development offer, was presented to the People Committee in June 2025, with significant assurance. Work continues to develop new leadership modules.

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

Key Controls

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

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions: SMART Actions	**Timescale**	**Lead**	**Progress update**
GC1) Initiate and embed a Trust wide Access Group (executive led)	June 2025	COO	Operational Delivery Group established, first meeting 27 June 2025. Head of Elective Care appointed (start date TBC.). Post holder will lead the TAG
GC2) Embed consistent use of Urgent Emergency Care (UEC) escalation process	April 2025	COO	Escalation process implemented. Further work in progress with YAS / EMAS to revise the ambulance handover process. DRI / YAS implementation of the 45 minute handover complete in July 2025.
GC3) Review Trust Validation Process with national best practice and initiate new process	November 2025	COO	Initial discussion with COO / CFO / CIO taken place. The Trust is participating in the NHSE 'DQ Sprints' during 2025/26. Once the Head of Elective Care has commenced in post, they will work with the DQ lead to review & revise DBTHs approach. NHSE supporting the Trust with review of current validation programme as part of Tier 2 support programme.
GC4) Clinical prioritisation action plan	December 2025	COO	Head of Elective Care has been appointed and will lead on this once they commence in post.
GC5) Elective Care improvement programme	December 2025	COO	Head of Elective Care has been appointed and will lead on this once they commence in post.
GC6) UEC Improvement programme to address ambulance conveyance rates and provide a single point of access (SPA) for ambulance crews to access advice and alternatives to conveyance	August 2025	COO	The UEC Improvement Programme Project Charters has been signed off and this is included in the annual plan. This metric is monitored through the UEC Improvement Programme Group (monthly). Impact already seen in ambulance 45minute handover times. Suggest metrics shared at F&P to demonstrate the gap in control has been evidenced and then close
GC7) Expansion of Patient Initiated Follow ups across all specialities Action plan	October 2025	COO	The Elective Care Improvement Programme Project Charters has been signed off and this is included in the annual plan. This metric is monitored through the UEC Improvement Programme Group (monthly). Suggest agreed metrics shared at F&P to demonstrate the gap in control has been evidenced and then close
GC8) Expansion of the use of Advice and Guidance action plan	October 2025	COO	The Elective Care Improvement Programme Project Charters has been signed off and this is included in the annual plan. This metric is monitored through the UEC Improvement Programme Group (monthly). Suggest agreed metrics shared at F&P to demonstrate the gap in control has been evidenced and then close
GC9) Urgent Treatment Centre First model to be implemented at all sites	October 2026	COO	The UEC Improvement Programme Project Charters has been signed off and this is included in the annual plan. This metric is monitored through the UEC Improvement Programme Group (monthly). Suggest agreed metrics shared at F&P to demonstrate the gap in control has been evidenced prior to closing.
GC10) Frailty and surgical SDEC implementation plan	March 2026	COO	The UEC Improvement Programme Project Charters has been signed off and this is included in the annual plan. This metric is monitored through the UEC Improvement Programme Group (monthly). Suggest agreed metrics shared at F&P to demonstrate the gap in control has been evidenced and then once assurance received this gap is close.
GC11) Current GIRFT programme review	September 2025	COO ~~/ EMD~~	The Improvement Programmes for UEC, Outpatients and Theatres are based on the NHSE Clinical and Operational Excellence Programme. As part of this programme, the monthly metrics recommended by Model Health are all included in the monthly oversight report. These are reviewed internally as part of the executive meeting structure. Suggest agreed metrics shared at F&P to demonstrate the gap in control has been evidenced and then close.
GC12) SPC charts to be used as standard across all reporting for services	July 2025	COO	Associate Director of Planning Performance and Improvement is supporting ops to ensure SPC charts are used as part of their weekly and monthly reporting frameworks. These have also been used as part of the annual plan trajectories as seen within the planning submission. Suggest action closed as this gap in control has been closed. Assurance provided through the SPC reporting.
GA1) Operational Delivery Group (Monthly) Chaired by the COO	July 2025	COO	Following the initial meeting in June there are now regular, monthly timetable now in place as part of the COO operational governance structure. This includes weekly Operational Delivery Group meetings plus the monthly Performance

			Review Meetings where actual operational delivery metrics are reviewed against planned trajectories.
GA2) Divisional Governance arrangements mapping exercise	November 2025	COO / DCEO	Part of a wider piece of work Trust wide. Currently led by the DCEO and Corporate Office. A governance specific questionnaire went to all divisions in July, results were reviewed in August and meetings have been set up in September 2025, to review what should be included within these arrangements, escalation criteria and ensuring all elements are covered within internal divisional governance arrangements. Once these meetings have taken place and evidence collated, a standardised approach will be collated and rolled out across the Trust.
GA3) Demand management reporting plan	August 2025	COO	Elective Care Improvement Support Team to work with the Trust to develop the expertise internally. Elective IST has completed the D&C modelling for T&O, and ENT is in progress. Skills are being transferred to the BI team. The COO and . Associate Director of Planning Performance and Improvement have agreed a timetable for all specialties. All complete by end March 2026
GA5) Implementation of Internal Audit recommendations for Outpatients Appointments	March 2026	COO	Timescales are on track for implementation of all recommendations

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

Key Controls

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

		ROSPA accreditation (3) Gold Accreditation		

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

Actions	Timescale	Lead	Progress update
GC1a: Confirm the funding availability for estates maintenance based on the findings of the estates review and associated business case by the end of quarter 1 of FY2025/26	June 2025	CFO	Cost pressure not funded for 25/26 due to the financial position of the Trust. As a result we will not yet be able to move to have preventative maintenance in line with industry guidance and estates infrastructure risks will remain higher than otherwise would have been the case.
GC1b : Once funding is confirmed, align the estates maintenance strategy to funding availability, adopting an approach that mitigates risk and regulatory non-compliance as far as reasonably practicable within any funding constraints that may remain.	November 2025	Head of Estates	Maintenance strategy under review by Head of Estates to confirm risk and regulatory non-compliance mitigated as far as reasonably practicable within current budget constraints due to cost pressure for additional resource not being funded for 25/26.
GC1c : Assess remaining gaps in compliance after the maintenance strategy is reviewed, complete a risk assessment and record the findings on the E&F risk register.	December 2025	Head of Estates	To be completed once GC1b complete
GC2: Complete site evacuation plans for DRI	May 2026	COO	The plan has been approved as version 1 and is on the HIVE available for colleagues to utilise. There were 2 multiagency exercises run in September 2025 and learning and improvement to be made which will result in a further report. More detailed work continues.
GC3: Draft site development plans for BH and MH	March 2026	Director of Infrastructure	Ongoing annual investment plans for F&P Quotes obtained for site development plan. Director of Infrastructure drafting proposal for consideration by the Trust Executive Team.
GC4: Review risk register and updated 6 facet survey data annually to inform capital planning process	March 2026	Director of Infrastructure	Annual investment plans for F&P to be brought to committee and reviewed ahead of the following year Action completed for 25/26 – action is an ongoing annual requirement – updated target completion date to reflect requirement to complete for 26/27
GA2: Address any outstanding gaps in compliance with EPRR core standards	March 2026	COO	Part of a wider piece of work regarding meeting EPRR core standards, directly monitored through the Audit and Risk Committee and Board. EPRR Assurance statement taken to Audit and Risk Committee 16 October 2025. Ongoing work to address the remaining compliance standards

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

Key Controls

Primary Risk Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) RC	**Gaps in Control** (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level) GC	**Sources of Assurance relating to effectiveness of the controls & associated Line of Defence and dates)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in Assurance** (Insufficient evidence as to effectiveness of the controls or negative assurance) GA	**Current Assurance Level Assigned,** (including where actions are in place to address gaps)
Annual , Medium- & Long-Term Planning	**GC1:** Medium Term Finance Plan requires review and updating	Annual Plan reviewed by the F&P Committee (2) Trust Board Approve the Annual Plan (2)		**Partial Assurance**
Cost Improvement Plans	**GC5**: Embedding of Medical rostering	CIP reported to F&P committee (2) HFMA Checklist Action Plan complete in April 2023. (3) CIP plans reviewed at Performance Review Meetings at divisional level monthly (2)		**Partial Assurance**
BAU Financial Operating policies, procedures Accounts Payable Estates Contract management	**GC8:** Capacity within the contract management arrangements at DBTH (generally – not Estates specifically) have been identified by management as an opportunity for improvement. The Executive Team have supported development of an invest-to-save Business case in this area.	Bank and Agency Spend Control Follow Up Audit Review (2) Reports to Audit and Risk Committee (2) Counter fraud reports (2), Internal Audit work plan (3) NHSE monthly finance and workforce submissions (3) External Auditors Annual Audit Letter (Clean Opinion) Internal Audit of Accounts Payable (3) [Significant Assurance] Internal Audit of Estates Contract Management 25/26 plan(3)	**GA1:** Recommendations from the HFMA checklist compliance self-assessment to be actioned	**Significant Assurance** **Significant Assurance** **Significant Assurance**
Specific Financial expenditure control measures: • Executive vacancy approval Panel Weekly (1) • Capital Investment Group and linked operational Control environments • CNO review of Nursing Agency and temp • Off framework protocol • Nursing rosters review • Weekly Non-pay review		Reports to Executive team (1) Reports to F&P Committee (2) Confirm and Support meetings with each division (1)		**Significant Assurance**

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions SMART (specific, measurable, achievable, relevant, and time-bound) actions.	**Timescale**	**Lead**	**Progress update**

GC1: Medium Term Finance Plan will be refreshed, reviewed by the CFO, aligned to capital plans and allocation of resources.	December 2025	CFO	24/25 underlying exit rate confirmed as £41.2M. Delivery of the 25/26 plan would reduce this to £37.2M by year end. National medium term financial planning process confirmed as running to December 2025 which the Trust will align with. Month 6 estimate of 25/26 exit rate is an underlying deficit of £35.5m
GC2: Don't currently have a rolling 3-year CIP programme	March 2026	DCEO	New DBTHi approach to improvement under leadership of Deputy CEO has been implemented. Rolling 3-year improvement programme to follow
GC5: Medical rostering project, measured via reduction in locum medical use and expenditure	March 2026	CFO / MD	Key project as part of the Pay Efficiency Workstream. Pay Efficiency Workstream Charter has now been signed off. UEC are fully live with the new system. Medicine and Women & Children's are partial. Anaesthetics are next with go-live planned at the end of September.
GC8: Review of contract management capacity within the procurement team	March 2026	CFO	Business case being developed to increase the resource available to contract management at DBTH in an 'invest to save' model
GA1: Recommendations arising from the HFMA self-assessment.	March 2026	CFO	Checklist completed which has generated some further improvements and recommendations. Action plan being implemented to address improvement areas between Q2 and Q4 25/26.

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

Key Controls

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

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions	**Timescale**	**Lead**	**Progress update**
GC2: Universal digital performance reporting action plan	August 2025	CIO	Complete: KPIs are in place and they are being reviewed regularly by the Digital Performance Group. Recommend action to be closed.
GC3: Agree Digital Enabling Plan 2025-2030	October 25	CIO	On track and draft complete. Engagement ongoing and will go through Trust operational groups and committees in September / October ahead of approval at Trust Board in November 2025
GC4:NHSE Frontline Digitisation approval of the full business case for EPR	June 25	CIO	The EPR FBC has passed the NHSE Fundamental Criteria Review (FCR), a significant milestone, and will go onwards to Cabinet Office and the NHSE EPR Investment Board (EPRIB). While timelines have slipped slightly, it is on track for full approval by NHSE in early November 25., Our planning continues and process redesign, data cleansing, engagement and technical preparedness continues at pace and as planned. There are no concerns or issues to escalate.
GC5: Replace all end of Windows 10 life desktop hardware (desktops, laptops)	October 25	CIO	Orders have been placed for devices and the replacement programme is underway. There has been a small amount of slippage due to availability of appropriately skilled personnel. This is now on track to complete ahead of the support deadline in October 2025.
GC6: Unsupported and out of date core systems or systems running unsupported versions of Microsoft Server (2016 and below)	October 25	CIO	Terms of reference and scope agreed. This action also encompasses upgrades needed to the version of Microsoft Office that we use at DBTH which also goes end of life in October 2025, as well as upgrades needed to upgrade from unsupported versions of Microsoft Server. **Microsoft Server 2016:** We have updated all versions of Microsoft Server on all internet facing servers, as planned. There are two remaining internal servers used by the internal development team for legacy applications. The risk for those is mitigated by virtual patching and third party malware protection. They are both on the internal network and neither have exposure to the outside world. We plan to upgrade the version of Microsoft Server on these two internal servers by the end of March 26, and the risk is being managed within tolerance until then, given the mitigation and controls that are in place. **Microsoft Office 365:** We have carefully considered our options to mitigate the risk of using unsupported software and a business case is being presented at Corporate Investment Group on 29 September to upgrade users to the latest version. This is a critical upgrade to ensure DBTH utilise fully supported systems as part of their operational infrastructure.
GC7: Complete Digital Disaster Recovery and Business Continuity review	September 25	CIO	Review complete. Documentation (completed in July) has been shared with key stakeholders. Final comments have been reviewed and will be incorporated in the document by the end of September. Once reviewed this will close the gap in control on this element and suggest close September 2025.
GA2: Agree Cyber Assurance Framework Action Plan and complete actions	May 25	CIO	Plan was agreed in May 2025. All actions within the plan complete including actions CS3 and CS5 which were outstanding when this BAF was last reviewed. Audit and Risk Committee received a detailed cyber update in July 25. The action plan is regularly reviewed and updated in light of new risks or the changed cyber threat.

