Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC

BOARD MEETING - PUBLIC

5 May 2026

10:15 GMT+1 Europe/London

Boardroom, Doncaster Royal Infirmary, Armthorpe Road, Doncaster DN2 5LT

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2605 - A OPENING ITEMS

REFERENCES

Only PDFs are attached

00 - Board of Directors Public Agenda - 5 May 2026 v7.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 5 May 2026 at 10:15am
Boardroom, Doncaster Royal Infirmary

		Purpose	Page	Time
A	**OPENING ITEMS**			**10:15**
A1	Welcome, apologies for absence and declarations of interest *Mark Bailey, Interim Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known*			5
A2	Action from Previous Meeting *Mark Bailey, Interim Chair*	*Review*		5
B	**PATIENTS**			**10:25**
B2	Patient Story *Karen Jessop, Chief Nurse*	*Note*		10
C	**PEOPLE**			**10:35**
C1	2025 National Staff Survey Results *Zoe Lintin, Chief People Officer* *Daniel Ratchford, Senior Director and General Manager – IQVIA*	*Assurance*		25
C2	DBTH Way in Action & Well-led Review Progress Report *Zoe Lintin, Chief People Officer* *Rebecca Allen, Associate Director of Strategy, Partnerships & Governance*	*Assurance*		10
D	**STRATEGY & PERFORMANCE**			**11:10**
D1	Chair's Report including Partnership Update *Mark Bailey, Interim Chair*	*Information*		10
D2	Chief Executive's Report including Partnership Update *Zara Jones, Acting Chief Executive*	*Information*		10

D3	Integrated Quality & Performance Report *(including finance report)* *Executive Directors*	*Assurance*		20
	- Mortality Review Update *Nick Mallaband, Acting Executive Medical Director*	*Assurance*		10
	- Health Inequalities Bi-annual Report *Zara Jones, Acting Chief Executive* *Dr Kelly MacKenzie, Consultant in Public Health*	*Note*		10
D4	Delivery of 2025/26 Strategic Success Measures *Executive Directors*	*Assurance*		10
D5	Medium Term Plan *Zara Jones, Acting Chief Executive* *Sam Wilde, Chief Finance Officer*	*Note*		10
LUNCH 12:30 – 13:00:				
E	**STATUTORY & REGULATORY**			**13:00**
E1	Maternity & Neonatal Safety Report *Karen Jessop, Chief Nurse* *Lois Mellor, Director of Midwifery*	*Assurance*		10
E2	Provider Licence Compliance & Self-certification *Rebecca Allen, Associate Director of Strategy, Partnerships & Governance*	*Approve*		5
E3	Unannounced Care Quality Commission Inspection of Children & Young People (verbal) *Karen Jessop, Chief Nurse*	*Note*		5
F	**POUNDS**			**13:20**
F1	2025/26 Going Concern Assumption & Delegation of Authority to Approve the Annual Report and Accounts *Sam Wilde, Chief Finance Officer*	*Approve*		10
G	**ASSURANCE**			**13:30**
G1	Doncaster & Bassetlaw Healthcare Services Update *Sam Wilde, Chief Finance Officer*	*Assurance*		5
G2	Chair's Assurance Log - Finance & Performance Committee *Stephen Radford, Non-executive Director*	*Assurance*		5
G3	Chair's Assurance Log - Quality Committee *Jo Gander, Non-executive Director*	*Assurance*		5
G4	Chair's Assurance Log - People Committee *Lucy Nickson, Non-executive Director*	*Assurance*		5

G5	Chair's Assurance Log - Audit & Risk Committee *Kath Smart, Non-executive Director*	*Assurance*		5
H	**INTEGRATED ASSURANCE**			**13:55**
H1	Board Assurance Framework Compliance & Trust Risk Register *Rebecca Allen, Associate Director of Strategy, Partnerships & Governance* *Executive Directors*	*Approve*		10
H2	Triangulation of Information to Identify Agenda Item Themes *Mark Bailey, Interim Chair*	*Discuss*		10
H3	Board Effectiveness and Demonstrating the DBTH Way • Was sufficient time allocated to enable focused discussion for items? • Did papers contain the appropriate level of detail? • Was open and productive debate achieved? • What could we do less of – more of going forward? • Were discussions courteous and in line with the DBTH Way? *Mark Bailey, Interim Chair*	Discuss		5
I	**CLOSING ITEMS**			**14:20**
I1	Minutes of the meeting held on 24 March 2026 *Mark Bailey, Interim Chair*	*Approve*		5
I2	Pre-submitted questions *Mark Bailey, Interim Chair*	*Discussion*		10
I3	Any other business (to be agreed with the Chair prior to the meeting) *Mark Bailey, Interim Chair*	*Discussion*		10
I4	Board of Directors Work Plan *Rebecca Allen, Associate Director of Strategy, Partnership & Governance*	*Information*		
I5	**Date and time of next meeting:** **Date:** Tuesday 7 July 2026 **Time:** 9:30am **Venue:** Boardroom, Bassetlaw Hospital	*Information*		
I6	**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. *Mark Bailey, Interim Chair*	*Note*		
J	**MEETING CLOSE**			**14:45**

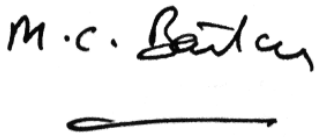
Governor Questions

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

***** For Governors in attendance, the agenda provides the opportunity for 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 theday.
- 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.



Mark Bailey
Interim Chair

2605- A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Standing item | Mark Bailey, Interim Chair | 10:15

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 (27.04.2026).pdf

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

Register of Interests

Mark Bailey, Interim Chair
Non-Executive Chair, Doncaster and Bassetlaw Healthcare Services Ltd
Non-Executive Director – Derbyshire Community Health Services Foundation Trust
Executive Coach – NHS Leadership Academy (voluntary)
Visiting Fellow – Cranfield University

Kath Smart, Non-Executive Director
Non-Executive Director & Audit Chair - Humber NHS Foundation Trust
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

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

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

Zoe Lintin, Chief People Officer
Trustee on the Board of the Students' Union of the University of Sheffield

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)

(as at 27 April 2026)

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:

Helen Best	Non-Executive Director
Zara Jones	Acting Chief Executive

(as at 27 April 2026)

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 27 April 2026)

2605 - A2 ACTIONS FROM PREVIOUS MEETING

Standing item | Mark Bailey, Interim Chair | 10:20

5 minutes

REFERENCES

Only PDFs are attached

A2 - BoD Action Log - 24 March 2026.pdf

Action notes prepared by: Angela O'Mara
Updated: 24 March 2026

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Action Log

Meeting	Public Board of Directors
Date of latest meeting:	24 March 2026

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

No.	Minute No.	Action	Responsibility	Target Date	Update
1.	**P26/01/D5**	**Action Plan - DBTH in Action** To consider the findings of the health and safety culture review alongside those of the wider DBTH in Action review when agreeing an action plan.	**ZJ**	**May 2026**	**Update 27/4/2026 -** the Health and Safety report is a source of information for the wider Culture & Leadership programme. Relevant themes include speaking up, leadership visibility, safety behaviours, local ownership and closing the loop on concerns are noted and will be cross-checked in the work outlined in other Board papers on the May agenda. Technical compliance and specialist health and safety risks will continue to be overseen through Health and Safety Committee, F&P and relevant specialist groups.
2.	**P26/03/C1** **P26/03/D2**	**Mortality Review Update** To provide an update to the Board to address discussion points relating to the Trust's SHMI, required improvement trajectory and reporting to provide assurance to the Quality Committee and Board on the learning from deaths.	**NM**	**May 2026**	**Update -** included on the agenda at D3

Action notes prepared by: Angela O'Mara
Updated: 24 March 2026

No.	Minute No.	Action	Responsibility	Target Date	Update
3.	P26/03/D2	**Mental Capacity Assessments** To report on the learning identified in Q2 2025/26 Learning from Deaths Report related to the completion of timely assessments and best interest documentation.	**KJ**	**Quality Committee**	**Action transferred to the Quality Committee** – Mental Capacity Act compliance included as a quality priority for 2026/27, approved by the Quality Committee on 23 April 2026. Quarterly progress reports to be received by the Quality Committee.
4.	**P26/03/D2**	**Sepsis Management** To undertake a deep dive into sepsis management, reflecting on the learning identified in Q2 2025/26 Learning from Deaths Report and performance reported via the IQPR in respect of antibiotic administration on positive sepsis screening.	**NM**	**Quality Committee**	**Action transferred to the Quality Committee** – report to be received by the Quality Committee on 4 June 2026.
5.	**P26/03/D3**	**Speaking Up Reports** To provide a discussion paper to enable the People Committee to determine the focus and requirements of future Speaking Up reports at both People Committee and Board.	**ZL**	**July 2026**	**Update** - Included on the People Committee action log, discussion paper to be included on June's agenda for subsequent confirmation with the Board in July 2026.
6.	**P26/03/D4**	**Guardian of Safe Working** To discuss with the Acting EMD the opportunity to consider right sizing of trainee posts at the Trust where there have been persistent gaps/vacancies	**ZL**	**May 2026**	**Update**: ZL discussed with NM including the funding income associated with hosting trainee posts and the Trust's role as a teaching hospital. It was concluded that it was unlikely there would be appropriate opportunities to right size or remove trainee posts in areas which experienced persistent gaps. However, there are opportunities to consider other routes to recruiting to any such gaps on a fixed term basis, such as increasing the use of locally employed doctors, with existing governance in place through the divisional structures where these issues could be explored. **Propose action is closed**

2605 - B PATIENTS

10:25

2605 - B1 PATIENT STORY

Information Item | Karen Jessop, Chief Nurse | 10:25

10 minutes

video clip & verbal

2605 - C PEOPLE

2605 - C1 2025 NATIONAL STAFF SURVEY RESULTS

Discussion Item | Zoe Lintin, Chief People Officer | 10:35

Daniel Ratchford, Senior Director and General Manager

25 minutes

REFERENCES

Only PDFs are attached

- C1 - 2025 National Staff Survey Results.pdf
- C1 - 2025 Staff Survey Results Presentation.pdf

Report Template			
Meeting Title:	**Board of Directors**	**Meeting Date:**	5 May 2026
Report Title/ Ref:	**2025 National Staff Survey Results**		
Sponsor:	Zoe Lintin, Chief People Officer		
Authors:	Zoe Lintin, Chief People Officer		
Appendices:	Appendix 1 - Summary of survey themes and questions		
Purpose of the report	This paper provides an overview of the 2025 staff survey results, together with assurance that the feedback is being considered within the emerging Culture & Leadership programme and steps are being taken to engage with teams to develop local improvement plans. The paper will be accompanied by a presentation at the Board by Daniel Ratchford, Senior Director & General Manager at IQVIA.		
Required action	Assurance		
Impacts on Strategic Risks (BAF 1-7)	BAF2		

Executive Summary – Key messages and Issues

Introduction

The 2025 staff survey results were published nationally on 12 March 2026 and our DBTH results were communicated through the usual channels on and after this date. The link to the full results is here: https://extranet.dbth.nhs.uk/staffsurvey/staff-survey-2025-26/, and the Hive also contains summary information and our resources to support managers with local engagement.