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

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

2511 - E5 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL ASSURANCE 2025/26

Discussion Item | Denise Smith, Chief Operating Officer | 13:40

5 minutes

REFERENCES

Only PDFs are attached

- E5 - Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2025-26.pdf
- E5 - Appendix A - EPRR Annual Assurance.pdf
- E5 - Appendix B - EPRR Annual Assurance.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Emergency Preparedness Resilience and Response (EPRR) Annual Assurance 2025/26**			
Executive Sponsor:	Denise Smith, Chief Operating Officer			
Authors:	David Harvey, Emergency Planning Officer Jeannette Reay, Emergency Planning Officer			
Appendices:	Appendix A: NHSE Emergency preparedness, resilience and response (EPRR) annual assurance process for 2025 - 2026 Appendix B: DBTH Core Standards Self-Assessment			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1			

Executive Summary – Key messages and Issues

This report sets out the emergency preparedness, resilience and response (EPRR) annual assurance process for 2025/26 and the Trust's self-assessment against the EPRR Core Standards.

The Trust has completed the initial self-assessment; this is attached at Appendix B for information. The self-assessment shows the Trust as **fully compliant with 51 of the 62** core standards and partially compliant with the remaining 11 core standards. This gives 82% compliance and overall assessment of partially compliant.

Recommendations

The Trust Board of Directors is asked to receive the report for ASSURANCE

Healthier together – delivering exceptional care for all	
Patients	Strengthens patient safety and service continuity during emergencies through improved preparedness and response planning.
People	Supports staff training, resilience, and confidence through enhanced command training and increased EPRR capacity.
Partnerships	Builds multi-agency collaboration, particularly through joint evacuation planning with ICBs and emergency services.
Pounds	Reduces financial risk by mitigating disruption and ensuring efficient emergency response.
Health Inequalities	Ensures emergency planning considers and protects vulnerable patient groups.
Legal/ Regulation:	Demonstrates compliance with statutory duties under the Civil Contingencies Act and NHS Core Standards for EPRR.
Partner ICB strategies	Aligns with and supports the resilience priorities of both South Yorkshire and Nottinghamshire ICBs.

<table>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>EPRR Group 10 October 2025
Executive Team 15 October 2025
ARC 16 October 2025</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>By 31 October 2025: Self-assessment and submission of evidence to the ICB</td></tr>
<tr><td>Is this in line with Current risk appetite

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

This report sets out the:

- Emergency preparedness, resilience and response (EPRR) annual assurance process for 2025/26
- Trust self-assessment against the EPRR Core Standards

2. Background

The Trust has a responsibility for developing and monitoring compliance with the mandatory obligations within the Civil Contingencies Act (2004), and ensuring compliance with the National Guidance set out in the NHS England Emergency Planning Resilience and Response (EPRR) Framework (2015).

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

3. Final Outcome of the Annual Assurance Process for 2024/25

The Trust final self-assessment and Accountable Emergency Officer statement of compliance was submitted on 31 October 2024. This showed a final self-assessment of fully compliant in 34 of the 62 core standards and partially compliant in 28 of the 62 core standards, giving 55% compliance and overall assessment of non-compliant.

4. Annual Assurance Process for 2025/26

The NHS England Emergency preparedness, resilience and response (EPRR) annual assurance process for 2025 - 2026 is set out at Appendix A.

The Trust is asked to undertake a self-assessment against the individual core standards and rate the compliance for each. The compliance level for each standard is defined as follows:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

There are no deep dive standards for 2025/26.

The NHS South Yorkshire ICB process for EPRR core standards assurance for 2025 - 2026 is as follows:

- **31 October 2025**: Self-assessment and submission of evidence

- **November:** Informal review meetings to be held between the ICB and the Trust EPRR team to review submissions
- **18 November 2025:** Check and challenge at the Local Health Resilience Partnership
- **Late November:** ICB meets with NHS England NEY team to review the South Yorkshire submissions
- **December 2025:** The final ratings for South Yorkshire will be shared with the NEY Regional Health Resilience Partnership (RHRP)
- **December 2025 / January 2026:** Trust Boards to report on their finalised organisational positions at a public meeting and share the papers with the ICB

5. Organisational assurance rating

The overall organisation assurance rating is based on the percentage of core standards the organisation assesses itself as being 'fully compliant' with, the criteria for each overall rating is as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against **89% - 99%** of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against **77% - 88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

6. Trust self-assessment

The Trust has completed the initial self-assessment; this is attached at Appendix B for information and shows a comparison with the 2024/25 outcome.

The initial self-assessment shows the Trust as fully compliant in 51 of the 62 core standards and partially compliant in 11 of the 62 core standards; this gives 82% compliance and overall assessment of partially compliant. This is an improvement from 31% in 2023/24 and 55% in 2024/25. The Trust has also moved from an overall rating of non-compliant to partially compliant.

It is noted that in three of the core standards, in the HAZMAT/CBRN domain, the Trust self-assessment has moved from 'fully compliant' to 'partially compliant', the rationale for this is summarised in the following table:

No	Standard Title	Rationale for 'partial compliance' self-assessment	Context	Remedial Actions
59	Decontamination 24/7 capability availability	Insufficient numbers of ED staff with decontamination training compliance recorded	Training records are now recorded on ESR and therefore there is improved visibility and oversight of training compliance	Confirm and roll out new training programme
60	Equipment and supplies	Number of PRPS units held by the Trust does not meet the number specified by NHS England	Change in National requirements	Risk assessment to determine PRPS unit needs / evaluation of stock increase options (including

				options for SY procurement)
64	Staff training - recognition and decontamination	Lack of Initial Operational Response (IOR) training for all staff	Change in Regional requirements	Confirm and roll out new training package to all staff

7. Summary and next steps

By 31 October 2025, the Trust self-assessment and evidence will be submitted to the ICB. During November 2025, review meetings will be held between the ICB and the Trust to review the submission. In December 2025 the final ratings for South Yorkshire will be shared with the NEY Regional Health Resilience Partnership (RHRP). The Trust Board will then receive the finalised position and statement of compliance.

8. Recommendations

The Trust Board of Directors is asked to receive the paper for ASSURANCE.

Date published: 1 July, 2025
Date last updated: 1 July, 2025

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2025/26

Publication (/publication)

Content

Classification: Official
Publication reference: PRN01970

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2025/26

Thank you for your continued leadership and commitment to EPRR. We recognise that the healthcare landscape continues to evolve, and with that comes a degree of uncertainty. Nonetheless, maintaining our readiness to respond to emergencies remains both a vital priority and a statutory duty for the NHS. This includes the cross government pandemic exercise as well as the EPRR exercise programme.

Under the NHS Act 2006, NHS England has a statutory duty to ensure that the NHS in England is properly prepared for dealing with an emergency. This includes monitoring the compliance of each ICB and service provider with EPRR requirements via the NHS EPRR annual assurance process. This process for 2025/26 has now begun and this note contains a summary of actions for NHS organisations to take.

The assurance process uses organisational self-assessments of compliance with the NHS Core Standards for EPRR. The outcome of this process should be used by organisations to identify areas of good practice and issues that require further development. It is expected that organisations will use their self-assessment to guide their annual work plan and priorities the development of local arrangements.

ICBs will again take the lead across the Local Health Resilience Partnership to ensure that providers of NHS funded services remain accountable for their arrangements

NHS Core Standards for EPRR

The core standards can be found in the NHS core standards for EPRR self-assessment tool. ICBs and service providers are asked to undertake a self-assessment against the individual core standards relevant to your organisation type and rate their compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS Core Standards for EPRR
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards for EPRR
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards for EPRR
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards for EPRR

Deep dive

Typically, each year as part of the annual process, a deep dive is conducted to gain additional insight in a specific area. We will not, however, be conducting a deep dive this year.

Action to take

EPRR Assurance Process

Stage 1: Self-assessment

- all NHS organisations must complete a self-assessment against the current NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) relevant to their specific organisation.

Stage 2: Local assurance

- integrated Care Boards (ICBs) must work with their commissioned providers of NHS-funded services to establish a process that gives confidence in their compliance ratings.
- the self-assessment results and ICB review outcomes must be formally presented at each organisation's public board meeting for executive approval and sign-off.
- organisations without public boards must still obtain executive approval and sign-off, and publish results in a public area, such as their annual report.
- ICBs must collaborate with Local Health Resilience Partnership (LHRP) partners to develop a process that encourages sharing of learning and good practice examples.
- provider organisations must submit an assurance outcome report to their ICB, including their self-assessment against core standards, an action plan for addressing areas of partial or non-compliance, and their overall organisational compliance rating.

Stage 3: Regional assurance

- NHS England Regional Deputy Directors of EPRR and their teams must work with ICBs to establish a process that gives confidence in ICB organisational compliance ratings.
- the outcomes from this process must be formally presented at each ICB's public board meeting for executive approval and sign-off.
- NHS England Regional Deputy Directors of EPRR and their teams must create opportunities for ICBs to come together formally to discuss the outcomes of their assurance processes, promoting the sharing of learning and good practice examples across the region.
- ICBs must provide NHS England Regional EPRR teams with an assurance outcome report that includes their self-assessment against core standards, action plans for addressing areas of partial or non-compliance, common risks, good practice examples, and organisational compliance information for all organisations within their geography.

Stage 4: National assurance

- NHS England Regional Deputy Directors of EPRR must submit an assurance outcome report to the NHS Resilience Team before Wednesday 31 December 2025, including details of their regional process, preparedness levels, common risks, good practice areas, and organisational compliance ratings for each NHS organisation in their geography.

The board of each NHS Organisation is responsible for EPRR and should be engaged as part of this process. This includes holding the Accountable Emergency Officer (AEO) to account for delivering the organisation's EPRR responsibilities.

If you have any queries, please contact your ICB EPRR lead leads in the first instance or your NHS England's Regional EPRR.

Thank you for your continued dedication to this vital aspect of our work.

Yours sincerely,

Dr Mike Prentice, National Director for NHS Resilience, NHS England

Leaf Mobbs, National Programme Director for Urgent & Emergency Care, NHS England

Date published: 1 July, 2025
Date last updated: 1 July, 2025

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Ref	Domain	Standard name	Standard Detail	Self Assessment 2024/25	Self Assessment 2025/26
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Fully Compliant	Fully Compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Fully Compliant	Fully Compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Fully Compliant	Fully Compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Fully Compliant	Fully Compliant
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Fully Compliant	Fully Compliant
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Fully Compliant	Fully Compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Fully Compliant	Fully Compliant
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Fully Compliant	Fully Compliant
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Fully Compliant	Fully Compliant
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness.	Fully Compliant	Fully Compliant
27	Response	Access to planning arrangements	Arrangements should be supported with access to documentation for its activation and operation Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Fully Compliant	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Self Assessment 2024/25	Self Assessment 2025/26
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Fully Compliant	Fully Compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Fully Compliant	Fully Compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Fully Compliant	Fully Compliant
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Fully Compliant	Fully Compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Fully Compliant	Fully Compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Fully Compliant	Fully Compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Fully Compliant	Fully Compliant
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Fully Compliant	Fully Compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Fully Compliant	Fully Compliant
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Fully Compliant	Fully Compliant
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Fully Compliant	Fully Compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Fully Compliant	Fully Compliant
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Fully Compliant	Fully Compliant
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Fully Compliant	Fully Compliant
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Fully Compliant	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Self Assessment 2024/25	Self Assessment 2025/26
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Fully Compliant	Fully Compliant
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Fully Compliant	Partially Compliant
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Fully Compliant	Partially Compliant
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Fully Compliant	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Self Assessment 2024/25	Self Assessment 2025/26
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Fully Compliant	Fully Compliant
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Fully Compliant	Fully Compliant
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Fully Compliant	Partially Compliant
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Fully Compliant	Fully Compliant

2511 - E6 NHSE PROVIDER CAPABILITY SELF-ASSESSMENT FRAMEWORK

Information Item | Zara Jones, Deputy Chief Executive | 13:45

5 minutes

REFERENCES

Only PDFs are attached

- E6 - NHSE Provider Capability Self-Assessment Framework.pdf
- E6 - Appendix 2 - DBTH Provider Capability Self-assessment Submission - signed.pdf
- E6 - Appendix 3 - Regional NHS Self assessment submission.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**NHS England Provider Capability Self-Assessment Framework**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance			
Appendices:	Appendix 1: Board discussion and reasons for ratings Appendix 2: NHS National Submission Appendix 3: Regional NHS Self-assessment submission.			
Purpose of the report	~~Assurance~~	**Decision**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	Board capability and its compliance to the framework impacts the effectiveness to monitor the Trusts Strategic risks.			

Executive Summary – Key messages and Issues

This report provides an overview of the NHS England Capability Self-Assessment Framework issued under the NHS Oversight Framework (NOF). The attached documentation was signed by the Trust Chair on behalf of the whole of DBTH Board of Directors and submitted to NHSE in line with the national deadline on 22nd October 2025. This paper is shared for information within the public board of directors due to the timing of the submission, it weas not possible to share prior.

It sets out a constructive approach for NHS trust boards to reflect on their organisational capability and engage in an open, evidence-based dialogue with regional oversight teams. This work should not be viewed as a tick-box exercise but will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability

The framework is not intended as a compliance-driven mechanism but rather as an opportunity to foster self-awareness, honesty, and learning, ensuring that organisations are supported in navigating the complex challenges they face. Following submission of the assessment, and scrutiny by the regional team, each trust receives a rating which is set out in the covering paper.

Details of the Framework were highlighted in October's Board development session, which was a dedicated workshop to review the work of the executive team to provide evidence which supported the initial ratings. The process for approvals was as follows:

- Sharing with Executive Team - 3 and 17 September 2025
- Board Development Session and workshop - 7 October 2025
- Further discussion and finalising ratings at executive team - 15 October 2025
- Sharing updated template with wider Board colleagues - 17 October 2025
- Agreement of submission with all board members, signed by the Trust Chair - 20 October 2025
- Submission of the templates and accompanying board paper to NHS England regional team - 22 October 2025
- Sharing of templates at Public Board of Directors - 4 November 2025

The Board of Directors reviewed the ratings applied to the national submission (Confirm / Partially met / not met) and this is shown in Appendix 3.

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td colspan="2">The Board of Directors is asked:
• To note and be assured on the capability self-assessment process
• To note the previously agreed submission of the NHS England Provider Capability Self-Assessment Framework for DBTH at the agreed ratings.</td></tr>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>Review and assessment of the Trust capability is a key factor in delivery of safe and effective services to patients.</td></tr>
<tr><td>People</td><td>Review and assessment of the Trust capability is a key factor in supporting our people to deliver safe and effective care.</td></tr>
<tr><td>Partnerships</td><td>Review and assessment of the Trust capability is a key factor in effective and positive partnerships.</td></tr>
<tr><td>Pounds</td><td>Review and assessment of the Trust capability is a key factor in delivery of the financial sustainability.</td></tr>
<tr><td>Health Inequalities</td><td>Review and assessment of the Trust capability is a key factor in delivering positive outcomes for health inequalities</td></tr>
<tr><td>Legal/ Regulation</td><td>It is a regulatory requirement to complete and return the NHSE Provider capability self-assessment return.</td></tr>
<tr><td>Partner ICB strategies</td><td>These documents have no positive or negative impact on ICB Strategies</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>As outlined above</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Public Board on 4 November 2025</td></tr>
<tr><td>In line with Current risk appetite

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

NHS England Capability Self-Assessment Framework

Background

NHS England has introduced a structured self-assessment process for NHS trusts and foundation trusts to evaluate their capability across six key domains. The self-assessment aims to:

- Strengthen internal governance and assurance processes.
- Promote openness and a culture of 'no surprises' between trusts and oversight bodies.
- Guide appropriate and proportionate regional support and intervention.

Trusts are expected to complete this self-assessment annually and submit it within eight weeks, along with supporting evidence.

The Six Capability Domains

The self-assessment is structured around six core areas reflecting the fundamental responsibilities of provider boards:

Domain	Focus Areas
1. Strategy, Leadership & Planning	Clarity of organisational priorities; collaboration with system partners; board skills.
2. Quality of Care	Systems for continuous improvement; patient safety; board-level quality governance.
3. People and Culture	Staff engagement and feedback; workforce capability; fostering a safe culture.
4. Access and Delivery	Performance against national standards; addressing health inequalities.
5. Productivity and Value	Use of data and benchmarking to drive improvement and reduce unwarranted variation.
6. Financial Performance & Oversight	Financial governance, risk management, and system alignment.

Boards are encouraged to be candid in areas where the organisation may be underperforming or facing systemic challenges. The intention is not to assign blame but to acknowledge issues early, demonstrate leadership ownership, and develop credible action plans to build a 'no-surprises' culture.

The Assessment Process

The self-assessment process follows three key stages and following this initial introduction is expected to be an annual approach for all providers:

<u>Trust Board Self-Assessment</u>

- Reflect on each domain and determine whether the trust meets expectations.
- For any unmet criteria, outline the reasons why and actions being taken or that are planned to mitigate.
- Submit completed template and evidence to the regional team.

<u>Oversight Team Review</u>

- Regional teams will consider the trust's self-assessment triangulating this with third-party data, performance history, and known risks to develop a holistic view of capability.

- A capability rating will be assigned and discussed with the board.

Ongoing Oversight

- The assessment will inform regional oversight throughout the year.
- It is a snap-shot position and therefore any material in-year changes (e.g. adverse inspection reports or unexpected performance drops) must be reported promptly.

Capability Ratings

NHS England will assign a capability rating to each trust as follows:

Rating	Indicative criteria
Green	*High confidence in management* • No evident concerns arising from the self-cert or subsequent performance. • No concerns arising from third parties. • High confidence in the trust's ability to deliver on its priorities based on track record over past 12-24 months.
Amber-green	*Some concerns or areas needing addressing* • After following up with the trust, some concerns emerging across more than one domain but not yet a significant issue affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. • Trust has prepared plan(s) to address any problems and timing to address • Historic issues/track record
Amber-red	*Material issue needs addressing, or failure to address issues over time* • Issues with self-assessment or subsequent issues across multiple domains • Failure to deliver on agreed plans to address a material issue • Potentially in breach of licence.
Red	*Significant concerns arising from poor delivery and other issues* • Material and or long-running concerns at the organisation that management have been unable to get a grip over. • Provider likely to be, or actually, in breach of licence

Third-Party Information and Oversight

NHS England may use insights from multiple sources, including:

- **Regulators** (e.g. CQC, GMC, NMC, ICO)
- **Professional bodies** (e.g. Royal Colleges)
- **Patient and staff feedback** (e.g. Healthwatch, staff surveys)
- **System partners** (e.g. ICBs, local authorities)
- **Whistleblowers and ombudsmen reports**

Trusts are encouraged to share any relevant third-party information proactively to support the principles of openness and partnership.

Expectations of the Board

This framework is not a tick-box exercise. It requires the board to:

- Reflect with humility and honesty on areas of challenge or underperformance.
- Demonstrate a culture of continuous learning and responsiveness.
- Take ownership of issues, even where root causes may be outside direct control.
- Build confidence with regulators through transparency and action.

The review process is summarised in Appendix 2 and represents the discussions at the board development session on 7th October 2025, and the presentation of the evidence from which the Board has drawn its

conclusions. Where the stated criteria and key lines of criteria have not been fully met, the board is assured of the actions plans and mitigating actions to address this.

Conclusion

This framework is an opportunity - not just a requirement. Its timing fits in well with the externally well-led review and cultural diagnostic conducted in 2025 (awaiting final reports). It allows the DBTH board to take a clear view of where it is currently, where it needs to improve, and how it can work together with system partners and regulators to build a safer, more sustainable, and compassionate health service.

This process enables the DBTH Board to continue its focus on the key areas to address under performance and to maximise the opportunities of collaborative working to address this.

Appendix 1

I. Strategy, leadership and planning

Self-assessment criteria	Indicative evidence or lines of enquiry	Supporting information	Evidence
The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	The Trust has an agreed approach to managing system capital resource, which is undertaken through Capital Investment Group, reporting into the Finance and Performance Committee and the DBTH Board and conducted in the context of the wider system capital plan. The new Digital Enabling Plan 2025-2029 is due to be approved by Board at the beginning of November 2025. A draft version was reviewed at the Executive Team meeting on 1st October 2025 and includes reference and linkage to both local and national priorities. The Trust's digital plan is based on a national digital maturity plan. The Trust has agreed on a collective approach to digital convergence across South Yorkshire through the Acute Federation Board and is in the process of initiating an electronic patient record that is one of the key strategic priorities for DBTH. The refreshed Trust strategy is informed by national, system and SYB and North Notts and Nottinghamshire priorities, and wider partnership feedback. Our strategy builds on the unique strengths of the Trust including its status as an integrated care organisation and a key teaching hospital in the area.	Minutes of the SYB Acute Federation Board (March 4, 2024) Digital Converge papers to Acute Federation Board (March 4, 2024) Digital strategy, EPR Business Case. DBTH refreshed strategy which highlights the EPR strategic priority together with the NHSE business case. Link to new strategy on website : https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/
The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	Is the trust currently complying with the conditions of its licence? Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of	The Trust is not currently in breach of licence and is meeting all terms of its licence. Continuation of Services Section 7 and self-assessment on compliance to conditions of the licence. The Trust is not under any imposed conditions or PIP	Current provider licence *Paper to Board in May 2025 Ref 2a + Appendix 1 Code of Governance Compliance review 2025

	the national Performance Improvement Programme (PIP)?	Significant assurance on the NHS Code of Governance Compliance report to Audit and Risk Committee on 16 October 2025.	
The board has the skills, capacity and experience to lead the organisation.	Are all board positions filled and, if not, are there plans in place to address vacancies? What proportion of board members are in interim/acting roles? Is an appropriate board succession plan in place? Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	All Board roles except the executive medical director are filled substantively. There are plans in place that NHSE are engaged with. There is one interim (Acting) position at the board currently Succession plan conversations have taken place in respect of executive and non-executive directors over the past 18 months. Plans are in place with the recognised vacancies that are currently known about which includes a skills audit. Options for succession planning have been to CoG Remcom and also discussed with the regional NHSE team. Responsibilities and accountabilities of executive team are set out in executive director role descriptions; these are amended as required.	Rem Com papers on succession planning for NED and executives Executive director job descriptions.
The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	Is the trust contributing to and benefiting from its NHS trust collaborative? Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? Can the board evidence that it is making a positive impact on the wider system, not just the	The Trust is part of the acute federation and has benefited shared pathology service and supporting the wider transformation this is expected to bring. Each of the Trust's Executive Directors meets with their counterparts in other trusts through regular and formal Professional Partnership Groups. Across South Yorkshire, recruitment of newly qualified adult nurses has traditionally been undertaken in isolation by the four acute hospital trusts. This was inefficient as there was significant	Acute Federation agenda and papers Acute Federation annual report

	organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	duplication through 4 separate processes where candidates were often involved with multiple organisations, this absorbed a large amount of resource from both senior nurses and Human Resource departments. Over 3 or 4 newly qualified recruitment cycles, working collaboratively, the four trusts have reached a position where there is a single recruitment process coordinated by one host trust, which has slim lined the resource requirements and made the whole process more efficient. Having a single process with coordinated oversight across South Yorkshire made it easier for the trusts to support newly qualified nurses graduating from South Yorkshire universities to obtain their first post, before there were any further asks in relation to the graduate guarantee. Members of the Board – Executive and Non-Executive - fully participate in a wide range of meetings and discussions with system partners; with the Integrated Care Board (ICB). The System meetings have been mapped to executives, and these are discussed for impact on DBTH in board meetings, committee and executive team agendas as partnership updates. The Pathology shared service is a system wide initiative that DBTH is a part of. And are looking at a similar arrangement for imaging services in SYB. DBTH is also working at place within north Notts and SYB including the Mexborough Elective Orthopaedic Centre (MEOC), where robotic technology is shared across partners for the benefit of patients.	

II. Quality of care

Self-assessment criteria	Indicative evidence or lines of enquiry	Supporting information	Evidence
Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	The trust can demonstrate and assure itself that internal procedures: - ensure required standards are achieved (internal and external) - investigate and develop strategies to address substandard performance - plan and manage continuous improvement - identify, share and ensure delivery of best practice - identify and manage risks to quality of care There is board-level engagement on improving quality of care across the organisation. Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community.	The Trust has a Quality Committee which meets bimonthly and is supported by the governance structure of the executives (Chief nurse and medical director) which monitors and reports trust wide assurance on a variety of aspects of quality and safety (e.g. safeguarding, radiation, mortality, incidents). Quality Committee receives a number of reports that highlight that required standards are achieved, performance issues are tackled, continuous improvement is fostered, best practice is shared and risks are managed. Mortality Improvement • Mortality Data Assurance Group – great progress made, increasing structured judgement reviews, improvements made in clinical coding and depth of coding • SHMI consistent improvement last 3 months, now within expected range • Sepsis Action Group established and improvement plan in place Medical Staff Performance • Trust follows the Maintaining High Professional Standards to address any issues with substandard performance within the medical workforce The Board receives the Trust's integrated performance report which includes information around quality and safety data and information. Board members undertake a range of visits to clinical and non-clinical areas as part of the Board visits programme. Clinical Directors leadership development sessions are held quarterly	Integrated Quality performance report (IQPR) Current training compliance report Quality committee workplan / Agendas and supporting papers Evidence documentation in folder: 1 to 84. Plus: People Committee report - Appraisal (Oct25), Education reports (Feb, Mar, Oct). WEG report inc. SET Aug25

	Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.	Chief Nurse Oversight Framework, quality summits, NICE red flag event reporting Commenced the in full (IQIPs) accreditation process Internal processes in place to ensure delivery of best practice, e.g. • Infected blood inquiry – good progress made against the recommendations ahead of the governance formally adopting Risk Management Group established - Trust wide membership and the Datix system used to report incidents, investigations and outcomes GMC/NMC Civility Event – O&G held Feb 25 – excellent feedback with marked improvement on how Medics see GMC in before & after event scores GMC Civility Event – Paediatrics July 2025 – excellent engagement and active contribution from the Medics and Nursing colleagues. Executive and Non-Executive Director visit programme Maternity safety champion visits/meeting bimonthly Reporting of IQPR to Quality Committee Quality elements monitored through the Performance Assurance Framework. Medical Job Planning Process in Place: • Monitoring/formal notice of job plan compliance • Appeal/Medication process strengthened with clear timescales • Focused work in specialties with complex rotas and job plans Virtual ward pathways in place The Trust works collaboratively with system partners to maintain oversight and escalation of patients who no longer require hospital-based care. Delays to discharge are addressed through a multi-agency approach. Longer length of stay reviews are undertaken on a weekly	

		basis to identify and address any barriers to progressing care plans or discharge. The Trust Benchmarks against local organisations and peers with similar demographic profiles - particular around mortality performance. Internal clinical governance review undertaken and signed off through Effective Assurance Group and Patient Safety assurance Group. Medical Appraisal - robust process in place with scheduling throughout 2024/25, as of 15/9/25: Q1 – 87 appraisals due, 80 completed = 92% Q2 – 120 appraisals due, 47 completed = 39% On track to achieve 95% completion rate by end of March 2026. Medical Workforce group established, Chaired by Associate Medical Director for Workforce - meets monthly Appraisal Season 2025 achieved a 93.28% completion rate. SET training achieving or slightly below 90% target each month. Regular reports to Workforce & Education Group on SET compliance and verbal updates during appraisal season, with final report at the end of the season. Oversight through regular reporting at People Committee on SET and annual report on appraisal season.	
Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? Does the board consider variation in experience for those with protected characteristics and patterns of actual and	The Trust's Quality Committee receives a comprehensive Patient experience and engagement report, alongside the integrated performance report which sets out key metrics including Friends and Family and complaints responses. (65-76) The Trust's Finance and Performance Committee has received the Health Inequalities IPR which provides data and detail on the experiences of different communities. This is now monitored directly	Evidence documents 39 – 82

	expected access from the trust's communities?	by the Board of Directors with a full HI session held as a development session in 2025.	
	Is the board satisfied that it receives timely information on quality that is focused on the right matters? Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?	The Board has confirmed through its annual effectiveness survey that it receives timely information on quality. It also felt that it had the right blend of skills, expertise and experience, to enable it to face present and future challenges successfully, including those relating to quality.	
	Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?	The Trust uses CARE accreditation and PLACE assessments as part of its governance processes. (77;78;79)	
	How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?	Executive Medical Director and Chief Nurse review all Equality Impact Assessments relating to its Policies and Guidelines (61; 62; 63; 64)	
	Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	Internal audit of the complaints policy and implementation of actions managed through the quality committee and referenced on the BAF (80;81;82)	

III. People and culture

Self-assessment criteria	Indicative evidence or lines of enquiry	Supporting information	Evidence
Staff feedback is used to improve the quality of care provided by the trust.	Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? Does the board engage with staff forums to continually consider how care can be improved? Can the board evidence action taken in response to staff feedback?	The Board receives the Annual staff survey analysis, the annual learner survey report. The board receives a review of all EDI data from across the trust, with detailed review at People Committee. Staff forums and networks have been re-launched and linked to a prior BAF action plan. Identifying new network chairs and Executive sponsorship and supporting them into role with Board oversight and reporting on actions through people committee and the BAF. There is a clear approach for engagement across the Trust with the leadership teams on the staff survey results and engagement sessions with teams to formulate actions plans that target improvements	WRES / WDES report to BoD in July 2025 WRES / WDES report to BoD in 2024-25 to People Committee Staff survey benchmarking report 2024 S24 presentation to board on staff survey EDI Update Feb 2025 on Gender pay gap EDI Update report to People Committee June 25
Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	Does the trust regularly review skills at all levels across the organisation? Does the board see and, if necessary, act on levels of compliance with mandatory training?	The appraisal process at the Trust enables evaluation of colleague skills and experience. The Trust also carries out Annual Learning Needs Analysis as part of business planning. This forms the basis for education programmes. People Committee receive updates on SET compliance at every committee meeting. Managers are sent a regular notification of compliance rates and areas that require focus.	Appraisal form Sample learning Needs Analysis Template Learning needs assessment IPR (see earlier) February 2025 Education Report submitted to People committee for information and assurance.