3879 colleagues completed the survey equating to a response rate of 54%, against a sector average response rate of 47%. This is a decline from a 62% response rate the previous year, with a decline in sector average response rate from 49%.

Overview of results

Appendix 1 shows the Trust's position against the People Promise themes and the national performance for comparator trusts, together with a summary of the year-on-year changes between 2024 and 2025 showing whether questions have improved, declined or stayed the same.

The Trust has performed better than the sector in six of the seven People Promise themes and in line with national average on the seventh ('We are a team'). Of the two additional themes measured nationally, the Staff Engagement score is lower than average and the Morale score is higher. 7% of questions have shown significant improvements since 2024, 17% have shown significant decline and 76% have shown no significant movements. Of the People Promise and additional themes, 'We each have a voice that counts' is significantly lower in 2025 than 2024, 'We work flexibly' is significantly higher in 2025 than 2024 and the remaining themes show no significant difference year on year.

As previously noted at People Committee and in Board discussions, there was an expectation that our 2025 staff survey results would decline given the challenging local and national context including the wider employee relations climate, operational and financial challenges and some specific local matters.

In summary, the question areas which have seen improvement include flexible working, learning and development, feeling safe and healthy at work as well as many of the immediate manager questions. The

significant improvement in the 'We work flexibly' theme demonstrates evidence of the impact of the targeted cultural workstream in this area since the introduction of the current People Plan.

The question areas which have declined include raising concerns and confidence in speaking up, engagement, involvement in decision-making and some of the team-working questions. The decline in confidence in speaking up, whilst not welcomed, has not been a surprise in the context and triangulates with comments made by some colleagues in the DBTH Way in Action review. The themes and feedback from the external Freedom to Speak Up peer review were also discussed in detail at the People Committee in April and Board in May 2026, enabling further triangulation and identification of further actions.

Next steps and responding to feedback

The staff survey results, both the data and qualitative narrative comments, form an important 'input' into the new Culture and Leadership programme. They provide rich and comprehensive feedback on how our colleagues experience working at DBTH, and as such, will also be used as part of a suite of success measures for assessing the impact of the programme over time. The staff survey findings are being considered alongside the independent Well-led review, DBTH Way in Action culture review and Freedom to Speak Up feedback to provide a triangulated evidence base for the Trust's Culture & Leadership programme.

The staff survey results at a local team level are considered alongside other people and quality metrics by the established data triangulation group, which includes representatives from the People & OD, Patient Safety and Freedom to Speak Up teams. The staff survey results and participation rates are also analysed though other means, such as professional group and protected characteristics.

The Culture and Leadership programme forms part of the Trust's wider Reset programme, with a separate paper being presented at the May Board in the context of the medium-term plan. In addition to the Reset programme governance, the People Committee will receive progress and exception reports on the Culture and Leadership programme through the Engagement and Leadership papers presented at each Committee meeting. The key focus areas within the Culture and Leadership programme include:

Priority Theme	Key Actions 2026/27	Lead Oversight	Evidence and Outcomes
Speaking up	Deliver FTSU improvement actions and strengthen feedback loops to colleagues	People Committee	FTSU metrics and feedback, next survey results
Colleague voice	Team engagement sessions and local action plans across divisions/directorates	PRMs / People Committee	Completion of plans, engagement feedback
Team working and behaviours	Targeted support for teams with lower results, alongside "Line in the Sand" behavioural standards roll-out	Divisions / People Committee	Local survey data, turnover, sickness trends, casework
Leadership visibility	Increased senior leader engagement and listening activity across sites	Executive Team	Engagement activity and colleague feedback
Wellbeing & morale	Continue wellbeing support and flexible working improvements	People Committee	Absence, retention, morale indicators, next survey results

Overall cultural development	Deliver Culture & Leadership programme informed by survey and reviews	Board / People Committee	Programme milestones and trend data, next survey results

As in previous recent years, our approach to a year-round cycle of engagement at DBTH sets clear expectations for leaders about how they engage with their teams to discuss the staff survey results in engagement sessions and co-create action improvement plans. There are supporting resources available as well as guidance and input from the People & OD team, which is targeted where there are areas of most need. In addition to the Chief People Officer oversight of the development of these plans and completion of engagement sessions, there is also wider Executive team oversight including through the Performance Review Meetings for divisions and directorates.

The People Committee discussed at length the report on the staff survey results at the April meeting and took significant assurance that appropriate systems and mechanisms were in place to listen and respond to the feedback, including correlation with other workstreams and metrics. A detailed presentation of the results will be delivered at the Board meeting by IQVIA, the external survey provider. An overview of the results was also presented at the monthly IQIG meeting with NHS England in March 2026.

The Board can be assured that the Trust accepts the staff survey results, the feedback is taken seriously and is triangulated with other sources of evidence to inform future strategic plans notably in relation to the Culture and Leadership programme. In addition, there is governance and support in place to provide oversight of divisional and directorate action improvement planning.

At this stage, the Board is being asked to take assurance on the robustness of the data, the appropriateness of the response and the strength of governance arrangements. Assurance on impact and improvement in colleague experience outcomes is not yet available and will be demonstrated over time through interim indicators, people metrics data and future pulse checks and staff survey results.

Recommendations

The Board of Directors is asked to:

- Discuss the report and staff survey results, alongside the detailed presentation by IQVIA
- Take assurance regarding the staff survey response actions and governance including the correlation with the Culture and Leadership programme and triangulation with other workstreams, feedback and metrics. The People Committee reported significant assurance on the staff survey response actions, overall approach, governance and triangulation with other evidence at their meeting on 21 April 2026.
- The assurance on delivery of actions and impact on outcomes will need to be assessed later in 2026/27, through interim measures and future survey results, given the complexity of cultural improvement work being embedded over a period of time.

Healthier together – delivering exceptional care for all	
Patients	A positive, engaged and supported workforce contributes to the delivery of good patient care.
People	Actions are taken to respond to the staff survey results to continue to improve colleague experience.
Partnership	Some programmes of work involve working with system partners.
Pounds	Improved wellbeing and morale positively impact on attendance at work and retention therefore reducing costs for bank/agency.
Health Inequalities	Actions identified to improve team and colleague wellbeing, which may link to health inequalities.
Legal/regulation	-

<table>
<tr><td>Partner ICB strategies</td><td>Staff survey learning has previously been shared across partner organisations through events.</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>Results communicated widely
People Committee – 21 April 2026</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Presentation at Board in May 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></td><td></td><td>People</td><td></td></tr>
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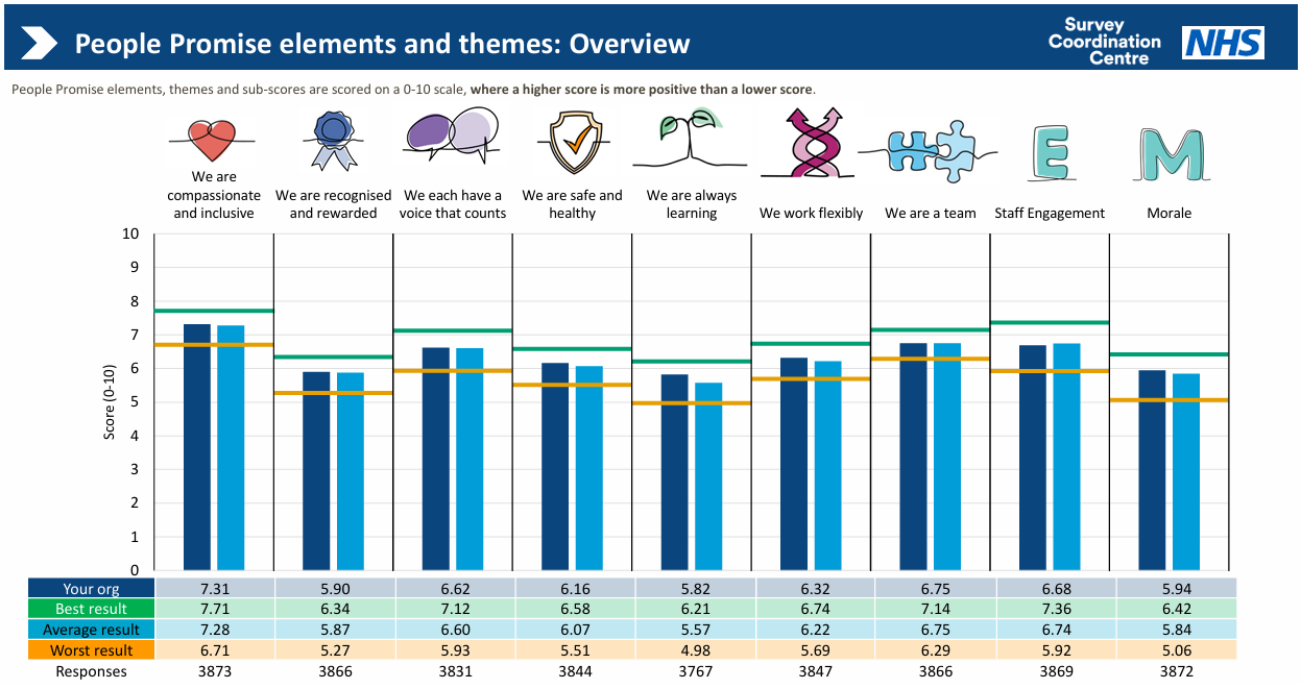
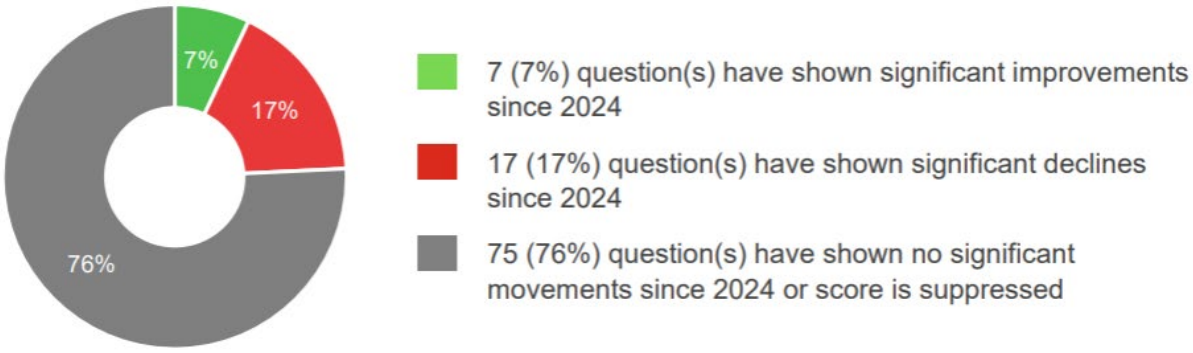
Appendix 1

People Promise themes and sector comparison



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.31	5.90	6.62	6.16	5.82	6.32	6.75	6.68	5.94
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3873	3866	3831	3844	3767	3847	3866	3869	3872

Comparison between 2024 and 2025 DBTH results



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

2025 National NHS Staff Survey Results

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Why is staff engagement important?