Staff can express concerns in an open and constructive environment.	Does the board engage effectively with information received via Freedom to Speak Up (FTSU) channels, using it to improve quality of care and staff experience?	The Board receives FTSU reports biannually with the most recent being May November 2024 (Doc 1) and May 2025 (Doc 2). The next report is scheduled for November 2025. Reports are provided in a format that is aligned to the 2024 – 2028 Speaking Up Strategy (Doc 3a, 3b & 4) This has been renamed as the Speaking Up Strategic Enabling Plan in 2025, to reflect the changes to organisational strategy development. This format ensures that the Board receives information in relation to performance across all six strategic themes, the impact of National and Regional policy and guidance on performance, and national and local data themes and reporting trends. The Board heard how changes in who was speaking up and the percentage of people speaking up around behaviours had changed in 2024-2025 and therefore a commitment was made to undertake a "Deep Dive" to explore these changes in line with wider data sources. The methodology for this is proposed to use triangulated feedback and wider data from: •External Culture Review – The DBTH Way in Action (report pending) •2024 Staff Survey Results •External FTSU Peer review (report pending) The Board demonstrates commitment to listening to and learning from Speaking Up concerns, through regular planned discussions between the FTSU Lead Guardian and the Chief Executive, the Executive Lead for Speaking Up (Chief People Officer) and the Deputy Chief Nurse. Additionally, there is also a planned quarterly joint meeting between the FTSU Guardians, the Executive Lead for Speaking Up (Chief People Officer) and the Non-Executive Director – with the Speaking Up portfolio. Responses to escalated concerns focus on learning and improvement, in line with a Just Culture and where possible learning is shared wider to enable wider learning. Sharing Speaking Up experiences is also	FTSU presentations to board of directors FTSU Documents 1-9

		encouraged and a story featured in the 2023 Board Development Session, allowing Board members the opportunity to hear from a colleague first hand and explore the impact this had personally, professionally and organisationally. A further Board Development Session was held in 2024, exploring the Speaking Up Feedback from the CQC report and ensuring all Board members were compliant with the NHSE/NGO national FTSU training requirement for senior leaders. (Board development slides are available to upload if required)	
	Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?	All complaints received through the FTSU Guardian service and those raised directly to the Executive or Board, are taken seriously and processed in line with the FTSU Policy, Process and the associated Guide for Managers and Leaders (Doc 5, 6a, 6b & 7). These documents demonstrate the clear processes to follow when raising concerns, the lines of escalation and timeframes for responding to and actioning concerns, prior to escalation to Executive and Board for exception reporting. The streamlined process for raising concerns, was approved by the Board in 2024 as part of the Strategic Development Plan and these images have been disseminated across the Trust (including all sites).	
	Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?	Improving confidence and competency, and in turn consistency in all responses made to Speaking Up, the Trust has mandated all three levels of NHSE/NGO National Speak Up Training and as part of the Strategic Enabling Plan, has committed to delivering this alongside a wider just culture and compassionate leadership lens. Responses to concerns are shared using a "Sharing what we have heard and learnt" internal publication sharing annual data, specific concerns, learning and actions taken. (Docs 8 & 9).	
	Is there a safe reporting culture throughout the organisation? How does the board know?	The FTSU annual Self-Assessment/Reflection and Planning Tool is approved by the Board each year and performance against its actions is monitored biannually as part of the FTSU reporting process. The 2024 document is provided for consideration (doc 10.) as the 2025 review is still pending completion due to awaiting the feedback from the previously mentioned Culture and Peer review, which will provide	

	Is the trust an outlier on staff surveys across peers?	the Board with a greater sense of reflection from across the organisation. Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture, allows the Board to consider the consistency in how leaders receive and respond to concerns and the impact this has on the perceptions of psychological safety and futility when speaking up. In addition, the Board considers the Staff Survey results both independently and as part of the FTSU reporting process. Questions 25e and 25f provide an indication of the above and document 2 demonstrates how a reduction in these scores in 2024, was discussed and explored as part of reporting and discussion in May 2025. The Trust is not an outlier across some of our acute peers, there is a difference between some of our local trusts who provide community and or mental health services. Board reports (provided) do explore national and regional comparisons, and appropriate challenge was received by Board members to reflect the need to address our internal reduction in confidence, regardless of our stable position in benchmarking.	

IV. Access and delivery of services

Self-assessment criteria	**Indicative evidence or lines of enquiry**	**Supporting information**	**Evidence**
Plans are in place to improve performance against the relevant access and waiting times standards.	Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? Where waiting time standards are not being met or will not be met in the	There are Monthly operational performance reports to the Finance & Performance Committee which covers all national waiting time standards and with a deep dive into actions on a bi-monthly basis. The reports detail performance against the national standard and the Trust planning submission (trajectory). It also includes an exception report where performance is off plan in month with clear The monthly IQPR demonstrates all national waiting time standards	F&P committee work plan and ToR

	financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?	Monthly Performance Review Meetings provide oversight of Divisional performance against the national waiting time standards. Performance is monitored against planned trajectory with weekly oversight meetings and reports through to the executive team.	
The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.	The Trust has a strategy in place to tackle health inequalities and has begun to develop measures to identify inequalities in access, DNAs (was not brought) and elective waiting lists (equity index). There are plans in place to implement a fair waiting list pilot (WHaLES) and we have undertaken targeted work to address inequalities in access for specific groups including people experiencing homelessness, sex workers and those with significant substance misuse issues. The equity index document provides a snapshot of our currently developed equity indices and this will be embedded into our existing data dashboards	Health-Inequalities-Strategy-2024-FINAL-VERSION.pdf Equity Index.pptx HI Action Log
Appropriate population health targets have been agreed with the integrated care board.	Is there a clear link between specific population health measures and the internal operations of the trust? Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	The Trust's strategic priorities are explicitly aligned to local population health needs identified through the Joint Strategic Needs Assessment, Integrated Care Board priorities, and local system intelligence. Health inequalities update was provided to the Board of Directors Sept 2025 - which described the focus on reducing DNAs with a health inequalities lens and the fair waiting list pilot which was developed by partner colleagues in Barnsley NHS FT. (WHaLES) These priorities are translated into operational plans and quality improvement programmes. The documented evidence provides the action log which summarises the work to improve access, experience and outcomes for people experiencing homelessness, sex workers and those with significant substance misuse issues.	Equity Index.pptx HI Action Log Health Inequalities update to Board Sept 25 word Doc

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry	Supporting information	Evidence
Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: • review its performance against peers • identify and understand any unwarranted variations • put programmes in place to reduce unwarranted negative variation. The trust's track record of delivery of planned productivity rates.	The improvement plans for UEC, Theatres and Outpatients have used Model Health Data to identify opportunities for improvement. Model Health System metrics are also to track progress against plans The latest published information reported to the Finance & Performance committee (M2 2025/26) shows a 4.8% improvement in implied productivity in the last 12 months driven primarily by a 3.4% reduction in real term costs. This compares favourably with the 2.6% regional average improvement in implied productivity over the same period. However, DBTH implied productivity is still 11.4% behind pre-covid (2019/20) levels, the regional average is 6.8% behind pre-covid levels	(I) Month 5 Finance and Activity Report (slide 13)

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry	Supporting information	Evidence
The trust has a robust financial governance framework and appropriate contract	Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial	In terms of having a robust financial governance framework the Trust has recent re-assessed itself using the HFMA Improving NHS Financial Sustainability: Are You Getting the Basics Right' self-assessment tool. None of the 72 statements were scored at 1 (never holds true) or 2	(i)DBTH 25/26 Internal Audit Final Plan including 3-year strategy

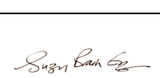
management arrangements.	systems and processes, and to ensure the reliability of performance data. Have there been any contract disputes over the past 12 months and, if so, have these been addressed? Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?	(often not in place). An action plan has been agreed to improve the 24 items scoring at 3 (holds true about half the time) (vi) The 2025/2026 Internal Audit Programme includes planned audits of both Estates and Facilities Contract Management and Data Quality - Cancer Metrics. The 3-year Strategic Audit Plan 2024-27 includes 8 Finance and Sustainability audits. There have been no major disputes over the last 12 months and the Trust has commissioned KPMG to review some significant contracts retrospectively from a management perspective (iii and iv). Reviews have identified potential contract leakage Monthly Finance and Activity report includes aligned information on pay costs and worked Whole Time Equivalents (WTE) on slides 10-11. There is also aligned information on efficiency savings in £ and efficiency WTE reductions in establishment on both a recurrent full year effect basis (slides 15-16) and an in-year basis (slides 17-18) from the month 5 finance and activity report	(ii)DBTH 24/25 Accounts payable final report (iii) KPMG Contract management review phase 1 FINAL Report (iv) KPMG Contract Management Review phase 2 DRAFT report (v) Contract management team invest to save (A&B) (vi) HFMA Checklist (vii) Month 5 finance and Activity report
Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.	Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? Does the board track performance against planned surplus/deficit and	The Trust has risks on both corporate risk register and Board Assurance Framework related to not achieving its financial plan which are monitored through the Risk Management Group and Performance and Performance Committee. Monthly Finance and Activity report includes aligned information on efficiency savings in £ and efficiency WTE reductions in establishment on both a recurrent full year effect basis (slides 15-16) and an in-year basis (slides 17-18). It also sets out all financial risks and measures the overall level of financial risk both gross and net of mitigations (slides 3 to 4) from the month 5 finance and activity report The Trust Quality and Performance Impact Assessment Process Surplus/deficit performance versus plan is included within monthly finance and activity report (slides 3,6) and there is also an analysis of	(i) Month 5 Finance and Activity Report (ii) QPIA process

	where performance is lagging it understands the underlying drivers?	the estimated underlying deficit at the end of the financial year (slide 7) from the month 5 finance and activity report.	
The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	Is the board contributing to system-wide discussions on allocation of resources? Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	The CFO is a member of system FCEDG group and has recently taken on chairing the South Yorkshire Acute Collaborative Procurement Board. The CEO sits on the South Yorkshire Integrated Board The Trust's financial plans align with those of its partner organisations and the joint forward plan for the system. At the time of the April planning submission there were unidentified savings in both the Trust plan and overall system plan The Trust does all it can to maintain positive partner relationships and support the system. However, it must maintain its own financial prudence and there would have been some disappointment from both the Local Authority and SY ICB that the DBTH wasn't able to proceed with a particular proposal for Health on the High Street due to affordability grounds. To Note, some opportunities to strengthen consistency were identified through the self assessment against the HFMA 'Getting the Basics Right' checklist. These were reported through both Finance and Performance committee and IQIG along with action plan to address those. Attention now being turned to the 'Strengthening Financial Management' framework. Delivery of financial plan for each of the last 8 years. Trust has been on plan with delivery of 2025/26 financial plan throughout H1.	(i) Actions and notes from latest FCEDG meeting (ii) Agenda for South Yorkshire Acute Collaborative Procurement Boars September 2025 Meeting (iii) Draft minutes of the South Yorkshire ICB meeting held on 7th May 2025 (iv) 2025/26 financial plan paper presented to Trust Board

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*Following the launch of the new Trust strategy the view of the Board is 'confirmed' for the criteria set out here for this domain. Further work is required to embed the ambitions with clear measures to ensure the board know it is meeting the health need. Some of the enabling plans are due for refresh over the next 12-18 months.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Partially confirmed**	*The Trust is in the Integrated Quality Improvement Group (IQIG) process with the region with actions and transition criteria linked to CQC Action Plan and Paediatric Audiology. Work is progressing well. It has also been noted by the Board in agreeing this submission that there is further work to do in transforming data reporting into meaningful information and insights that will more effectively triangulate evidence on delivery. This aspect of the work also impacts on the measurable outcomes .*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Partially confirmed**	*The impact of known issues, and the journey to bring about cultural change was recognised by the Board and a culture and Freedom to Speak up Review have been commissioned in 2025. In this context it is recognised that there will be further work required and a need to achieve consistency in embedding practices and addressing behaviour and cultural issues.* *Once these reports are completed and available, these will inform actions to create a compliant position for the Trust. These items also link to transition criteria for IQIG as referenced in the Quality domain.*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*The Trust is in Tier 2 for elective waits. Plans are in place to be fully compliant by December 2025 for 65 weeks and by March 2026 for 52 weeks.* *There is further work ongoing to ensure health inequalities are captured within our data reporting.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*Productivity improvements using a coordinated approach to benchmarking is in place and will be further embedded over the next 12 months.*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*Some opportunities to strengthen consistency identified through self assessment against the HFMA 'Getting the Basics Right' checklist. Reported through both Finance and Performance committee and IQIG along with action plan to address those. Attention now being turned to the 'Strengthening Financial Management' framework. The Board has noted the wider system clinical strategy which will further ensure appropriate use of resources and support the delivery of the 2025/26 financial plan building upon the delivery of the financial plan in each of the last 8 years. Trust has been on plan with delivery of 2025/26 financial plan throughout H1.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors



Name	Suzy Brain England OBE, Chair of the Board
Date	22 October 2025

Provider Capability - Self-Assessment evidence signpost template

		Provide links to evidence and any supplementary information to support self assessment
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	*See accompanying board paper + other evidence available if requested:* *Minutes of the SYB Acute Federation Board (March 4 2024)* *Digital Converge papers to Acute Federation Board (March 4 2024)* *Digital strategy, EPR Business Case.* *DBTH refreshed strategy which highlights the EPR strategic priority together with the NHSE business case.* *Link to new strategy on website :* *https://www.dbth.nhs.uk/about-us/how-we-are-run/trust-strategy/*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	*See accompanying board paper + other evidence available if requested:* *Quality Committee ToR* *Evidence chest documents (1-84)*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	*See accompanying board paper + other evidence available if requested:* *People Committee ToR* *EDI update ppaer to People Committee June 25* *Gender paygap paper to People Committee Feb 2025* *Staff survey results 2024 + report to board staff survey results 2025*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	*See accompanying board paper + other evidence available if requested:* *Finance and Performance Committee ToR* *https://www.dbth.nhs.uk/wp-content/uploads/2024/03/Health-Inequalities-Strategy-2024-FINAL-VERSION.pdf*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*See accompanying board paper + other evidence available if requested:* *Finance and Performance Committee ToR* *Evidence slide pack DBTHi* *(I) Month 5 Finance and Activity Report (slide 13)* *Model Hospital and opportunity costs built into plans*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	*See accompanying board paper + other evidence available if requested:* *Finance and Performance Committee ToR* *Evidence chest documents (1-15)*

2511 - E7 USE OF TRUST SEAL

Information Item | Zara Jones, Deputy Chief Executive | 13:50

5 minutes

REFERENCES

Only PDFs are attached

E7 - Use of Trust Seal.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	4 November 2025
Report Title/ Ref:	**Use of Trust Seal**			
Executive Sponsor:	Zara Jones, Deputy Chief Executive			
Authors:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance Angela O'Mara, Deputy Company Secretary			
Appendices:	None			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 4 and BAF 5. The use of the seal is a primary control in relevant contract management and leases.			

Executive Summary – Key messages and Issues

Purpose of the report

This report provides the Board of Directors with details of significant transactions which have required the application of the Trust seal.

Summary of Key Points

In accordance with the Standing Orders of the Board of Directors (paragraph 9, Annex 8 of the Trust's Constitution) the Trust seal has been used on six occasions since November 2024, in relation to the following transactions:

Lease – Roof top at Bassetlaw District General Hospital (BDGH)
Date seal applied: 18 December 2024
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) EE Limited and Hutchinson 3G UK Limited
Signatories: Richard Parker OBE, Chief Executive & Jonathan Sargeant, Chief Finance Officer

Contract - Same Day Emergency Care and Minors redevelopment at BDGH
Date seal applied: 23 April 2025
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) O&P Construction Services Limited
Signatories: Richard Parker OBE, Chief Executive & Sam Wilde, Chief Finance Officer

Contract - W&C Roof Replacement at Doncaster Royal Infirmary
Date seal applied: 1 July 2025
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Bermar Building Company Limited
Signatories: Richard Parker OBE, Chief Executive & Sam Wilde, Chief Finance Officer

Contract - Pharmacy Robot at Doncaster Royal Infirmary
Date seal applied: 1 July 2025
Between:

(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Bermar Building Company Limited
Signatories: Richard Parker OBE, Chief Executive & Sam Wilde, Chief Finance Officer

Contract – Second CT Scanner at BDGH
Date seal applied: 1 July 2025
Between:
(1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Bermar Building Company Limited
Signatories: Richard Parker OBE, Chief Executive & Sam Wilde, Chief Finance Officer

Lease - Roof space at BDGH
Date seal applied: 11 August 2025
Between:
1) Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
(2) Bauer Radio Limited
Signatories: Richard Parker OBE, Chief Executive & Sam Wilde, Chief Finance Officer

Recommendations
The Board is asked to note the use of the Trust seal.

Healthier together – delivering exceptional care for all	
Patients	The use of the Trust seal has no direct impact on patients
People	The use of the Trust seal has no direct impact on people
Partnerships	The use of the Trust seal has no direct impact on partnerships
Pounds	The use of the Trust seal is a control for ensuring the trust is spending public money wisely
Health Inequalities	The use of the Trust seal has no direct impact on health inequalities
Legal/ Regulation:	The Trust seal is applied in accordance with the Standing Orders for the practice and procedure of the Board of Directors
Partner ICB strategies	The use of the Trust Seal has no direct impact on ICB Strategies

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **N/A**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

2511 - E8 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Mark Bailey, Non-executive Director | 13:55

5 Minutes

REFERENCES

Only PDFs are attached

E8 - Chair's Assurance Log - Finance & Performance Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Finance and Performance Committee - Chair's Highlight Report to Trust Board

Subject:	Finance and Performance Committee Meeting	**Board Date: 4 November 2025**
Prepared By:	Kath Smart – Deputy F&P Committee Chair & Non-Executive Director	
Approved By:	Committee Members	
Presented By:	Mark Bailey/ Kath Smart	
Purpose	The paper summarises the **key highlights** from the Finance and Performance Committee meeting held on 23rd October 2025	

Matters of Concern/Escalation Items (with Partial or No Assurance)	Major Actions Commissioned / Work Underway
Access Performance – September 2025 Of the 10 metrics included in the annual plan, 3 are on plan for the month and 7 are off track. Action plans to meet 25/26 requirements are in place. Emergency Care: 4-hour access is below planned trajectory with plans to enable improvement including the UEC front door work. Ambulance handover still showing sustained step change in performance with average times ahead of trajectory. Elective Care: 18-week Referral to treatment – is slightly below trajectory. 52 weeks has plans in place to achieve, with Trauma and Orthopaedics and Ear Nose Throat position posing risks which are being closely monitored, 65 weeks due to be delivered by December 2025. Cancer: 28-day Faster Diagnosis Standard (FDS) is behind plan due to an increase in referrals; 31 days above standard; 62 days behind trajectory. Action plans for access standards to meet all 2025/26 national standards. Month by month improvement trajectories with evaluation of effectiveness of improvement areas or recovery actions. The confidence assessment at this stage mid-year is with caution given winter risks and the challenge remaining to further reduce time in Emergency Department (ED). **Financial Performance – Month 6** Year to date £1.2m surplus in line with plan although again has required bringing forward non-recurrent technical benefits planned for later in the year (amount reducing month on month); in-month surplus was £2.9m in line with plan. Recurrent cost improvement delivery now exceeds full year plan. In-year cost improvement (including non-recurrent savings) meeting target in the month, year to date and full year forecast. Capital expenditure behind plan. Business cases being developed to deliver capital plan and ensure no slippage at year-end. Above in-month plan levels of elective, outpatient new and day case activity. Follow-up	**DBTHi – Productivity Update** Work commissioned to gain assurance on continued plans to improve DBTH productivity including a quarterly update to F&P using the implied productivity index **Board Assurance Framework (BAF) – BAF 4 and 5** Agreed that a review of the BAF alongside the Provider Capability Assessment should be carried out once NHSE had reviewed the Trusts self-assessment. **Security Management – Violence and Aggression incidents** Committee asked for further work to be done on this including: - data analysis, data points to be mapped, review other Trusts processes, especially in ED, and confirm if V&A is on/ should be on BAF 2. **Access Performance** Review of audiology recovery trajectories to take place in November 2025

outpatient slightly behind in-month plan, although year to date all points of delivery remain cumulatively above plan.

New risk included regarding Elective Recovery Fund (ERF) overperformance not being fully funded and risk score around capital non-delivery increased.

Cash balance in line with plan despite reduced level of capital expenditure.

Note: Cashflow forecasts do not include risk in late quarter 3 / 4 from loss of deficit support funding per advice of South Yorkshire Integrated Care Board and suggest Trust will require cash support at some point in quarter 4. Trust maintaining close scrutiny of position.

DBTHi – Driving improved Productivity Update

Good oversight of the data used to drive the DBTH Improvement approach, confirming Trusts productivity is an improving picture. Work commissioned (see box opposite) to gain assurance on continued plans to improve productivity

Security Management - update

The Local Security Management update provided good assurance on processes and plans in place to mitigate security issues. However, Committee discussion about increase in V&A incidents was partially assured. Committee asked for further data analysis, data points to be mapped, review other Trusts processes, especially in ED, and confirm if this should be on the Board Assurance Framework (BAF).

Significant or Full Assurances to Provide	Decisions Made
Ratification of Bottled Gages contract award The Committee reviewed the process and outcome and gave **significant assurance** and recommended approval to Board. **Digital Enabling Plan** A comprehensive plan 2025-2029 was considered to be clear, concise and measurable by the Committee which addresses the move from analogue to digital and focuses on 5 key ambitions which all have plans and metrics attached. Further additions of a high level workstream overview/ Gantt chart dependencies were requested as part of Finance & Performance role in tracking delivery. This was recommended to Board for approval. **Digital Update & Data Quality Progress** An update on key projects and key strategic IT programmes confirmed good progress. Updates were given in terms of EPR preparedness; Telephony; Clinical System changes; Corporate system changes and Data Quality Metrics/ kitemarking. The Committee agreed to have a Deep Dive on Data Quality & Kitemarking sometime during 2026.	**Ratification of Bottled Gases contract award** This was recommended to Board for approval **Digital Enabling Plan** This was recommended to Board for approval **DRI East Ward Block - OBC** The Committee considered the high-level option appraisal, overview and development plans for the EWB, noting the significant capital requirements requiring support, and potential ongoing revenue implications. Further detailed queries to be passed to relevant officers for clarification prior to Board. The OBC was considered as consistent with the Board approved Estate Master plan and was recommended to Board for approval.

Theatres Cost Improvement Programme Deep Dive The Committee considered the evidenced data led approach (using Model Hospital / GIRFT national benchmarking and established productivity / efficiency best practice). This demonstrated the Trust were not in the upper quartile for areas under measurement, although confirmation of CIP delivery already achieved during the year was £0.5m. Oversight of actions to deliver (Monday.com) was requested to give significant assurance. **Capital Infrastructure Programme – Estates Investment** An overview of the capital plan delivery in Estates improvements gave Committee **significant assurance** of continuing delivery. **Local Security Management update** The Local Security Management update provided good assurance on processes and plans in place to mitigate security issues. However, Committee discussion about increases in Violence & Aggression incidents concluded partial assurance (see above)	**Board Assurance Framework (BAF) – BAF 4 and 5** Assurance ratings confirmed and agreed for the key risks with updated action plans and confirmation sought that papers reviewed by F&P had not changed the risk rating of BAF 4 (Care Environment) or BAF 5 (Finance). Position with some BAF actions were queried and agreed that a review of the BAF alongside the Provider Capability Assessment should be carried out once NHSE had reviewed the Trusts self-assessment.

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

2511 - E9 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 14:00

5 Minutes

REFERENCES

Only PDFs are attached

E9 - Chair's Assurance Log - Quality Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality Committee Meeting - Chair's Highlight Report to Trust Board

Subject:	Quality Committee	**Board Date:** 4 November 2025
Prepared By:	Jo Gander, Non-executive Director & Quality Committee Chair	
Approved By:	Quality Committee Members	
Presented By:	Jo Gander, Non-executive Director & Quality Committee Chair	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 9 October 2025	

Matters of Concern (Partial or No Assurance)	**Work / Major actions commissions**
• C Difficile exception report received and Quality Committee noted the rising number of CDI cases and the risk of exceeding the set threshold for the financial year **Partial Assurance**	The following items were received for information: • Moss Pilot briefing • Trust Implementation Status update on Martha's Rule • Trauma and Orthopaedics escalation paper • Bassetlaw Deep Dive paper • Paediatric Service Review Escalation paper • Prevention of future deaths report
Significant or Full Assurances to Provide	**Decisions Made**
• Maternity & neonatal Safety Report **Significant Assurance** • **Significant Assurance** • Clinical Audit & Effectiveness report **Significant Assurance** • CQC closed action plan **Significant Assurance** • Patient Safety report **Significant Assurance** • Mortality Deep Dive **Significant Assurance** • Skin Integrity Exception Report **Significant Assurance** • Nursing/Medic SJR plan **Significant Assurance** • Board Assurance Framework Risk 1,including Trust Risk Register **Significant Assurance**	• Quality Committee workplan approved • Patient Experience Framework, Gap Analysis & Next Steps proposal approved • Quality Committee took assurance from the detail provided within the Maternity & Neonatal Safety & Quality report - Reviewed and approved on behalf of the Trust Board Perinatal Mortality Review Tool (PMRT) Q1 noting that there had been 2 still births, no foetal losses and 2 neonatal and post-natal deaths. - Reviewed and approved on behalf of the Trust Board progress updates on Single Delivery Plan, Maternity Self-Assessment & Clinical Negligence Scheme for Trusts - Reviewed and approved on behalf of the Trust Board Avoiding Term Admissions Into Neonatal Units (ATAIN) Q1 - Reviewed and approved on behalf of the Trust Board the approach proposed for the Special Care Baby Unit (SCBU) non-clinical co-ordinator - Reviewed and approved on behalf of the Trust Board the Trust Quality Metrics - Reviewed and approved on behalf of the Trust Board that the posts required for Saving Babies Lives Care Bundle are in place. - Reviewed and approved on behalf of the Trust Board the short and long term locum position was now fully compliant - Reviewed and approved on behalf of the Trust Board the number of Maternity and Neonatal