The NHS 10 Year Health Plan (10YHP) emphasises that **reform must be driven by frontline staff,** with the NHS Staff Survey helping assess how effectively organisations are enabling this.

The NHS 10YHP positions **staff engagement as central to workforce sustainability and retention,** emphasising the need to improve the lived experience of people working in the NHS.

High workforce turnover undermines the NHS 10YHP by **reducing capacity, losing organisational knowledge,** and **diverting resources away from transformation into recruitment and training costs.**

Evidence consistently shows that engaged staff deliver **better patient experience, safety and outcomes,** all of which are critical to achieving the ambitions of the NHS 10YHP.

The NHS 10YHP depends on a healthy workforce, with **staff wellbeing** and **burnout** closely linked to **engagement, retention and the ability to sustain long-term reform.**

Methodology

Main survey

- Survey run on paper and online between September and November 2025
- Two reminders sent to staff who didn't respond to paper survey, six reminders for online
- Sample designed to ensure good statistical comparability between organisations and over time
- The comparator group is made up of 71 Acute and Acute & Community Trusts contracted to IQVIA.

Bank survey

- Survey run online only between September and November 2025
- Two SMS reminders and up to six email reminders sent to staff who didn't respond
- Full census of eligible staff were invited to take part, staff must have worked in the six months between 1st March 2025 and 1st September 2025 and not have a substantive or fixed term contract
- No sector comparison.

Until the Coordination Centre publishes the national results, there is an embargo on the publication of any survey results found in this presentation.

National results are to be published on 12th March 2026 by the Coordination Centre.

Response Rate

	Usable Sample	Completed				Response Rate
		Paper	Online	Telephone	Total	
2025 Org.	7,227	236	3,643	0	3,879	53.67%
2025 IQVIA	941,326	22,954	434,056	8	457,018	48.55%
2024 Org.	7,367	59	4,511	0	4,570	62.03%
2024 IQVIA	962,001	30,868	458,721	12	489,601	50.89%

- Impacts on response rate:
  - Accuracy of staff records, and internal distribution
  - Communication
  - Pro-active management of survey process
  - Communication of results
  - Response and action from senior management.

Summary of Key Themes

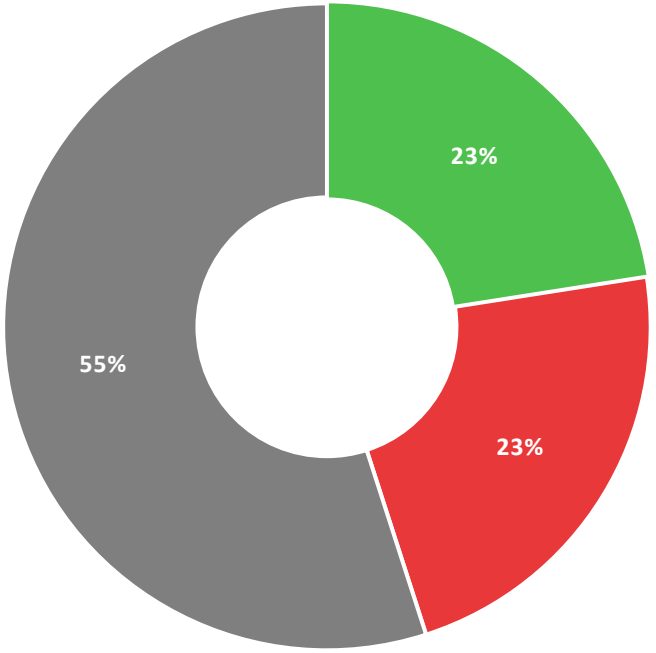
- The overall Staff Engagement score for the organisation is **6.68** and the score for Morale is **5.94**
- Successes to Celebrate
  - *Scores on the theme of '**We are Safe and Healthy**' are better than the sector*
  - *People scores, on **learning** and **appraisals**, are better than the sector*
  - ***Flexible working** scores have improved, and are better than the sector*

- Areas of Focus for 2026
  - *Scores around **burnout**, **frustration**, and **strained work relationships** have all declined*
  - *Fewer staff feel **safe raising concerns***
  - *Scores around a **compassionate culture** have declined, and are worse than the sector*

Summary of Scores

People Promise/Theme	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Staff engagement	6.74	Not Significant	6.68	Significantly Worse	6.75
Theme - Morale	5.95	Not Significant	5.94	Significantly Better	5.88
People Promise 1 - We are compassionate and inclusive	7.35	Not Significant	7.31	Not Significant	7.28
People Promise 2 - We are recognised and rewarded	5.87	Not Significant	5.90	Not Significant	5.88
People Promise 3 - We each have a voice that counts	6.70	Significantly Declined	6.61	Not Significant	6.62
People Promise 4 - We are safe and healthy	6.18	Not Significant	6.16	Significantly Better	6.09
People Promise 5 - We are always learning	5.84	Not Significant	5.82	Significantly Better	5.64
People Promise 6 - We work flexibly	6.20	Significantly Improved	6.31	Significantly Better	6.23
People Promise 7 - We are a team	6.71	Not Significant	6.74	Not Significant	6.75

Headline Findings – Question Benchmarking

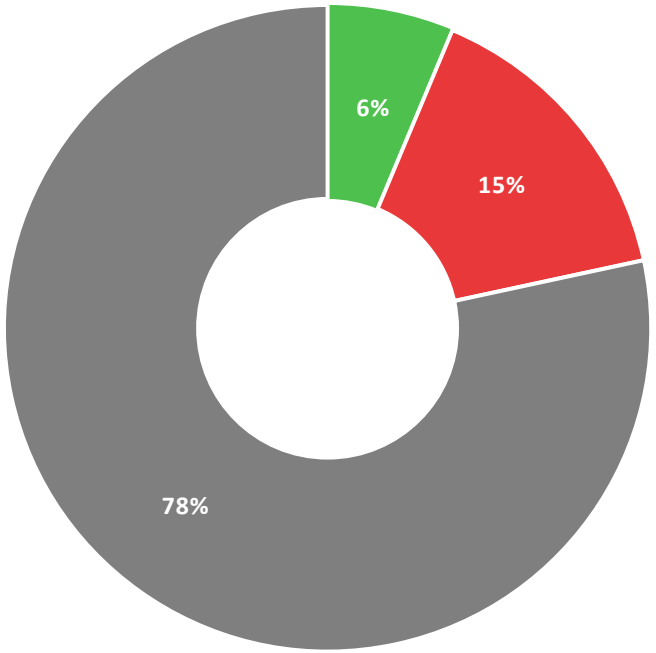


25 (23%) question(s) scored significantly better than the sector

25 (23%) question(s) scored significantly worse than the sector

61 (55%) question(s) showed no significance in relation to the sector average or comparisons could not be drawn

Headline Findings – Question Local Changes



7 (6%) question(s) scored significantly better than in 2024

17 (15%) question(s) scored significantly worse than in 2024

87 (78%) question(s) showed no significance in relation to the 2024 score or comparisons could not be drawn

Staff Engagement & Morale

Staff Engagement

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Staff engagement	6.74	Not Significant	6.68	**Significantly Worse**	6.75
Sub-score 1 - Motivation	6.92	Not Significant	6.87	Not Significant	6.86
2a. I look forward to going to work.	53.5%	Not Significant	51.3%	Not Significant	51.7%
2b. I am enthusiastic about my job.	69.0%	Not Significant	67.9%	**Significantly Better**	65.4%
2c. Time passes quickly when I am working.	67.1%	Not Significant	67.7%	Not Significant	69.1%
Sub-score 2 - Involvement	6.71	Not Significant	6.74	Not Significant	6.76
3c. There are frequent opportunities for me to show initiative in my role.	70.8%	Not Significant	72.0%	Not Significant	72.2%
3d. I am able to make suggestions to improve the work of my team / department.	68.5%	Not Significant	68.0%	**Significantly Worse**	69.8%
3f. I am able to make improvements happen in my area of work.	52.0%	Not Significant	52.2%	**Significantly Worse**	54.7%

Staff Engagement (continued)

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
Sub-score 3 - Advocacy		6.61	Significantly Declined	6.46	Significantly Worse	6.61
25a.	Care of patients / service users is my organisation's top priority.	72.9%	Significantly Declined	70.0%	Significantly Worse	71.5%
25c.	I would recommend my organisation as a place to work.	58.0%	Significantly Declined	55.6%	Significantly Worse	57.8%
25d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	59.1%	Significantly Declined	56.4%	Significantly Worse	62.2%

Morale

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Morale	5.95	Not Significant	5.94	**Significantly Better**	5.88
Sub-score 1 - Thinking about leaving	6.18	Not Significant	6.17	**Significantly Better**	6.02
26a. I often think about leaving this organisation.	29.1%	Not Significant	29.9%	Not Significant	29.0%
26b. I will probably look for a job at a new organisation in the next 12 months.	19.7%	Not Significant	20.0%	Not Significant	20.9%
26c. As soon as I can find another job, I will leave this organisation.	14.5%	Not Significant	14.7%	**Significantly Better**	16.7%
Sub-score 2 - Work pressure	5.29	Not Significant	5.29	Not Significant	5.25
3g. I am able to meet all the conflicting demands on my time at work.	47.8%	Not Significant	46.8%	Not Significant	46.6%
3h. I have adequate materials, supplies and equipment to do my work.	52.7%	Not Significant	54.5%	Not Significant	54.1%
3i. There are enough staff at this organisation for me to do my job properly.	32.9%	Not Significant	33.1%	Not Significant	31.8%

Morale (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Sub-score 3 - Stressors	6.37	Not Significant	6.37	Not Significant	6.36
3a. I always know what my work responsibilities are.	86.4%	Not Significant	86.8%	Not Significant	86.5%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	47.9%	Not Significant	47.4%	**Significantly Worse**	49.2%
5a. I have unrealistic time pressures.	28.4%	Not Significant	27.7%	**Significantly Better**	25.5%
5b. I have a choice in deciding how to do my work.	50.5%	Not Significant	51.8%	Not Significant	51.4%
5c. Relationships at work are strained.	46.0%	**Significantly Declined**	43.2%	**Significantly Worse**	45.3%
7c. I receive the respect I deserve from my colleagues at work.	67.8%	Not Significant	67.5%	**Significantly Worse**	70.9%
9a. My immediate manager encourages me at work.	71.0%	Not Significant	72.5%	Not Significant	71.7%

People Promises

We are compassionate and inclusive

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1 - We are compassionate and inclusive		7.35	Not Significant	7.31	Not Significant	7.28
People Promise 1, Sub-score 1 - Compassionate culture		6.98	**Significantly Declined**	6.85	**Significantly Worse**	6.97
6a.	I feel that my role makes a difference to patients / service users.	88.1%	Not Significant	88.2%	Not Significant	88.0%
25a.	Care of patients / service users is my organisation's top priority.	72.9%	**Significantly Declined**	70.0%	**Significantly Worse**	71.5%
25b.	My organisation acts on concerns raised by patients / service users.	68.9%	**Significantly Declined**	66.5%	**Significantly Worse**	68.2%
25c.	I would recommend my organisation as a place to work.	58.0%	**Significantly Declined**	55.6%	**Significantly Worse**	57.8%
25d.	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	59.1%	**Significantly Declined**	56.4%	**Significantly Worse**	62.2%