	Safety Investigation (MNSI) / Early Notification Scheme (ENS) cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place

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

2511 - E10 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Lucy Nickson, Non-executive Director | 14:05

5 minutes

REFERENCES

Only PDFs are attached

E10 - Chair's Assurance Log - People Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board

Subject:	**People Committee**	**Board Date: 4 November 2025**
Prepared By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 21 October 2025	

Matters of Concern (Moderate, LIMITED or No Assurance)	**Work Underway / Major actions commissions**
There were no items in which moderate, limited or no assurance was given	

Significant Assurances	**Decisions Made**
IQPR People Metrics – Significant Assurance SPC charts are now included in reporting to show trends for SET, sickness absence and turnover. Variance in turnover figures is being addressed and thought to be linked to reporting. The appraisal season concluded with 93.28% appraisal completion The 90% target for SET Training has been more challenging this financial year, with three months achieving over 90% but by September the current figure is at 88.8% - this appears to be linked to annual renewals becoming due **Health & Wellbeing – Significant Assurance** The trust has successfully retained its Menopause Accreditation The Occupational Health service retained its SEQOHS Accreditation in July 2025 The flu vaccine campaign and programme commenced in October, and uptake appears to have started fairly well. Oversight on progress against targets and reporting is well established. **Engagement and Leadership – Significant Assurance** Staff Survey season has commenced and closed November 28th. Uptake appears reasonable to date but the established work to ensure engagement on this remains focussed. Trust-wide actions taken in response to last year's survey continue to be implemented. The committee heard about the approach being taken to support sexual safety in the workplace, which is in line with national expectations. **Education Report - Significant Assurance** SET compliance was 88.84% for the end September 2025 but is expected to be impacted by the introduction of level 3 safeguarding adults and fire safety training frequency. The 2025 GMC National Training Survey results reveal a mixed picture, with deterioration across multiple indicators. The committee heard about the detailed work	**Job Planning 360 Assurance Report- Significant Assurance** The Committee was presented with the final report for the 360 job planning audit. Due to the ongoing nature of work supporting effective job planning within the Trust, it was agreed that the current action plan and next steps overview should be reported to People Committee for completeness and in order to strengthen assurance as the work continues to progress.

that is in place to better understand these results and to look to areas for improvement, although it should be noted that nothing in practice or support to those completing this survey has changed in the last 12 month. The committee was assured on the actions being taken to explore this as opposed to the results themselves.
Q1 saw 12 new apprentices start across six programmes and a high retention of all apprentices, which is very pleasing.

Appraisal Season – **Significant Assurance**

For the second consecutive year DBTH has achieved the 90% standard for appraisals, with a total completion rate of 93.28%

Designated Body Annual Report and Statement of Compliance - Significant Assurance

The Trust is classified as a Designated body for its employed doctors. All DBs are required to submit an annual report regarding medical revalidation and appraisal for 2024/25 to the relevant committee of the board. The committee received the report and statement of compliance and noted its readiness for submission to NHSE by the 31st October 2025, it being signed by the Chief Executive

Speaking Up (FTSU) Bi-Annual report – Significant Assurance

A comprehensive report was presented which provided detail of activity and performance, including regulatory requirements and best practice for the period April – October 2025. The report also informed the committee about the national picture and changed to the FTSU guidance and governance structures that are expected. The PC agreed to receive an additional focussed FTSU report in February to ensure progress is made on future actions regarding a changing national Framework, Peer review and value circle outputs.

Workforce Supply and Demand Pay Efficiency– Significant Assurance

The committee received an update on the pay efficiency workstream which is part of the CIP. In addition, the paper highlighted areas referred to as 'hot spots', which include highest turnover and sickness rates, high bank and agency spend and medical vacancies impacting on locum expenditure.
The paper also included an update on National planning guidance and the schedule for 2026/27, which indicates earlier than expected completion and submission dates this time.

Safe Staffing and Skill Mix: Significant Assurance

Overall Care Hours (CHPPD) per patient reduced in the reporting period. RNs showed consistency while RMs declined due to vacancies and absences. Eight in-patient wards triggered <10% below planned staffing levels between June and August but no significant safety events were reported, and the committee were assured on management and mitigations. In relation to Midwifery, eleven newly qualified midwives commence in post in October 2025 and an additional twelve are due during the winter period. Several wards flexed their bed base beyond funded levels to meet demand during the reporting period which also contributed to staffing challenges.

Resident Doctors 10-point Plan – **Significant Assurance**

In August 2025 NHSE launched a 10-point plan to improve the working lives of resident

doctors, with Trusts required to complete a baseline audit and oversight at Board level. DBTH submitted a baseline audit against the recommendations in September 2025, assessing compliance against 10 priority areas. Of the 18 resulting actions, 6 (39%) are fully compliant, 7 are actively progressing and the remainder await national guidance. **Establishment Control - Significant Assurance** Review at committee level was referred from Audit & Risk Committee following non-prioritisation of establishment control as an audit - at this time. The focus is to ensure information held by HR and Payroll systems are aligned, focussing on AfC roles only. The committee heard about the project in place to review and improve data quality within ESR and the financial ledger, which is critical for the new workforce solution which is expected to replace ESR by 2030 **Board Assurance Framework (BAF) - Significant Assurance** A report was presented setting out the latest information used to assess risk mitigation actions within the BAF risk 2 and Trust risk register. Specific controls requiring actions for completion were all on track and achieved within agreed timescales. The committee took assurance on the actions and updates, recommending the position to the Board of Directors in November 2025.	

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

2511 - E11 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 14:10

5 minutes

REFERENCES

Only PDFs are attached

E11 - Chair's Assurance Log - Audit & Risk Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Audit and Risk Committee (ARC) - Chair's Highlight Report to Trust Board

Subject:	**Audit & Risk Committee**	**Board Date: 4 November 2025**
Prepared By:	Kath Smart, Non-executive Director & Committee Chair	
Approved By:	Audit & Risk Committee Members	
Presented By:	Kath Smart, Non-executive Director & Committee Chair	
Purpose	The paper summaries the key highlights from the Audit and Risk Committee meeting held on 16 October 2025	

Matters of Concern (with moderate, partial, limited or no assurance)	**Work Underway / Major Actions Commissioned**
a) Audit Reports i. **Data Quality Audit – Cancer Faster Diagnosis** Standard – **limited** assurance - The internal audit review was to validate performance information reported in respect of the 28 day cancer faster diagnosis standard. The audit concluded that the monthly compliance data reported to F&P was consistent with those reported to NHSE with a slight discrepancy for one month. Sample testing of compliant and breach cases highlighted some data quality errors and issues with the clock start date recording. 1 High, 1 Medium and 1 Low risk recommendation were made, and the report was referred into Finance & Performance Committee. Management accepted all the recommendations and progress will be monitored. ii. **SBS Assurance Statement** – This was provided from the auditors of the Shared Business Services and was awarded a **partial** assurance as there were 3 areas in which controls were found not to be operating as described in some items sampled. **b) Management Reports** i. **Emergency Planning Annual Submission** – This management review demonstrated there has been continual improvements in the arrangements for emergency planning & provided an update on the progress with the Trusts arrangements. The Trust statement of compliance showed 51/62 standards as "fully compliant" and 11/62 as "partially compliant", which results in 82% compliance rate and this falls into NHSE category of partially compliant. Plans are underway to improve this and work to achieve the next category. All Audit actions relating to Business continuity were noted as now being achieved. ii. **Implementation of Management of Reviews, Visits, Inspections Policy** – This policy implementation has been monitored by ARC. It was noted progress continues to be made, although there are still difficulties with ensuring comprehensive oversight/outcomes of all such visits. It was noted the importance of ensuring the Trust was sighted on outcomes &	a) All the internal audit reports have agreed deadlines for implementation of actions. ARC will continue to monitor delivery; b) Debrief of the Year end process – A report provided by Management and EY confirmed a number of areas for joint learning and improvement were to be implemented for the 2025/26 Year end accounts process; c) CounterFraud – ARC has requested additional work which the The Local Counter Fraud Specialist (LCFS) is undertaking in the form of two Local Proactive Exercises. These will be reported back to February's ARC

suggested for future Internal audit plan. ARC agreed to stand down monitoring. **c) <u>Key risks to escalate</u>** None	
Significant Assurances to Provide	**Decisions Made**
a) **Counter Fraud arrangements and progress Q2 25/26 – Significant assurance** was given to the arrangements in place to prevent, detect and investigate fraud. The Trust is meeting the required published standards of the NHS Counter Fraud Authority. Discussion was held about the new legal framework under the Economic Crime & Corporate Transparency Act (from 1/9) and it was assessed the Trust was meeting its duty to prevent fraud. More information to be brought to the next ARC. b) **Internal Audit :-** Audit Recommendations closure rate for high & medium risks -100% (timeliness for high & medium risks) & First follow-up rate (all risks) – 89% therefore **Significant Assurance** & evidence of continual improvement & good risk mitigation; c) **Code of Governance Compliance** – This self-assessment was reviewed by ARC and confirmed to be very factual in nature. ARC accepted the explanations for those which were not compliant, which were few / minor in nature. d) **Register of Interests, Hospitality and Sponsorship** – The current compliance level of 94% for decision makers declarations was viewed to be positive and represent significant assurance. Work has been requested on raising awareness for those who are not decision makers, in particular secondary employment (see Work Commissioned from Counterfraud above). e) **Risk Management & BAF – Significant Assurance -** ARC reviewed the risk report, the routine risk report and the current BAF. Support was given to the newly developed KPI's as a positive development. Chairs presented high-level overviews of the BAF's in relation to their Committees. Compliance with BAF being presented at Board/ Committee was noted and positive. In-line with the Audit Committee's role, following the Audit and Risk Committee a confidential session was held with non-executive directors and the Chief Finance Officer to discuss the appointment of auditors. The Committee was assured this is progressing in line with the planned procurement process.	a) ARC reviewed and APPROVED the EPR Impairment proposal which is considered to be consistent with national guidance and the original business case for the Electronic Patient Record system.

2511 - F INFORMATION

14:15

2511 - F1 BOARD OF DIRECTORS WORKPLAN

Information Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

REFERENCES

Only PDFs are attached

F1 - Board Work Plan.pdf

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
ANNUAL WORK PROGRAMME FOR THE BOARD OF DIRECTORS

AGENDA ITEM/ACTION	LEAD PERSON / DOCUMENT ORIGINATOR	FREQUENCY	NEXT DUE	07/05/2024	02/07/2024	03/09/2024	05/11/2024	07/01/2025	04/03/2025	06/05/2025	01/07/2025	02/09/2025	04/11/2025
OPENING ITEMS													
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting										
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting										
Chair's Report (including partnership updates and impact on DBTH)	Chair of the Board	Every Meeting	Every Meeting										
Chief Executive's Report (including partnership updates and impact on DBTH)	Chief Executive	Every Meeting	Every Meeting										
BOARD LEARNING & REFLECTION													
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	H&WB		Wendy's Story	Frailty Services			Staff Survey			HI Case
PATIENTS													
Audiology Service Update	Deputy Chief Executive	Every Meeting	Nov-25										
Maternity & Neonatal Update	Director of Midwifery	As per schedule	Nov-25										
Learning from Deaths	Executive Medical Director	Quarterly	TBC		verbal								
Patient Experience Annual Report	Chief Nurse	Annual	Sep-26										
Winter Plan	Chief Operating Officer	Annual	Sep-26										
Quality Accounts	Chief Nurse	Annual	Jul-26										
Safeguarding Annual Report	Chief Nurse	Annual	Sep-26										
Clinical Audit Plan	Executive Medical Director	Annual	Sep-25										
Infection Prevention & Control Annual Report	Chief Nurse	Annual	Sep-26										
PEOPLE													
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Nov-25										
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-26										
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-26										
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Nov-25										
Staff Survey Results	Chief People Officer	Annual	May-26										
Maternity Workforce	Director of Midwifery	Bi-annual	Jan-26										
Research & Innovation Case Study	Chief People Officer	Annual	Jul-26										
PARTNERSHIP													
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	As required	Nov-25										
Wider Partnership updates	DCEO	As required											
POUNDS													
Financial Position	Chief Financial Officer	Every Meeting	Every Meeting										
Financial Plan	Chief Financial Officer	Annual	May-26										
Going Concern	Chief Financial Officer	Annual	May-26										
Delegation for the Approval of Annual Accounts and Annual report	Chief Financial Officer	Annual	May-26										
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-26										
Annual Business Plan	Chief Financial Officer	Annual	Jul-26										
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-26										
ASSURANCE & GOVERNANCE													
Integrated Quality & Performance Report	COO/CN/EMD/CPO	Every Meeting	Every Meeting										
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Nov-25										
Board Risk Appetite	Deputy Chief Executive	Annual	May-26										
Review of Strategic Risks	Deputy Chief Executive	Annual	May-26										
2025/2026 Strategic Priorities Success Measures	Deputy Chief Executive	Annual	May-26										
Delivery Update 2025/26 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	Nov-25										
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-26										
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-25										
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	Nov-25		verbal								
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Nov-25										
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Nov-25										
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Nov-25										
~~Chair's Assurance Log - Charitable Funds Committee~~	CFC Chair	Post Committee											
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-26										
~~Annual Report - Chartable Funds Committee~~	Chair of CFC	Annual											
Board Work Plan (approval)	AD of Strategy, Partnerships & C	Annual	Mar-26										
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annually	Jan-26										
Trust Seal	AD of Strategy, Partnerships &	Annually	Nov-25										
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & C	Annual	May-26										
Board Effectiveness	AD of Strategy, Partnerships & C	Annual											
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & C	Annual	May-26										
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & C	Annual	May-26										
Terms of Reference - People Committee	AD of Strategy, Partnerships & C	Annual	May-26										
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & C	Annual	May-26										
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Deputy Chief Executive	As Req'd	As Req'd									Green Plan/HI	
ENABLING STRATEGIES													
Nursing, Midwifery & Allied Health Professionals Strategy 2023/27	Chief Nurse		2027										
People Strategy 2023/27	Chief People Officer		2027										
Research & Innovation Strategy 2023/28	Chief People Officer		2028										
Speaking Up Strategy 2024/28	Chief People Officer		2028										
Tackling Health Inequalities 2023/28	Director of Recovery,		2028										
Digtal Enabling Plan	Chief Finance Office												
TRUST POLICIES													
CORP/FIN 1 - A Standing Orders - Board of Directors	AD of Governance	Annual	May-26										
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	May-26										
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	May-26										
CORP/FIN 1 - D Fraud, Bribery and Corruption Policy and Response Plan	Chief Financial Officer	2 Yearly	Mar-26										
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships & C	3 yearly	Mar-28										
CORP/COMM 11 - Management of Reviews, Visits, Inspections and Accreditations Policy	AD of Strategy, Partnerships & C	2 yearly	Dec-25										
CORP/COMM 25 - Establishment and Administration of Committees Policy	AD of Strategy, Partnerships & C	3 yearly	Feb-26										
CORP/FIN 4 - Standards of Business Conduct and Employees Declarations of Interest Policy	AD of Strategy, Partnerships & C	3 yearly	Jun-26										
CORP/RISK 30 - Risk Identification, Assessment, and Management Policy	AD of Strategy, Partnerships & C	3 yearly	Oct-26										
CORP/COMM 1 - Approved Procedural Documents (APDs) Development and Management Policy	AD of Strategy, Partnerships & C	3 yearly	Mar-27										
INFORMATION													
Work Plan	AD of Strategy, Partnerships & C	Every Meeting	Every Meeting										
Appointment of External Auditors	Chief Financial Officer	As Req'd											
Appointment of Internal Auditors	Chief Financial Officer	As Req'd											
CLOSING ITEM													
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting										
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting										
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting										
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting										
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd										