We are compassionate and inclusive (continued)

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1, Sub-score 2 - Compassionate leadership		7.01	Not Significant	7.07	Not Significant	6.99
9f.	My immediate manager works together with me to come to an understanding of problems.	68.0%	**Significantly Improved**	70.0%	Not Significant	68.8%
9g.	My immediate manager is interested in listening to me when I describe challenges I face.	70.7%	Not Significant	71.5%	Not Significant	71.3%
9h.	My immediate manager cares about my concerns.	69.1%	Not Significant	70.0%	Not Significant	69.9%
9i.	My immediate manager takes effective action to help me with any problems I face.	66.8%	Not Significant	67.7%	Not Significant	66.8%
People Promise 1, Sub-score 3 - Diversity and equality		8.61	Not Significant	8.56	**Significantly Better**	8.35
16a.	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	6.3%	Not Significant	6.2%	**Significantly Better**	9.4%
16b.	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	6.8%	Not Significant	6.9%	**Significantly Better**	9.1%
21.	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	72.4%	**Significantly Declined**	69.2%	Not Significant	69.0%

We are compassionate and inclusive (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1, Sub-score 4 - Inclusion	6.80	Not Significant	6.77	Not Significant	6.81
7h. I feel valued by my team.	67.6%	Not Significant	67.6%	Not Significant	69.0%
7i. I feel a strong personal attachment to my team.	62.2%	Not Significant	62.8%	Not Significant	62.6%
8b. The people I work with are understanding and kind to one another.	67.1%	Not Significant	66.3%	**Significantly Worse**	69.0%
8c. The people I work with are polite and treat each other with respect.	68.3%	Not Significant	66.6%	**Significantly Worse**	70.1%

Additional – Discrimination

	Question	2024 Score	Significance	2025 Score	Significance	Sector Score
15.	Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?	-	N/A	58.2%	Significantly Better	53.1%
16c01.	On what grounds have you experienced discrimination? Age	-	N/A	25.1%	Significantly Worse	17.0%
16c02.	On what grounds have you experienced discrimination? Disability	-	N/A	15.2%	Significantly Worse	9.9%
16c03.	On what grounds have you experienced discrimination? Gender reassignment	-	N/A	1.3%	Not Significant	1.6%
16c04.	On what grounds have you experienced discrimination? Marriage and civil partnership	-	N/A	0.8%	Not Significant	1.3%
16c05.	On what grounds have you experienced discrimination? Pregnancy and maternity	-	N/A	1.5%	Significantly Better	2.8%
16c06.	On what grounds have you experienced discrimination? Race	-	N/A	43.9%	Significantly Better	55.2%
16c07.	On what grounds have you experienced discrimination? Religion or belief	-	N/A	9.2%	Not Significant	8.8%
16c08.	On what grounds have you experienced discrimination? Sex	-	N/A	14.3%	Not Significant	15.6%
16c09.	On what grounds have you experienced discrimination? Sexual orientation	-	N/A	4.6%	Not Significant	3.3%
16c10.	On what grounds have you experienced discrimination? Other	-	N/A	20.6%	Not Significant	21.2%

Additional – Unwanted sexual behaviour

	Question	2024 Score	Significance	2025 Score	Significance	Sector Score
17a.	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public?	8.6%	Not Significant	8.7%	Not Significant	8.0%
17b.	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues?	2.8%	Not Significant	2.8%	**Significantly Better**	3.5%

Additional – Adjustments

Question		2024 Score	Significance	2025 Score	Significance	Sector Score
31b.	Has your employer made reasonable adjustment(s) to enable you to carry out your work?	71.9%	Not Significant	73.3%	Not Significant	73.9%

We are recognised and rewarded

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 2 - We are recognised and rewarded	5.87	Not Significant	5.90	Not Significant	5.88
4a. The recognition I get for good work.	52.3%	Not Significant	52.9%	Not Significant	52.1%
4b. The extent to which my organisation values my work.	41.9%	Not Significant	42.6%	Not Significant	42.2%
4c. My level of pay.	29.7%	**Significantly Improved**	32.0%	Not Significant	31.0%
8d. The people I work with show appreciation to one another.	64.9%	Not Significant	63.5%	**Significantly Worse**	66.0%
9e. My immediate manager values my work.	69.8%	Not Significant	71.7%	Not Significant	71.7%

We each have a voice that counts

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 3 - We each have a voice that counts	6.70	**Significantly Declined**	6.61	Not Significant	6.62
People Promise 3, Sub-score 1 - Autonomy and control	6.87	Not Significant	6.90	Not Significant	6.91
3a. I always know what my work responsibilities are.	86.4%	Not Significant	86.8%	Not Significant	86.5%
3b. I am trusted to do my job.	89.5%	Not Significant	88.4%	**Significantly Worse**	89.8%
3c. There are frequent opportunities for me to show initiative in my role.	70.8%	Not Significant	72.0%	Not Significant	72.2%
3d. I am able to make suggestions to improve the work of my team / department.	68.5%	Not Significant	68.0%	**Significantly Worse**	69.8%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	47.9%	Not Significant	47.4%	**Significantly Worse**	49.2%
3f. I am able to make improvements happen in my area of work.	52.0%	Not Significant	52.2%	**Significantly Worse**	54.7%
5b. I have a choice in deciding how to do my work.	50.5%	Not Significant	51.8%	Not Significant	51.4%

We each have a voice that counts (continued)

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 3, Sub-score 2 - Raising concerns		6.53	**Significantly Declined**	6.33	Not Significant	6.33
20a.	I would feel secure raising concerns about unsafe clinical practice.	72.0%	**Significantly Declined**	69.5%	Not Significant	70.1%
20b.	I am confident that my organisation would address my concern.	57.6%	**Significantly Declined**	54.2%	Not Significant	54.7%
25e.	I feel safe to speak up about anything that concerns me in this organisation.	62.5%	**Significantly Declined**	59.3%	Not Significant	59.1%
25f.	If I spoke up about something that concerned me I am confident my organisation would address my concern.	50.4%	**Significantly Declined**	46.5%	Not Significant	46.6%

Additional – Errors, near misses or incidents

	Question	2024 Score	Significance	2025 Score	Significance	Sector Score
18.	In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	32.0%	Not Significant	31.9%	Significantly Better	35.3%
19a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	59.0%	Not Significant	57.3%	Significantly Worse	59.9%
19b.	My organisation encourages us to report errors, near misses or incidents.	85.6%	Significantly Declined	83.8%	Significantly Worse	85.2%
19c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	67.1%	Significantly Declined	64.4%	Significantly Worse	67.3%
19d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	58.4%	Not Significant	57.2%	Significantly Worse	61.0%

We are safe and healthy

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4 - We are safe and healthy		6.18	Not Significant	6.16	**Significantly Better**	6.09
People Promise 4, Sub-score 1 - Health and safety climate		5.53	Not Significant	5.52	**Significantly Better**	5.42
3g.	I am able to meet all the conflicting demands on my time at work.	47.8%	Not Significant	46.8%	Not Significant	46.6%
3h.	I have adequate materials, supplies and equipment to do my work.	52.7%	Not Significant	54.5%	Not Significant	54.1%
3i.	There are enough staff at this organisation for me to do my job properly.	32.9%	Not Significant	33.1%	Not Significant	31.8%
5a.	I have unrealistic time pressures.	28.4%	Not Significant	27.7%	**Significantly Better**	25.5%
11a.	My organisation takes positive action on health and well-being.	58.2%	Not Significant	57.8%	**Significantly Better**	54.5%
13d.	The last time you experienced physical violence at work, did you or a colleague report it?	71.2%	Not Significant	72.5%	Not Significant	70.7%
14d.	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	51.3%	Not Significant	52.9%	Not Significant	52.6%

We are safe and healthy (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4, Sub-score 2 - Burnout	5.06	Not Significant	5.03	**Significantly Better**	4.95
12a. How often, if at all, do you find your work emotionally exhausting?	32.1%	Not Significant	33.2%	Not Significant	34.5%
12b. How often, if at all, do you feel burnt out because of your work?	29.2%	**Significantly Declined**	31.2%	Not Significant	32.0%
12c. How often, if at all, does your work frustrate you?	34.9%	**Significantly Declined**	37.0%	Not Significant	36.8%
12d. How often, if at all, are you exhausted at the thought of another day/shift at work?	28.1%	Not Significant	30.0%	Not Significant	29.1%
12e. How often, if at all, do you feel worn out at the end of your working day/shift?	40.3%	Not Significant	41.2%	**Significantly Better**	43.1%
12f. How often, if at all, do you feel that every working hour is tiring for you?	18.4%	Not Significant	19.2%	**Significantly Better**	20.9%
12g. How often, if at all, do you not have enough energy for family and friends during leisure time?	27.9%	Not Significant	27.9%	**Significantly Better**	30.3%

We are safe and healthy (continued)

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4, Sub-score 3 - Negative experiences		7.94	Not Significant	7.94	Not Significant	7.90
11c.	During the last 12 months have you felt unwell as a result of work related stress?	40.3%	Not Significant	41.9%	Not Significant	42.9%
11d.	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	58.3%	Not Significant	57.4%	Not Significant	56.1%
13a.	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	17.1%	**Significantly Improved**	15.4%	**Significantly Worse**	14.0%
13b.	In the last 12 months how many times have you personally experienced physical violence at work from managers?	0.5%	Not Significant	0.4%	**Significantly Better**	0.8%
13c.	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	1.5%	Not Significant	1.2%	**Significantly Better**	2.0%
14a.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	23.5%	Not Significant	23.0%	**Significantly Better**	24.9%
14b.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	6.9%	**Significantly Declined**	8.3%	**Significantly Better**	9.2%
14c.	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	16.0%	Not Significant	16.9%	Not Significant	17.8%

Additional – Health, well-being and safety at work

Question		2024 Score	Significance	2025 Score	Significance	Sector Score
10b.	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	36.3%	Not Significant	34.4%	Not Significant	33.4%
10c.	On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	44.8%	Not Significant	45.1%	**Significantly Better**	48.7%
11e.	Have you felt pressure from your manager to come to work?	21.4%	Not Significant	21.2%	Not Significant	20.6%
11b.	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Examples may include back pain, neck or arm strains, and joint pain.	-	N/A	42.1%	Not Significant	41.4%

Additional – Food

Question	2024 Score	Significance	2025 Score	Significance	Sector Score
22. I can eat nutritious and affordable food while I am working.	46.8%	Significantly Improved	49.3%	Significantly Worse	52.9%

We are always learning

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 5 - We are always learning	5.84	Not Significant	5.82	**Significantly Better**	5.64
People Promise 5, Sub-score 1 - Development	6.53	**Significantly Declined**	6.43	**Significantly Better**	6.31
24a. This organisation offers me challenging work.	66.3%	Not Significant	67.5%	Not Significant	66.8%
24b. There are opportunities for me to develop my career in this organisation.	56.3%	**Significantly Declined**	53.5%	**Significantly Better**	51.9%
24c. I have opportunities to improve my knowledge and skills.	69.4%	Not Significant	69.0%	Not Significant	67.6%
24d. I feel supported to develop my potential.	57.3%	Not Significant	56.2%	**Significantly Better**	54.4%
24e. I am able to access the right learning and development opportunities when I need to.	60.8%	**Significantly Declined**	58.2%	Not Significant	57.4%