LEGEND KEY - (ensure reason entered in comments column or cell as appropriate)

Presented as planned
Planned for future meeting(s)
Rescheduled for valid reason(s) - as stated
Not considered as planned
Items added to the work plan post agreement - ensure reason entered in comments column

Process for administration of actions logs/work plans:

A review of the work plan administration process has been undertaken. Each Year a Board work plan MUST be assigned a separate worksheet (plan) for each Year. Once agreed, ***no changes to workplan must be added without correct audit trail tracking and comments****. If an item has been identified for addition to a workplan then this* ***must*** *be added to the appropriate board/board committee meeting action log so full audit trail is available. Full annotation of whether a report has been to committee or not MUST be logged on to the workplan with appropriate comments as to why and when it will be presented and appropriate colour coding used identified in the legend (see above legend key). An additional column has been added to each work plan at the end headed "comments" to log any required supplementary information for audit/tracking purposes.*

2511 - G CLOSING ITEMS

14:15

2511 - G1 MINUTES OF THE MEETING HELD ON 2 SEPTEMBER 2025

Decision Item | Suzy Brain England OBE, Chair of the Board | 14:15

5 minutes

REFERENCES

Only PDFs are attached

G1 - Board of Directors Draft Minutes - 2 September 2025.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in public on Tuesday 2 September 2025 at 10am via MS Teams

Present:	Mark Bailey - Non-executive Director Suzy Brain England OBE - Chair of the Board Hazel Brand - Non-executive Director Jo Gander - Non-executive Director Karen Jessop - Chief Nurse Dr Emyr Jones - Non-executive Director Zara Jones - Deputy Chief Executive Zoe Lintin - Chief People Officer Dr Nick Mallaband - Acting Executive Medical Director Lucy Nickson - Non-executive Director Richard Parker OBE - Chief Executive Kath Smart – Non-executive Director Denise Smith - Chief Operating Officer
In attendance:	Yasmin Ahmed - Deputy Director of Finance Rebecca Allen - Associate Director of Strategy, Partnerships & Governance Kirsty Edmonsdon Jones – Director of Infrastructure (item D3-D5) Emma Shaheen - Director of Communications & Engagement Anneleisse Siddall - Corporate Governance Officer (minutes) Sean Tyler – Head of Compliance (item D4-D5)
Public in attendance:	Sheila Walsh Eamonn Harrigan Mark Bright Vic Ragoobur Vivek Panikkar Hannah Beardmore Helen Best
Apologies:	Sam Wilde - Chief Finance Officer

ACTION

P25/09/A1 **Welcome, apologies for absence and declarations of interest**

The Chair welcomed everyone to the Board of Directors meeting, including observers. Apologies for absence were noted, and no conflicts of interests were declared.

P25/09/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 1 and 3 - Trust Strategy and 2025/26 Success Measures - actions closed

Action 4 - Audiology Reporting –The Acting Executive Medical Director confirmed a detailed plan and had been worked through with NHSE Intensive Support Team. The Deputy Chief Executive confirmed that the detailed plan and performance data would be shared with the Finance and Performance committee.

Action 5 - Doncaster & Bassetlaw Healthcare Services - action not yet due.

P25/09/A3 **Chair's Report including Partnership Update (Enclosure A3)**

The Board received and noted the Chair's report, which provided an overview of activities, visits, and key events in the Trust calendar since the last Board of Directors meeting. She highlighted the areas of partnership and engagement work that she had done within her role

The Chair noted that increased engagement, central communications and meetings had increased following changes at NHS England, specifically noting the arrival of the Acting Chief Executive Officer, Jim Mackey, it was also acknowledged that changes at the Integrated Care Board (ICB) level were still pending, but the Board was being kept informed of developments.

The Board:

- ***Noted the Chair's Report***

P25/09/A4 **Chief Executive's Report (Enclosure A4)**

The Chief Executive's report provided an overview of items of interest at a local, system and national level connected to the work of the Trust and aligned to its own and its partners strategic priorities. The report enclosed a combination of items for consideration including several major transitional capital schemes, such as the groundbreaking event for the new Critical Care facility.

The Board's attention was drawn to staff achievements, and the upcoming flu vaccination campaign, noting its importance and the encouragement for both staff and the wider community to participate. Although the COVID vaccine was not as widely available, the Trust would encourage uptake when possible. He confirmed that while the severity of the upcoming seasons could not be predicted, vaccination remained a key preventative measure for both patients and our colleagues and families.

The Board:

- ***Noted the Chief Executive's Report***

P25/09/B1 **Audiology Service Update (Enclosure B1)**

The Acting Executive Medical Director provided an update on the audiology services and reported four Audiology main work streams which had progressed within the last

12 months, these included completion of digital upgrades, implementation of new equipment, and refurbishment of audiology rooms.

He confirmed that in line with the improvement plans staff competencies against the required standards were scheduled to be assessed by Senior Audiologists from Sheffield Teaching Hospital in September 2025 prior to an NHS England review in September 2025.

In response to a question from Non-executive Director, Emyr Jones, the Acting Executive Medical Director confirmed staff competencies were addressed within the new audiology structure via regular monitoring, and on completion of the NHS England national reviews it was anticipated that colleagues would be required to undertake national registration.

Since the last update, the Trust was able to track audiology service waiting lists, which had shown 800 paediatric cases waiting to be seen, he added that all patients had been risk-assessed and most were low category risk, graded at clinical prioritisation 4.

Of the risk-assessed harm review figures ten were low, ten moderate, and one severe, with several reviews still awaiting expert independent sign-off. He noted that mutual aid from Nottinghamshire Trust had been requested, and additional options were under consideration to address the backlog of patients waiting.

The Chief Nurse recognised that some children were awaiting harm reviews and asked for their status and associated safety measures. The Acting Executive Medical Director confirmed that all the children had undergone clinical reviews and were placed on appropriate care pathways, with the completion of some reviews still pending.

Non-executive Director, Kath Smart, questioned the sufficiency of colleague well-being support and family assistance to help with travel where mutual aid appointments were further away. The Acting Executive Medical Director acknowledged the challenges that patients were facing and confirmed that the Trust continued to assist families with travel arrangements and aimed to provide convenient appointment times.

The Deputy Chief Executive, Zara Jones, further added that several families had declined mutual aid due to travel preferences, all escalations were communicated to the ICB and NHS England, as required.

The Chief Executive Officer noted that significant pressure persisted system wide for audiology services and the issue had been raised with the ICB and Acute Federation.

The Board:

- ***Noted the Audiology Service Update***

P25/09/B2 **Learning from Deaths Report (Enclosure B2)**

The Acting Executive Medical Director confirmed that the Trust's learning from deaths process had developed significantly over the past 24 months, which included the reporting of Standard Hospital-level Mortality Indicator (SHMI), following the NHS England standard.

He reported that the Trust's SHMI, was decreasing and within expected boundaries, attributing this to the work of the Sepsis Committee, improved care, and a focus on clinical coding.

He confirmed that the number of Structured Judgement Reviews (SJRs) had achieved 9%, with 51 SJRs completed in the last quarter. Further recruitment efforts were carried out to recruit more medical reviewers from colleagues, but the process had stalled, further work was required, and updates on this subject would continue to be taken to the Quality Committee.

Non-executive Director, Lucy Nickson, sought clarification on patient prioritisation for transfers from Bassetlaw Hospital to Doncaster Royal Infirmary. The Acting Executive Medical Director confirmed that there had been prior delays of up to 16 hours and outlined the improvements made which included, immediate ambulance booking, direct transfer to Doncaster A&E when beds were unavailable, a surgical ward round in the Emergency Department, and a surgical tracker system. He expressed confidence that these changes would reduce risk and confirmed that the coroner had been informed of the implementation of these processes.

The Chief Executive Officer further elaborated that the ambulance service regarded patients in hospital as being in a place of safety and prioritised transfers based on clinical need, the newly implemented processes ensured that any deterioration in a patient's condition was identified early to try to ensure that the patients are transferred to the most appropriate location for their treatment as soon as possible.

Non-executive Director, Mark Bailey, commended the inclusion of good practice and asked about prioritising and implementing patient safety changes. The Acting Executive Medical Director confirmed that action plans were monitored through governance structures within the division and audits were commissioned as required. He confirmed that significant changes, such as the surgical tracker, were monitored until project completion.

Non-executive Director, Kath Smart, asked how the Trust ensured learning was embedded, specifically through the clinical audit programme. The Acting Executive Medical Director confirmed that many actions resulted in audits within the programme and oversight from specialty governance through board-level committees, though this was a work in progress.

The Board:

- ***Noted and took Partial assurance from the Learning from Deaths Report***

P25/09/B3 **Winter Plan 2025/26 (Enclosure B2)**

The Chief Operating Officer confirmed that the Board was required to approve the winter plan schemes, involving a £1.3m investment towards workforce costs.

She confirmed that the Trust would participate in a regional 'stress test' exercise and was required to submit a Board Assurance Statement by the end of September 2025. She requested that the Board delegated authority to the Finance and Performance Committee for the final sign-off, as the Board would not reconvene prior to the deadline.
Non-executive Director, Joanne Gander, noted the absence of virtual wards within the document, the Chief Operating Officer confirmed that as the Trust was not the provider, the virtual ward and that this was not part of the Trusts investment plan but assured her that the virtual ward would remain central to the wider system plan, with capacity expected to match the previous year.

Non-executive Director, Lucy Nickson, asked whether the lighter-touch assurance process would affect performance management. The Chief Operating confirmed that the process granted Boards greater autonomy, however this was still linked into the elective plans and overall delivery.

Non-executive Director, Hazel Brand, asked if the regional exercise would include both South Yorkshire and Nottinghamshire. The Chief Operating Officer confirmed this was a Northeast and Yorkshire event, which did not include the Midlands.

Non-executive Director, Emyr Jones, commented on the shift of assurance responsibility from external management to the Board and, given the delegation to the Finance and Performance Committee, highlighted the need for members to have the assurance statement in advance for scrutiny.

The Chair asked the Chief Operating Officer to confirm staff recruitment for newly qualified nurses. The Chief Operating Officer confirmed that recruitment was included within Trust plans, with some medical staffing through the internal bank and domestic and portering staff was also covered within it. She noted that substantive nursing staff recruitment was in progress.

The Chief Executive Officer confirmed that statutory oversight by the ICB and NHS England would continue, with Boards expected to be fully assured of the proposed plans.

The Board:

- ***Noted the national winter planning and preparedness requirements for winter 2025/26***
- ***Approved the winter schemes for 2025/26***
- ***Delegated authority to the Finance and Performance Committee to sign off the Board Assurance Statement prior to submission***

P25/09/B4 **DBTH Tackling Health Inequalities Update (Enclosure B4)**

The Deputy Chief Executive provided an update on Health Inequalities, which confirmed that 83% of the workforce had completed health inequalities training and

referenced interventions underway, including collaborative work with South Yorkshire colleagues on an elective waiting list tool.

A Board-level action plan was implemented with individual pledges from Board members, and the integration of health inequalities metrics had been included within the Integrated Quality and Performance Report via an equity index.

In response to Non-executive Director, Lucy Nickson's, question relating to interventions with external partners, the Deputy Chief Executive confirmed that an informal group facilitated exchanges, but further formal governance was needed to support enhanced partnership working.

Non-Executive Director Kath Smart inquired about the effects on Emergency Department demand and high-intensity users in relation to evidence-based interventions. The Deputy Chief Executive confirmed that various interventions had been shown to have a positive impact, and she cited the work with partners such as Mind, but acknowledged that increased interventions would require additional partnerships.

The Chief Operating Officer confirmed a multidisciplinary group focused on high-intensity users already existed and they had reported reduced attendances as a result.

Non-executive Director, Kath Smart, also asked about the robustness of the fair waiting list pilot tool. The Deputy Chief Executive confirmed that the tool, as piloted in Barnsley, had not disadvantaged those further down the waiting list.