We are always learning (continued)

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 5, Sub-score 2 - Appraisals		5.15	Not Significant	5.21	**Significantly Better**	4.95
23a.	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	92.7%	**Significantly Improved**	94.1%	**Significantly Better**	86.3%
23b.	It helped me to improve how I do my job.	25.6%	Not Significant	24.8%	**Significantly Worse**	27.3%
23c.	It helped me agree clear objectives for my work.	36.6%	Not Significant	37.3%	Not Significant	36.3%
23d.	It left me feeling that my work is valued by my organisation.	33.2%	Not Significant	35.1%	**Significantly Better**	33.2%

Additional – Personal development

Question	2024 Score	Significance	2025 Score	Significance	Sector Score
24f. I am able to access clinical supervision opportunities when I need to.	56.4%	Not Significant	55.3%	Not Significant	53.9%

We work flexibly

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 6 - We work flexibly	6.20	**Significantly Improved**	6.31	**Significantly Better**	6.23
People Promise 6, Sub-score 1 - Support for work-life balance	6.35	Not Significant	6.39	**Significantly Better**	6.30
6b. My organisation is committed to helping me balance my work and home life.	49.3%	Not Significant	50.1%	Not Significant	48.7%
6c. I achieve a good balance between my work life and my home life.	57.2%	Not Significant	57.6%	**Significantly Better**	55.9%
6d. I can approach my immediate manager to talk openly about flexible working.	70.0%	Not Significant	71.4%	Not Significant	70.3%
People Promise 6, Sub-score 2 - Flexible working	6.06	**Significantly Improved**	6.23	Not Significant	6.17
4d. The opportunities for flexible working patterns.	53.0%	**Significantly Improved**	55.7%	Not Significant	56.4%

We are a team

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 7 - We are a team	6.71	Not Significant	6.74	Not Significant	6.75
People Promise 7, Sub-score 1 - Team working	6.62	Not Significant	6.60	**Significantly Worse**	6.66
7a. The team I work in has a set of shared objectives.	72.9%	Not Significant	72.9%	Not Significant	73.6%
7b. The team I work in often meets to discuss the team's effectiveness.	56.4%	Not Significant	55.6%	**Significantly Worse**	61.8%
7c. I receive the respect I deserve from my colleagues at work.	67.8%	Not Significant	67.5%	**Significantly Worse**	70.9%
7d. Team members understand each other's roles.	70.7%	Not Significant	70.7%	Not Significant	71.3%
7e. I enjoy working with the colleagues in my team.	80.4%	Not Significant	78.8%	Not Significant	79.7%
7f. My team has enough freedom in how to do its work.	57.8%	Not Significant	58.5%	Not Significant	59.2%
7g. In my team disagreements are dealt with constructively.	54.2%	Not Significant	52.5%	**Significantly Worse**	56.3%
8a. Teams within this organisation work well together to achieve their objectives.	53.2%	Not Significant	53.3%	Not Significant	54.4%

We are a team (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 7, Sub-score 2 - Line management	6.80	Not Significant	6.89	Not Significant	6.84
9a. My immediate manager encourages me at work.	71.0%	Not Significant	72.5%	Not Significant	71.7%
9b. My immediate manager gives me clear feedback on my work.	64.1%	**Significantly Improved**	66.9%	**Significantly Better**	65.0%
9c. My immediate manager asks for my opinion before making decisions that affect my work.	56.4%	Not Significant	57.0%	**Significantly Worse**	59.2%
9d. My immediate manager takes a positive interest in my health and well-being.	68.4%	Not Significant	69.8%	Not Significant	70.1%

Next steps with your results

IQVIA can partner with you to accelerate an improvement in staff engagement

- Share the results across the organisation including breakdowns for staff groups / directorates.
- **Analyse the results** to understand if issues are prevalent in certain areas.
- Read free-text comments to gain depth into the issues.
- **Thematic analysis of free-text comments**

- Encourage teams to discuss the results and share their understanding of the issues.
- **Facilitate staff representative groups** to collate issues and ideas.
- Run **staff focus groups** if there are issues in a specific area.
- Undertake **root cause analysis** if required for organisational issues.

- Review previous action plan – what has and hasn't worked?
- **Prioritise 3 areas** where you can make a **step change**.
- Communicate your organisation-wide action plan to all staff.
- Engage managers across the organisation in creating action plans for their own teams - **provide training if needed.**

- Create, and publicise, opportunities for staff members to be involved in initiatives.
- Invest in **external support to accelerate the implementation of changes: from process development and toolkits to capability development, training and culture change.**
- Measure the impact of your actions and share regular updates with all staff on the progress you are making.

Speak to us if you would like support in any of these areas. Email: MR-Consultancy@iqvia.com
Website: https://www.iqvia.com/locations/united-kingdom/solutions/nhs-solutions/insight-and-feedback

Summary of Key Themes

- The overall Staff Engagement score for the organisation is **6.68** and the score for Morale is **5.94**
- Successes to Celebrate
  - *Scores on the theme of '**We are Safe and Healthy**' are better than the sector*
  - *People scores, on **learning** and **appraisals**, are better than the sector*
  - ***Flexible working** scores have improved, and are better than the sector*

- Areas of Focus for 2026
  - *Scores around **burnout**, **frustration**, and **strained work relationships** have all declined*
  - *Fewer staff feel **safe raising concerns***
  - *Scores around a **compassionate culture** have declined, and are worse than the sector*

Appendix

Questionnaire Changes

- Questions continue to align with the NHS People Promise. The survey tracks progress towards the seven elements of the People Promise.

Substantive Survey

- Five new questions have been added for 2025: q33-37 on the Socio-Economic factors
- Four questions from 2024 have been modified for 2025: extra response options added for q16c and q28, updated question wording for q11b and q15
  - Due to these changes q11b, q15 and q16 are no longer considered comparable over time and no trend data has been provided

Bank Survey

- Mandatory from 2023 for any organisation with at least 200 eligible bank only workers
- Five new questions have been added for 2025: q42-46 on the Socio-Economic factors
- Four questions from 2024 have been modified for 2025: extra response options added for q21c and q37, updated question wording for q16b and q20
  - Due to these changes q16b, q20 and q21c are no longer considered comparable over time and no trend data has been provided

People promise 1 and 4, and their relevant sub-scores have been recalculated to exclude questions that are no longer comparable. Furthermore, trend data for the relevant WRES/WDES metrics has been omitted.

For more information, please find the survey documents here

2605 - C2 DBTH WAY IN ACTION & WELL-LED REVIEW PROGRESS REPORT

Discussion Item | Zoe Lintin, Chief People Officer | 11:00

Rebecca Allen, Associate Director Strategy, Partnerships & Governance

10 minutes

REFERENCES

Only PDFs are attached

C2 - DBTH Way in Action & Well-led Review Progress Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**DBTH Way in Action and Well-led review progress update**			
Executive Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Rebecca Allen, Associate Director, Strategy, Partnerships and Governance Zoe Lintin, Chief People Officer Denise Smith, Chief Operating Officer Karen Jessop, Chief Nurse			
Appendices:	Appendix 1 – table of recommendations with progress update			
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	All strategic risks are impacted			

Executive Summary – Key messages and Issues

This report provides a progress update to the Board of Directors on the actions taken against the recommendations of The DBTH Way in Action and Well-led reports presented to the Board of Directors in January 2026. The report sets out the themes of the recommendations made, which have been mapped to each individual recommendation and the specific actions that have been taken to address these.

Overall Position

Across all Well-Led themes, the Trust demonstrates strong delivery momentum, with the majority of recommendations completed or on track and embedded within core governance, leadership, and assurance processes. The Board can take significant assurance that foundational actions have been implemented, governance arrangements strengthened, and oversight mechanisms improved.

However, for recommendations relating to culture, leadership behaviours, engagement and strategic enablement, assurance remains partial, as expected, because impact will be realised over time rather than at the point of action completion. Cultural change is not transactional, behavioural change is more complex and will require time to embed and realise the positive impact consistently across the organisation. In addition, cultural changes must be considered within the national context, the regional NHS landscape and the local Reset Programme and other local factors.

Key Strengths

Governance, management and sustainability: Clear evidence of strengthened Board and committee assurance processes, refreshed BAF, improved IQPR reporting, and effective use of Internal Audit and Board development to test assurance.

Leadership visibility and behaviours: Structural and procedural changes (e.g. standing agenda items, revised leadership forums, increased executive engagement) are complete and embedded.

Freedom to Speak Up and lived experience: Reporting quality has improved, learning loops are clearer, and independent insight (peer review, patient stories) is embedded into governance**.**

Quality improvement and innovation: Executive ownership and reporting arrangements are clarified, with alignment to medium-term planning priorities.

Key Challenges and risks

Outcome and impact evidence: Many actions demonstrate completion or activity, but there is limited outcome-based evidence showing sustained cultural or behavioural change at divisional and frontline level.
Enabling plans and strategic alignment: Assurance is currently process-based, with plan refreshes occurring as cycles allow, rather than through a single, time-bound assurance approach.
Longer-term cultural change: Several recommendations extend into 2027; therefore, current assurance is foundation-level, not yet outcome-level.

Mitigation and Next steps
As part of the triangulation of information for these actions, the Staff Survey results have brought additional insights, supported learning and strengthened the focus on specific areas – as outlined in the Staff Survey paper presented to the Board of Directors (May 2026) alongside the presentation from IQVIA on the results.

The themes of the Freedom to Speak Up Peer Review were shared with the People Committee in February 2026 and provided further information from an independent external source against the information in the existing external reports. Both these sources of external independent information, alongside other feedback, staff survey results and data, have supported the focus for the Culture and Leadership Pillar that forms part of the DBTH Reset Programme as part of this pillar explicit outcome measures for the culture and leadership actions will be developed with delivery milestones and evidence of impact as the programme develops.

Please note Appendix one is a summary table for Board and not the complete action plans for each element described.

Recommendations

The Board of Directors is asked to:

- Take assurance that the Trust has responded effectively to the independent reviews, with strengthened governance and clear executive ownership. Assurance is partial but appropriate in relation to long-term cultural and behavioural change, with mitigating actions in place to demonstrate impact over time.

Healthier together – delivering exceptional care for all	
Patients	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports the delivery of safe and effective services.
People	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships.
Pounds	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports delivery of the strategic priority to be sustainable and spend money wisely.
Health Inequalities	Compliance to the Well-led domains and enabling a welcoming and inclusive culture supports a positive approach to tackling health inequalities.
Legal/ Regulation	It is a regulatory requirement for the Trust to assess itself against the Well-led domains and to address any cultural aspects a review may highlight
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies
Assurance Route	
Previously considered by - including date:	Executive Team oversight monthly Review through the Reset Board Board of Directors update March 2026
Any outcomes/next steps / time scales	Continued review at alternate Board of Directors meetings

In line with Current risk appetite Yes	**Risk Appetite levels: -** highlight only if this report is outside of Board Assessment

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Appendix 1 – Table of Actions and progress

Well-Led Review

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Shared direction and culture	01	We recommend that the Trust incorporates quantitative measures within the planned six-monthly evaluation reports, as well as narrative updates. The evaluation should draw on both internal and external data and reporting to assess progress against the Trust's strategic priorities and ambitions.	Quantitative measures included in reports to Board	Easily identifiable measures which provide assurance to the Board of delivery	Acting Chief Executive Officer	May 2026	Completed for May Board
	02	We recommend that the enabling plans are reviewed and refreshed to ensure full alignment with the new Strategy. Revised versions should be assured through the relevant Board sub-committees.	Enabling plans will be reviewed and refreshed when they become due for formal review; the Executive Team will have oversight of due dates. Refreshed plans will be assured through the Hospital Leadership Team prior to submission to the relevant sub-Board Committee for approval. Engagement with Trust colleagues and strategic partners will take place to inform the development of refreshed plans.	All enabling plans have gone through full review and approval process in line with formal review dates	Acting Chief Executive Officer	March 2027	On Track
	03	We recommend the Trust work with its strategic commissioners and wider partners to establish the strategic direction for Bassetlaw and Montagu Hospitals as part of its implementation of its new strategy.	Reset Programme established with Shape Pillar Clinical Site Strategy workshop with leadership Team December 2025. CEO discussions with ICBs held April 2026 re commissioner direction and support	Board approved strategic direction for BDGH and MH including strategic commissioners and system partners input and support	Chief Medical Officer and Chief Nurse	July 2026	On Track
	04	We recommend that the Trust considers how the DBTH Way and We Care values and example behaviours could be operationalised and monitored in line with the People Plan	Trust wide engagement sessions will be undertaken to co-produce the focussed behaviour and cultural priorities, from the DBTH Way, for 2026/27. All colleagues invited to be involved in selecting the three specific behavioural priorities to focus on and embed across the Trust in 2026/27. Communication and engagement across the Trust will commence in April 2026.	Three Trust-wide behavioural priorities explicitly defined, published and linked to the DBTH way descriptors Leadership job description templates and leadership development content updated to explicitly reference DBTH way behaviours Formal observation and reflective assurance confirm that DBTH way behaviours are being role-modelled (i.e. from walkaround feedback and other activities) Leadership time out/culture sessions show evidence of learning and action. Triangulation of behavioural outcomes across multiple sources, such as staff survey data, pulse checks, FTSU themes, HR casework analysis	Chief People Officer	September 2026	On Track
	05	We recommend that the Trust considers strengthening the People Plan by identifying the responsibility of team leaders to ensure regular communication and engagement with their staff.	The Trust will continue to develop and implement the culture and leadership programme, incorporating the recommendations from 'DBTH Way in Action' as well as triangulation from the staff survey and other sources of data. This will commence in Q1 of 2026/27 This will also be considered when the People Plan is due for review.	Team leader responsibilities for regular communication and engagement are explicitly defined in the People Plan, leadership role profiles and 2026/27 appraisal objectives, with evidence of assessment through appraisal outcomes. 80% of teams demonstrate regular engagement activity (e.g. meetings, huddles or equivalent), with divisional oversight identifying and addressing variation and areas of non-compliance. Measurable improvement in relevant NHS 2026 Staff Survey and pulse survey questions linked to communication, involvement and confidence in	Chief People Officer	July - March 2026/27	On Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				immediate managers, triangulated with reductions in engagement-related FTSU and HR themes. Routine evidence of feedback loops (“you said, we did”) at team and divisional level, with examples reported through governance routes showing how colleague engagement has informed local improvement actions.			
	06	We recommend that the Trust strengthens its approach to engaging frontline leaders in service improvement and efficiency initiatives, and reviews its corporate communications to ensure the language reflects a shared purpose and a ‘one team’ ethos.	The Trust will implement a revised decision-making structure. This will include the development of the Hospital Leadership Team whose membership will consist of the Executive Team and Divisional Directors. The Trust Leadership Team will remain in place and provide a regular leadership forum for all divisional and corporate leaders.	Increase front line leader engagement in service improvement and decision making by >10% as evidenced through QI programme plans, Reset programme pillars and HLT minutes. Improved colleague experience of leadership engagement, by a 3-5% point increase in relevant staff survey and pulse survey scores, particularly, “involvement in service improvement/QI”, “confidence that leaders listen and act”, “perception of joined up one team working”	Chief People Officer	April 2026	Complete
	07	We recommend that the Trust reviews current expectations, processes, and cultural norms in relation to medical leadership and engagement with medical staff. The Trust should ensure consistency in how professional behaviours are modelled and addressed across all staff groups to support an inclusive and equitable working culture.	The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The first event will take place in March 2026 and quarterly thereafter.	>10% increase in participation of medical leaders in leadership development, QI programmes and time out sessions Evidence of medical leadership in put into Trust and divisional priorities through HLT papers, improvement plans, governance minutes and the reset programme pillars. 3-5% percentage point improvement in relevant staff survey scores including: “senior leaders act consistently with the organisation’s values” “I feel safe to raise concerns” “staff are treated fairly and with respect” FTSU and HR case themes involving medical staff, reduce over time (recognising an increase initially will be expected) Medical leadership expectations explicitly aligned to the DBTH way with consistent standards applied across all staff groups, evidence from clinical leader’s time out feedback and discussion. Reduction in repeat behaviour related concerns linked to the same themes	Chief Medical Officer	September 2026	On Track
Capable, compassionate, and inclusive leaders	08	We recommend that the Trust considers introducing a standing agenda item across its governance meetings to reflect on whether the content and conduct of the meeting were consistent with the Trust’s values and agreed behaviours.	The Trust will include this as a standard agenda item for the Trust Board and Board sub-Committee meetings from May 2026	Routine completion of the values/behaviours reflection item across board and committee meetings and evidence in minutes. Committee/Board effectiveness surveys demonstrate improvement in metrics relating to meetings purpose, and conduct aligned to the DBTH way.	Acting Chief Executive Officer	May 2026	Complete
	09	We recommend that the Trust reviews its approach to leadership visibility, including the frequency, format, and purpose of Executive and Non-Executive walkarounds. Consistent and visible engagement by senior leaders, particularly in clinical areas, would help build staff trust and reinforce the organisation’s values.	The Trust will review its approach to leadership visibility and this will include the following: - An increase in Board member visits to all areas across the Trust - Opportunities for all colleagues to request Executive visits - Regular, informal executive walkabouts to all areas across the Trust	Paper to Trust Executives and Trust Board of Directors outlining proposal for increased engagement results in a more structured approach to engagement activities 3-5% point improvement in relevant staff survey results particularly “senior managers are visible and approachable” and “I feel listened to by senior leaders” Themes arising from walkarounds are captured systematically and escalated via the relevant forums where appropriate and translated into visible actions	Acting Chief Executive Officer	April 2026	Complete

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			These will form part of the refreshed approach to Trust wide communication and will be included within the new Culture and Leadership programme.	Triangulated visibility with FTSU intelligence, qualitative feedback from walkarounds and engagement sessions.			
	10	We recommend that discussions are held with leaders across the Trust, to develop a consensus on the balance between holding meetings face to face and via Teams.	The Trust will increase the proportion of Trust Board and Board Development meetings that are held face to face. Hospital Leadership Team and Trust Leadership Team meeting will be held face to face. It is for colleagues to determine how they conduct their own meetings beyond this throughout the Trust to take account of business need.	All Board meetings, HLT and TLT planned and held as face to face meetings.	Acting Chief Executive Officer	April 2026	Complete
	11	We recommend that the Trust undertakes development work with divisional leadership teams on how they work and lead on an integrated basis. This should incorporate a review of how the leadership teams inform Trust-wide decision making and assurance assessments.	The Trust is creating a development programme for Divisional Leadership Teams and the Trust Leadership Team. The Trust will continue to develop and deliver the Culture and Leadership programme, which is available to all colleagues across the Trust.	Sustained appraisal completion >90% with appraisal outcomes evidencing leadership behaviours, collective working and accountability Strengthening staff engagement scores from the current Trust baseline to narrow the gap to the national average in 2026. Quarterly pulse survey participation increases by 3% points to a meaningfully higher and sustainable level.	Chief People Officer	December 2026	On Track
Governance, management, and sustainability	12	We recommend the Trust reviews what information is included in the Integrated Quality Performance Report on health inequalities and finance.	The Trust has procured the 'Public View' tool to support an improvement in the standardised of reporting and benchmarking of quality and operational performance data. The Trust undertakes an annual review of the metrics included in the IQPR to ensure this is aligned to the NHS Oversight Framework, NHS Standard Contract and medium term plan. Future development of the IQPR will incorporate health inequalities information. There is a separate report to Board on Health Inequalities twice a year. Finance is included in the IQPR.	The IQPR will contain a clearly defined and refreshed set of metrics that are demonstrably aligned to the 2026/27 NHSE Oversight Framework, NHS standard contract and medium term planning priorities, with explicit mapping set out within the report. Health inequalities and finance metrics are routinely presented in a clear accessible and comparable format supporting meaningful discussion of variation, trend and impact rather than descriptive reporting alone The IQPR will consistently contain: Benchmarking against peers or national standards, Improvement trajectories and, where relevant, tolerance thresholds.	Chief Operating Officer	June 2026	On Track
	13	We recommend that the Trust strengthens the Integrated Quality Performance Report by using benchmarking, external data, improvement trajectories, and clear measures linked to the Trust's strategic ambitions. This will support moving to assurance rather than reassurance.	See above	See above	Chief Operating Officer	June 2026	On Track
	14	We recommend the Trust includes the actions being undertaken in relation to the elevated SHMI rate within the Trust Risk Register and consideration is given to appropriate inclusion within the BAF.	The elevated SHMI is included on the Trust risk register and is aligned to Strategic Risk 1 on the BAF. This will be regularly reviewed through Risk Management Group, Trust Board and relevant sub-Board Committee	The Elevated SHMI risk is actively managed through the Trust risk register and BAF, with Clear articulation of cause, controls and mitigating actions. Routine board and committee review, demonstrating effective oversight, challenge and decision-making linked to SHMI performance Evidence that actions identified through SHMI analysis are implemented, tracked and reviewed with learning embedded into clinical governance and QI processes Demonstrable improvement in SHMI trajectory over time Mortality data quality assurance internal audit scheduled for Q1/2 (360 assurance)	Chief Medical Officer	April 2026	Complete