The Chief Executive Officer affirmed that health inequalities were continually addressed through overview and scrutiny committees alongside health and wellbeing boards.

The Board:

- ***Noted the progress to date***
- ***Approved the proposed programme of work for the remainder of 2025/26 and 2026/27***

P25/09/C1 **Job Evaluation - Updated Nursing & Midwifery Profiles and Data Collection for Board Oversight (Enclosure C1)**

The Chief People Officer confirmed that appropriate systems and processes were in place for job evaluation, specifically nursing and midwifery profiles which were being monitored via the People Committee.

She advised that NHS England would be issuing a data collection survey in the autumn.

The Board:

- ***Noted the outlined workstreams and took assurance on the monitoring and management of this work via the People Committee***

P25/09/D1 **Integrated Quality & Performance Report (Enclosure D1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for June 2025 and remaining access, quality, and workforce standards for July 2025. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The Executive directors provided an overview of their respective key performance indicators.

The Deputy Chief Executive confirmed that that the publication of segmentation around the National Performance Framework was expected, and that the framework would be adapted for use with divisions and divisions would be scored accordingly and reported within the Finance and Performance Committee regular reporting regime.

Non-executive Director, Kath Smart, asked that additional information be included on trajectories for sepsis as it was noted that an action plan was in place, but required redesign to gain stability. The Acting Executive Medical Director confirmed that measurement challenges presented, as patients could be flagged with sepsis, but did not have the condition. He noted that the septicaemia SHMI had decreased, suggesting improved care, but recognised the ongoing need to enhance measurement and processes. An additional sepsis trajectory would be brought to the subsequent meeting.

Non-executive Director, Mark Bailey, asked about the likelihood that trajectories were not met, in relation to performance, staff sickness inducing increased bank/agency use, and forward look of job planning.

The Chief Operating Officer confirmed that there were significant challenges within Earn Nose Throat (ENT) and Trauma and Orthopaedics (T&O) services and its respective access of no more than 1% of patients waiting over 52 weeks by March 2026, however this was being worked on by the operational team and was monitored closely at the executive team.

The Chief People Officer confirmed detailed hotspot analysis was shared within the People Committee, as a continued focus.

The Acting Executive Medical Director confirmed efforts to measure delivery versus job planning payment were underway across the trust.

The Chief Executive Officer noted that unforeseen industrial action impacted delivery, ENT and T&O were under significant additional pressure. Strong controls were in place for sickness absence and staffing costs, and job planning had been reviewed and was now better aligned with capacity and demand. He emphasised the need for sustainable standards, likely requiring changes to service models and thus having less reliance on additional sessions.

Non-executive Director, Emyr Jones, praised the improved ambulance handover times but raised infection control concerns, suggesting a review of current processes. The Chief Nurse confirmed processes were continually reviewed and would routinely report into the Quality Committee.

The Board:

- ***Noted and took Significant assurance from the Integrated Quality & Performance Report***

Financial & Activity Report – Month 3 (Enclosure D2)

The Chief Finance Officer provided the Financial and Activity Month 3 update within the IQPR.

The Board:

- ***Noted the Month 3 financial and activity report***

P25/09/D3 **Board Assurance Framework including Trust Risk Register (Enclosure D3)**

The updated Board Assurance Framework (BAF) was received for assurance and approval following scrutiny by the Board's assurance committees.

Non-executive Director Kath Smart highlighted that, despite extensive controls, the estate's strategic risk score remained unchanged since July 2023. She attributed this to persistent risks and incidents and urged the board's attention to this issue.

The Deputy Chief Executive recommended that the board engage in a strategic discussion concerning estate risk. She observed that, despite substantial efforts to manage this risk, the target score remained at twenty, with no short-term reduction in risk. She also suggested the Board evaluate whether there was misalignment between the level of risk reported and the discussions held at the board level, considering that detailed conversations that took place at committee level.

The Director of infrastructure confirmed that plans were in place for a Board Development Session in December 2025, which would include training from the Health and Safety Executive specifically tailored to the Trust. She confirmed that the training would help the board seek assurance from the right sources and understand the risks presented by the site, noting that the estate risk score was likely to remain until funding was secured to address critical infrastructure issues.

Non-executive Director, Kath Smart, asked the Acting Executive Medical Director if actions on BAF Risk 1, structured judgement reviews (SJRs), would be updated as progress had been made. He confirmed that although SJRs increased from ten to fifty, the target was still pending, however actions would be refreshed.

The Board:

- ***Noted took significant assurance from the Board Assurance Framework, approved the content & noted the Trust Risk Register***

P25/09/D4 **Premises Assurance Model Assessment Report 2024/25 (Enclosure D4)**

The Director of Infrastructure confirmed that the Premises Assurance Model (PAM) Assessment Report 2024/25 was required to be submitted annually to NHS England. She clarified that the PAM provided evidence that robust systems were in place to

keep the estate and facilities safe, measuring compliance against legislation and prioritising capital investment.

The Head of Compliance provided a comprehensive overview of the PAM and its progress which was supported by successful annual PLACE assessments. One inadequate element remained which related to policies and procedures for air pollution control, which also linked to the green plan.

The Deputy Chief Executive Officer asked of the mortuary assessment's relevance to the South Yorkshire and Bassetlaw Pathology Network and responsibility allocation. The Head of Compliance confirmed that collaborative efforts took place with the Head Biomedical Scientist for Histopathology and Sheffield Teaching Hospitals, supported by the Local Security Management Specialist, which ensured the assessment was thorough and evidence based.

The Chief Nurse asked about the inclusion of bereaved relatives' experience in the mortuary, which highlighted the need for improved viewing rooms. The Head of Compliance noted capital funding was available for general improvements, but mortuary-specific needs were not fully outlined and would need to be addressed for future funding.

In response to the Chief Nurse's question related to anti-ligature compliance; the Head of Compliance confirmed that while not all areas were rated highly, significant work was undertaken on ligature risks, with more improvements planned.

In response to a question from the Chair, the Head of Compliance confirmed once the PAM was submitted it would be accessible for external viewing, with plans to triangulate benchmarked data with the potential of opportunities for capital funding.

Non-executive Director, Lucy Nickson, asked for clarification of the integration of patient experience feedback from the PAM alongside other data sources. The Head of Compliance acknowledged that the process required further refinement and emphasised the need to engage patient focus groups and external stakeholders. He further noted that ongoing efforts were essential to enhance these processes through the Patient Environment Group.

The Board:

- ***Approved the Premises Assurance Model Assessment Report 2024/25***

P25/09/D5 **Green Plan Refresh 2025 (Enclosure D5)**

The Director of Infrastructure presented the Green Plan Refresh for 2025, noting that the Trust had achieved a 39% reduction in emissions, due to renewable electricity, the phasing out of harmful anaesthetic gases, and reaching zero waste to landfill.

She outlined nine mandated focus areas with specific objectives, concluding that refreshed governance would improve accountability and delivery.

The Chief People Officer highlighted the importance of aligning the Green Plan actions with other initiatives, such as sustainable travel for learners. The Head of Compliance

confirmed that appropriate connections with the University of Sheffield had been made to progress this action.

Non-executive Director, Hazel Brand, asked if there were potential to reduce carbon emissions via shuttle buses and park and ride schemes, and asked if these had been addressed in the Green Plan. The Director of Infrastructure confirmed that expanding car parking at Doncaster was under consideration and could potentially phase out park and ride schemes if sufficient investment was obtained. She confirmed that shuttle buses between Montagu and Bassetlaw had reduced single vehicle journeys and would review the Green Plan to ensure inclusion of these measures.
Non-executive Director, Mark Bailey, asked about the process for tracking missed opportunities or actions that could not be funded, suggesting a ledger of opportunity cost for future reference. The Director of Infrastructure confirmed that once opportunities arose, an action plan was developed to include investment projects and business cases, ensuring readiness for funding opportunities.

The Board:

- ***Approved the Green Plan Refresh 2025***

P25/09/D6 **Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25 (Enclosure D6)**

The Chief Operating Officer presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2024/25, confirming that the report had already been discussed at the Audit and Risk Committee (ARC) and was a requirement under the EPRR core standards.

She confirmed that section one of the paper detailed the minimum elements needed to satisfy those standards and that the report set out progress against the work plan for 2024/25, flagging areas to be taken forward into the 2025/26 work plan.

The Board:

- ***Took Partial assurance from the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25***

P25/09/D7 **Proposed Amendments to the Trust Constitution (Enclosure D7)**

The Associate Director of Strategy, Partnerships and Governance proposed amendments to the Trust Constitution, confirming that the document had been reviewed to ensure alignment with the model constitution.

She stated that the amendments required both Board approval and Council of Governors sign-off, and that she had recently met with the Council of Governors, who had proposed several material changes and one clarification. The Associate Director of Strategy, Partnerships and Governance detailed these changes: the tenure of governors was to remain at nine years and a change in the number of elected public governors to increase to twelve, rather than the eleven in the proposed documents.

She further explained the inclusion of an option for a co-opted governor, allowing individuals with significant skills and experience to remain involved under exceptional circumstances, such as when elections could not be held.

Non-executive Director, Lucy Nickson, asked about the rationale for the proposed reduction in governor tenure from nine to six years and the subsequent decision to retain nine years. The Associate Director of Strategy, Partnerships and Governance confirmed that the initial proposal was influenced by NHS England's guidance on reducing terms for Non-executive Directors, but the Council of Governors decided that this should not apply to governors, especially as the constitution could be reviewed again in the future in light of the evolving national context.

Non-executive Director, Hazel Brand, queried the rationale for increasing the number of Doncaster publicly elected governors. The Associate Director of Strategy, Partnerships and Governance confirmed that the original proposal aimed to reduce the number of governors to reflect the number of vacancies typically carried by the Trust. The Council of Governors felt that the reduction was too great and requested an increase to twelve public governors in total, which would still leave vacancies but ensured an engaged group and members per elected group and that this was in line with benchmarking across other trusts.

The Board:

- ***Approved the revised Constitution and recommended it to the Council of Governors***

P25/09/D8 **Chair's Assurance Log – Finance & Performance Committee (Enclosure D8)**

The Board received the Finance & Performance Committee Chair's assurance logs from August 2025's committee meeting.

Non-executive Director, Mark Bailey, confirmed that the Committee had reviewed month three and took partial assurance as more evidence of sustainable recurrent improvements were required, however progress was being made in this area.

The Board:

- ***Noted and took Significant assurance from the Chair's Assurance Log***

P25/09/D9 **Chair's Assurance Log – Quality Committee (Enclosure D9)**

The Board received the Quality Committee Chair's assurance log which summarised the assurance taken, areas of ongoing work and decisions made by the Committee.

Non-executive Director, Jo Gander, highlighted the recent move of the maternity agenda to the Quality Committee from August 2025.

The Board:

- ***Noted and took Significant assurance from the Chair's Assurance Log***

P25/09/D10 **Quality Committee Terms of Reference (Enclosure D10)**

The Associate Director of Strategy, Partnerships and Governance confirmed that the notable update to the Quality Committee Terms of Reference included revised wording to reflect the inclusion of maternity and neonates.

The Board:

- ***Approved the Quality Committee Terms of Reference***

P25/09/D11 **Chair's Assurance Log – Audit & Risk Committee (Enclosure D11)**

The Board received the assurance log from the Audit & Risk Committee Chair, which provided a summary of reports concerning annual Emergency Preparedness, Resilience and Response, Cyber Security, Risk Management Policy, and audits conducted by internal auditors, 360 Assurance.

The Board:

- ***Noted and took Significant assurance from the Chair's Assurance Log***

P25/09/E1 **2024/25 Infection, Prevention & Control Annual Report (Enclosure E1)**

The Board:

- ***Noted the 2024/25 Infection, Prevention & Control Annual Report***

P25/09/E2 **2024/25 Safeguarding Annual Report (Enclosure E2)**

The Board:

- ***Noted the 2024/25 Safeguarding Annual Report***

P25/09/E3 **2024/25 Patient Experience Annual Report (Enclosure E3)**

The Board:

- ***Noted the 2024/25 Patient Experience Annual Report***

P25/09/E4 **Board of Directors Work Plan (Enclosure E4)**

The Board:

- ***Noted the Board of Directors Work Plan***

C25/09/F1 **Minutes of the meeting held on 1 July 2025 (Enclosure F1)**

The Board:

- ***Approved the minutes of the meetings held on 1 July 2025***

C25/09/F2 **Pre-submitted Governor or public Questions regarding the business of the meeting (verbal)**

No governor or public questions were received.

C25/09/F3 **Any other business (to be agreed with the Chair prior to the meeting)**

The Chair announced that Non-executive Director, Hazel Brand's, term as a Non-Executive Director was sadly coming to an end and that as a result, she would not be present at the next Board meeting. She outlined her service, noting her tenure as Non-Executive Director, former Lead Governor, and various positions within Trust and thanked Hazel for her contribution and service over many years.

The Chair specifically acknowledged Hazel's advocacy for Bassetlaw, describing her as a champion for the site, and expressed confidence that she would continue to support the Trust in other capacities.

The Chief Executive Officer thanked Hazel's professional contributions throughout her many roles and extended best wishes for her future activities.

C25/09/F4 **Date and time of next meeting (verbal):**

Date: 4 November 2025
Time: 10:30am
Venue: Boardroom, Montagu Hospital

C25/09/F5 **Withdrawal of Press and Public (Verbal)**

The Board:

- ***Resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

C25/09/F **Close of meeting (Verbal)**

The meeting closed at 12:55

2511 - G2 PRE-SUBMITTED GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 14:20

10 minutes

2511 - G3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Suzy Brain England OBE, Chair of the Board | 14:30

10 minutes

2511 - G4 DATE AND TIME OF THE NEXT MEETING

Information Item | Suzy Brain England OBE, Chair of the Board | 14:40

Date: Tuesday 6 January 2026
Time: 09:30am
Venue: MS Teams

2511- G5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Suzy Brain England OBE, Chair of the Board | 14:40

Board to resolve: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.