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
	15	We recommend the Board receives detailed information and assurance on actions being taken to mitigate the impact of the estate condition at the DRI, on Trust finances, quality, access, and staff experience.	Board Development Session in February 2026 included consideration of all actions and mitigations; and will aligned to the BAF and Trust Risk Register. Actions agreed from this session form part of the Trust capital plan	The Board receives regular, structured and triangulated assurance that the risks associated with the condition of the DRI estate are being actively mitigated, evidenced by: A clearly articulated estates-related risk recorded on the Trust Risk Register and, where material, the BAF, setting out causes, controls, mitigating actions and residual risk; Routine Board and Committee reporting demonstrating oversight of the impact of estate condition on: • quality and safety • operational access and flow • staff experience • financial sustainability. Evidence that agreed mitigating actions are prioritised, funded where possible, tracked and reviewed, with clear rationale documented where actions cannot proceed due to affordability or capital constraints. Clear line of sight between estates risks, mitigation plans and decision-making, including escalation to the Board where risks exceed appetite. Assurance that key estate risks at DRI are stable or reducing over time, or that the Board has explicitly accepted residual risk where improvement is not immediately feasible (as supported by evidence and national context).	Chief Finance Officer	April 2026	Complete
	16	We recommend that the Board and its committees undertake a review of their processes for generating assurance outcomes, including working to standard definitions for each level of assurance. This should be informed by a review of controls and assurance levels within the BAF, alignment with latest internal audit opinions, robust outcomes data, and enhanced levels of external validation.	The assurance process will be reviewed as part of the Board Development Session in April 2026, this will be led by an external facilitator and attended by internal auditors. Further information triangulated with the Internal Report of the BAF (Significant Assurance).	All Board and committee papers will explicitly state the level of assurance using the agreed definitions with consistent interpretation evidenced through paper quality and Chair challenge. BAF, internal Audit and outcomes data will demonstrably align. Ongoing external assurance (via Internal audit/external reviews) will confirm improving governance maturity and effective use of the BAF – resulting in a continued significant assurance opinion.	Acting Chief Executive	April 2026	Complete
	17	We recommend that a review is undertaken of the purpose and role of TLT. This review should consider the balance between decisions made at the Executive Team meeting and the TLT, and the degree to which the divisions are involved in Trust-wide decision-making processes.	The role and purpose of TLT reviewed and revised. This will become a development and engagement forum for senior divisional and corporate colleagues, taking place bi-monthly. A Hospital Leadership Team established as a decision-making forum, the membership of this will be the Executive Team and Divisional Directors.	Minutes of meetings where changes discussed TOR and Agenda demonstrate changed purpose HLT established TOR and Minutes provide evidence	Acting Chief Executive	Apri; 2026	Complete
	18	We recommend that an organisational accountability framework document is developed, aligned to the Performance Assessment Framework, the scope of which covers governance arrangements from service level to the Board.	The Trust is developing a Governance Manual which will comprise of: - Corporate Governance - Executive Led Operational Governance - Divisional Governance This will be aligned to the Performance Assessment Framework.	Board and committee papers consistently identify, accountable lead, decision making level and escalation route (where controls are insufficient). Risks, performance issues and improvement actions show a clear line of sight from ward to Board.	Chief Operating Officer	June 2026	On Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				Fewer instances of late or reactive escalation, evidenced through risk register review and reduction in new but long-standing risks reaching Board. Internal audit or external review confirms that governance and accountability arrangements are clearly articulated, consistently applied and aligned.			
	19	We recommend the Caring Group discusses how to ensure that lived experience is better harnessed and used within DBTH.	The terms of reference for the Caring Group will be reviewed and the programme of work for the Citizens Panel will be incorporated into this. Work will continue to implement the experience of care framework and specific task and finish groups will be established. A refined engagement strategy, with 'patients with lived experience' groups supporting more focussed actions. Patient Safety Partners attend the Caring Group A programme of digital stories will be established across all Divisions. A Patient Experience Plan and strengthened Terms of Reference will be developed. The Quality Committee will receive patient stories from Q1 of 2026/27.	Board and committee papers explicitly reference lived experience insights (via patient stories, citizens panel feedback, patient safety partners) and show how these have informed improvement priorities, risk mitigations, quality actions or service design. Caring group will identify a recurring patient experience theme for focused attention during 2026/27 and demonstrate a 10% reduction by year end. Feedback from patient safety partners/citizens panel included in the annual patient experience report confirming that their input leads to visible change	Chief Nurse	April 2026	Complete
	20	We recommend that the BAF is strengthened to ensure clear threat descriptions, outcome-based assurance sources, alignment with the new Trust Strategy, consistency in committee reporting, and sufficient time for Board review and challenge.	See responses to Q16 above. The BAF will be regularly reviewed and updates provided to the relevant sub-Board Committee and Trust Board.	See Q 16	Acting Chief Executive Officer	April 2026	Complete
Freedom to Speak Up	21	We recommend that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all.	The Trust will utilise the FTSU peer review to support any identified improvements in the FTSU process, reviewing effectiveness, feedback loops, and confidentiality understanding as part of wider cultural programme. An overview and key themes from the FTSU Peer review shared with the People Committee in February 2026 together with identified improvement plans and support to the wider culture and leadership programme, focusing on improvements to safe patient care. A FTSU report was presented to the Trust Board in March 2026.	>95% of individuals who use FTSU service reporting that they would feel confident to use the service again. All FTSU cases evidence timely feedback to individuals raising concerns with themes, learning and actions reporting. Board and committee papers demonstrate clear "you said, we did" learning. Reduction over time in repeat FTSU themes relating to the same issue. It is expected that the 'line in the sand' work will lead to an initial increase in FTSU cases regarding behaviours.	Chief People Officer	September 2026	On Track
	22	We recommend that FTSU reports to the Board includes learning and actions to strengthen the feedback and learning loop.	The FTSU reports to the Trust Board will be strengthened to highlight the assurance requirements, include learning and actions to strengthen the feedback and learning loop.	Evidence provided in reports and minutes to People Committee and Trust Board of Directors	Chief People Officer	April 2026	Complete
Workforce, equality, diversity, and inclusion	23	We recommend that the Trust reviews whether its operational assurance arrangements as set out in the Operational Assurance and Information Flows wiring diagram for staff engagement are sufficient.	The Trust is reviewing operational governance arrangements as part of the development of the Governance Manual (see 18).	See 18	Chief Operating Officer	June 2026	On Track

Theme	Ref	Recommendation	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			As part of this review, the Trust will consider opportunities to strengthen colleague engagement.				
	24	We recommend that the Trust strengthens workforce engagement and communication, ensuring changes to policies, roles, and systems are clearly explained to staff.	Trust Communications will be strengthened to ensure engagement in new policies, service and system changes. The Hospital Leadership Team will receive final recommendations and approve any changes, strengthening clinical engagement in the decision-making process. Trust communications to launch approved polices, service and system changes will be strengthened to ensure broader dissemination through the organisation.	Improvement to national average from Trust baseline in NHS staff survey questions on ability to contribute to improvements at work and communication with senior management. HLT TOR and minutes will reflect Divisional Director engagement in decision making Audit of document management processes to be completed in Q4 26/27	Chief People Officer	September 2026	On Track
Partnerships and communities – Lived Experience	25	We recommend that the Board considers the assurance it receives with regards to how patient and lived experience is central to monitoring and driving service improvement, and how it can elevate prominence at Board meetings.	The Trust will review the terms of reference and programme of work to include the Citizens Panel. Implementation of the experience of care framework will be supported through a task and finish group. A revised engagement strategy will be developed, with input from key 'patient with lived experience' groups. This will be reviewed annually. Patient Safety Partners attend Caring Group. A programme of digital patient stories will be implemented in all Divisions. The Quality Committee terms of reference will be updated to reflect the necessary changes.	3-5% improvement (from baseline) in NHS staff survey scores relating to, staff feeling informed about changes, understanding why changes are happening and having confidence that leaders communicate clearly. 5% increase in quarterly pulse survey participation. Reduction in FTSU themes, HR queries or escalation (recognising that there will be an initial increase as work commences). Board and committee papers demonstrate clear evidence that staff feedback influenced final decisions. Divisions supported to established shared decision-making councils.	Chief Nurse	May 2026	Complete
Learning, improvement, and innovation	26	We recommend that the reporting arrangements for implementation of the Quality Improvement and Innovation (QII) Strategy 2024-2028 are clarified.	QI sits within our new DBTHi function and the strategy implementation is being aligned to our Reset Programme now that our medium term plan is agreed.	Clear outcome metrics monitored against reset programme linked to quality improvement QI strategy reporting into HLT	Acting Chief Executive Officer	July 2026	On Track
	27	We recommend that the current approach to quality, improvement, and innovation team meetings and huddles across the Trust is reviewed and actions are agreed to support improvement in line with the QII Strategy objectives.	The Trust has developed the DBTHi team, who support the approach to quality, improvement and innovation. The approach to team meetings and huddles across the Trust will be reviewed to ensure actions are aligned to the QII strategic objectives.	DBTHi activity aligned with the Trust reset programme pillars, evidence of impact will be demonstrated via delivery of the reset programme and monitored via the reset programme board.	Acting Chief Executive Officer	May 2026	Complete

DBTH Way in Action Recommendations

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
Patient Care	6.1	The review team recommends that the Trust ensure that the 4Ps are appropriately balanced in their application within the Trust operating model.	The Trust will ensure balanced focus across the 4 P's, particularly when considering quality, patient safety and colleague working environment. This balance will also be considered as part of the annual review of the Trust risk appetite statements. 'Patients' will feature more explicitly in Board and sub-Board Committee agendas. Consistent and balanced messaging will be considered as part of all internal and external communications.	Board and committee papers will explicitly identify impacts on the 4 Ps via the cover sheet process. Workplans for relevant sub committees strengthened. 360 Audit facilitated risk appetite discussion held as part of Board development session on 14th April, balance considered as described and appropriate amendments made as agreed.	Acting Chief Executive Officer	April 2026	Complete
Belonging & Community	6.2	The review team recommends that the Trust ensures that it provides leaders with sufficient local human resources support, ensuring local leaders implement staff policies consistently across the Trust.	The People Business Partners team provide HR support to Divisions and Directorates. Training and support is offered as part of the support and development offer for managers and additional training is available when key HR policies are launched. HR toolkits and additional guidance are available on the Trust intranet (the Hive) also available on the Hive (intranet).	Named People Business Partner coverage in place for 100% of Divisions/Directorates. Internal audit assurance confirms consistent adherence to agreed HR processes where relevant (aligned with internal audit plan 26/27). >90% of Managers complete mandatory policy related training or toolkits following launch of new/revised policies FTSU and HR case work theme triangulation shows a reduction over time in concerns relating to inconsistency or unfair treatment. The 'line in the sand' work is expected to lead to an increase in such cases in the short term.	Chief People Officer	April 2026	Complete
	6.2	The review team recommends that the Trust takes the opportunity to further build on the DBTH Way to ensure that staff are fully engaged with the values and descriptors.	Trust wide engagement sessions are planned for 2026/27, to co-produce the cultural priorities and agree the focus behaviour areas from the DBTH Way. All colleagues will be encouraged to be involved with selecting the three specific behavioural priorities to embed across the Trust. This will be launched in Trust communications in April 2026. "One DBTH" expectations will be incorporated into team development and supervision arrangements.	Three Trust-wide behavioural priorities explicitly defined, published and linked to the DBTH way descriptors developed following different clinical engagement sessions and a Trust wide survey. 80% of sampled (anonymised) appraisals demonstrate explicit reference to DBTH way behaviours. Improvement to national average in relevant NHS staff survey questions related to team working.	Chief People Officer	December 2026	On Track
Value, Behaviour and Respect	6.3	The review team recommends that the Trust produces a clear action plan with SMART objectives to consistently tackle bullying and harassment within the Trust	The Trust will undertake a deep dive into bullying and harassment, with clear methodology and a multi professional review group. This is expected to conclude in Q2 of 2026/27. An action plan will then be developed to address the key findings. The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The Trust will implement an agreed "I will …" statement as part of 2026/27 appraisal programme.	Following completion of deep dive, action plan to be presented to Board complete with measurable objectives, success criteria, delivery milestones and named leads. Ongoing monitoring via People committee "I will .." behavioural commitment embedded within 2026/27 appraisal objectives for all colleagues included within >80% of sampled appraisals. Clinical leaders forum established and sustained with attendance and outputs demonstrating active leadership with ownership of behaviour, culture and professional standards. Reduction over time in FTSU and HR casework themes relating to bullying, harassment or inappropriate behaviour. The 'line in the sand' work is expected to lead to an increase in such cases in the short term.	Chief People Officer	December 2026	On Track

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
				Improvement to 2024 levels in staff survey questions "in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers" and "from colleagues" (currently above average).			
	6.3	The review team recommends that the Trust undertakes a review of the effectiveness of its implementation of EDI policies.	As part of the Culture and Leadership Programme and 'line in the sand' work, the EDI principles and policy will be strengthen and embedded. The EDI improvement plan will be refreshed in Q2 of 2026/27 and presented to People Committee.	An Internal Audit of the EDI policies from 2025/26 was undertaken, this gave an audit opinion of 'significant assurance'. EDI principles and "the line in the sand" expectations explicitly incorporated into leadership development. Reduction over time in EDI related case work for HR and FTSU WRES and WDES indicators demonstrate narrowing of inequalities over time, with any adverse trends escalated and mitigated via the EDI improvement plan and assurance to People Committee.	Chief People Officer	December 2026	On Track
	6.3	The review team recommends that the Trust further defines, embeds, and assures a zero-tolerance approach to the unacceptable behaviours identified by staff within this review, shaped by staff engagement.	The Trust has commissioned 'Civility Saves Lives' and 'A Kind Life' to deliver programmes to support and embed a zero tolerance approach to unacceptable behaviours. This will be prioritised for implementation in clinical Divisions initially, during Q2 – Q4. The Trust will launch the 'line in the sand' work in response to the culture review and staff survey feedback, this is a fundamental part of the Trust Reset Programme, as described in the Culture and Leadership programme. The Trust will undertake a deep dive into bullying and harassment, with clear methodology and a multi professional review group. This is expected to conclude in Q2 of 2026/27. An action plan will be developed to address the key findings. (See 6.3 above)	Evaluation of the Civility Saves Lives and A Kind Life programmes will be undertaken upon completion, utilising relevant staff survey metrics, and patient safety culture survey results (for operating theatres) results will lead to improvement plan as required. Following completion of deep dive, action plan to be presented to Board complete with measurable objectives, success criteria, delivery milestones and named leads. Ongoing monitoring via People committee Outcomes for the culture and leadership pillar of the reset programme, will be reported via the reset programme board.	Chief People Officer	December 2026	On Track
Psychological & Physical Safety	6.4	The review team recommends the Trust conduct a review of the effectiveness of its site parking arrangements, particularly at the DRI.	The Trust has recently approved a capital scheme to increase the amount of car parking at DRI . This is part of the overall capital plan for the DRI site.	Car parking review completed, business case developed and approved.	Chief Finance Officer	April 2026	Complete
Communication, Coproduction and Raising Concerns	6.6	The review team recommends that the Trust ensures all teams establish regular meetings or huddles where they are not already in place	The Trust has developed the DBTHi team, who support the approach to quality, improvement and innovation. The approach to team meetings and huddles across the Trust will be reviewed to ensure actions are aligned to the QII strategic objectives. The People Plan will be strengthened to clarify the expectations of leaders and teams in relation to communication dn information sharing.	Divisional leadership teams confirmed via Performance Review Meetings review that regular meetings are in place and established within the Divisions. Quality summit feedback includes establishing whether ward/team meetings exist and support to establish if required. Safety Huddle audit will commence in Quarter 1 2026/27, results will inform any required action plan and reported via patient safety assurance group	Chief People Officer	September 2026	On Track
	6.6	The review team recommends that the Trust continues and prioritises its development of a staff engagement strategy with clear timelines, deliverables and SMART objectives, approved by the board and developed in partnership with staff.	The Trust will implement an enhanced approach to colleague engagement. This will include - Informal walkarounds undertaken by Executive Team members.	Strengthening staff engagement scores from the current Trust baseline to narrow the gap to the national average. Themes arising from walkarounds are captured systematically and escalated via the relevant forums where appropriate and translated into visible actions	Chief People Officer	December 2026	On Track

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
			- face to face meetings with the Executive Team across all hospital sites. - 'Ask an Exec' open sessions. - Team Brief where open questions and dialogue are encouraged. - Acting CEO and Interim Chair vlog. Colleague engagement is a key element of the Culture and Leadership programme. A new engagement plan and approach will be co-produced with colleagues to define how they wish to be engaged, how information is shared, triangulated with the staff survey findings. Initial scoping will commence in Q1.	Triangulated visibility with FTSU intelligence, qualitative feedback from walkarounds and engagement sessions. Co-produced plan as part of the Culture and Leadership programme with measurable deliverables and timelines presented at People Committee for assurance as agreed.			
Freedom to Speak Up	6.7	The review team recommends that the Trust ensures the FTSU process meets its intended purpose, assessing the effectiveness of that process, ensuring feedback is given to those raising concerns and the importance of confidentiality is understood by all.	The Trust will utilise the FTSU peer review to support any identified improvements in the FTSU process, reviewing effectiveness, feedback loops, and confidentiality understanding as part of wider cultural programme, focusing on improvements to safe patient care and triangulated with the staff survey An overview and key themes from the FTSU Peer review will be shared at with the People Committee in February 2026 together with identified improvement plans and support to the wider culture and leadership programme, focusing on improvements to safe patient care. A FTSU report presented to the Trust Board in March 2026.	Relevant committee and Board minutes reflect that the reviews have been presented and support ongoing monitoring and assurance of improvement plans.	Chief People Officer	April 2026	Complete
Leadership Impact	6.8	The review team recommends that the Trust continue to try to resolve the relationship issues between the Executive team and some senior medical staff.	The membership of the Hospital Leadership Team includes the Divisional Directors, thereby strengthening clinical leadership in decision making. The Trust has commissioned 'Civility Saves Lives' and 'A Kind Life' to deliver programmes to support and embed a zero tolerance approach to unacceptable behaviours. This will be prioritised for implementation in clinical Divisions initially, during Q2 – Q4. The programme will be evaluated to assess effectiveness. The Trust will launch a clinical leaders forum, which will focus initially on developing the DBTH Way priorities and future models of working. The first event will take place in March 2026 and quarterly thereafter.	Evidence of medical leadership input into Trust and divisional priorities through HLT papers, improvement plans, governance minutes and the reset programme pillars. Clinical leader's forum established and sustained with attendance and outputs demonstrating active leadership with ownership of behaviour, culture and professional standards. Evidence provided in attendance and subsequent outputs once forum established. Evaluation of the Civility Saves Lives and A Kind Life programme will be undertaken upon completion, utilising relevant staff survey metrics, and patient safety culture survey results (for operating theatres) results will lead to improvement plan as required.	Chief Medical Officer	December 2026	On Track
Environment, Facilities and IT	6.9	The review team recommends that the Trust continues its review of its current utilisation of estates to ensure that staff have a safe working environment, and patients are cared for in appropriate conditions.	The Board Development Session in February 2026 will focus solely on the estate at DRI, this will include consideration of all actions and mitigations; and will be aligned to the BAF and Trust Risk Register. Actions agreed from this session will form part of the Trust capital plan. The first Hospital Leadership Meeting, in April 2026, will discuss clinical alignment and estate utilisation as part of the overall clinical strategy. Optimal service configuration and patient / colleague environment are key components of this work.	Board have a collective understanding of current estate condition and risks. Updated Estates master plans are developed for each of the Trust sites which integrate with wider plans within the SY ICS and Doncaster and Bassetlaw place more generally.	Chief Finance Officer	April 2026	Complete

Theme	Ref	Recommendation Description	What we are doing	How we will measure success	Accountable Executive	Date	RAG
	6.9	The review team recommends that the Trust consider how to disseminate information and engage staff with the development of the implementation of the EPR.	Dedicated communications and engagement resource is in place to support EPR awareness and engagement. The Chief Medical Officer is the Executive Lead for the EPR programme and clinical colleagues will be driving the development of the new EPR, with wrap around support from Digital colleagues. Regular communications are shred across the Trust through the Trust Leadership Team and all colleague bulletins.	Clinical colleagues engaged and contributing to EPR awareness – feedback via EPR Steering Group. EPR training figures 80% prior to go live ORBIT (EPR programme) has a dedicated space on the HIVE with a clear launch pad for colleague engagement.	Chief Medical Officer	December 2026	On Track

2605 - D STRATEGY & PERFORMANCE

11:10

2605 - D1 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

Information Item | Mark Bailey, Interim Chair | 11:10

10 minutes

REFERENCES

Only PDFs are attached

D1 - Chair's Report including Partnership Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Chair's Report including Partnership Update**			
Executive Sponsor:	Mark Bailey, Interim Chair of the Board			
Authors:	Adam Tingle, Deputy Director of Communications & Engagement			
Appendices:	None			
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1- 6			

Executive Summary – Key messages and Issues
This report provides the Board of Directors with an insight into the Chair's reflections, areas of focus and activities since the last Board report in March 2026.

Recommendations
The Board is asked to note the report.

Healthier together – delivering exceptional care for all	
Patients	This report highlights the commitment to the delivery of safe, exceptional, person-centred care by working in a joined up way and making use of collective experience.
People	This report recognises the importance of colleagues working together and in line with the DBTH Way.
Partnerships	This report acknowledges the importance of working with partners to achieve service delivery.
Pounds	This report recognises the need for the Trust to be efficient and spend public money wisely and within its means.
Health Inequalities	This report does not directly impact on health inequalities.
Legal/ Regulation:	This report does not identify any legal or regulatory impact.
Partner ICB strategies	This report does not impact on the strategies of our partner ICBs.

Assurance Route	
Previously considered by - including date:	Not applicable
Any outcomes/next steps / time scales	Not applicable
Is this in line with Current risk appetite **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

Mark Bailey
Interim Chair of the Board

Chair Report May 2026

As we begin the new financial year, it is important to recognise the year that has gone.

Across our Trust, colleagues have continued to deliver high quality care in the face of sustained pressure and rising demand, and that progress has been seen not only in the care we provide, but in how services have adapted and how teams have supported one another through challenging circumstances.

I would like to take this opportunity to place on record my thanks to colleagues across our hospitals and clinics for that continued commitment and the difference you make every day to our patients and communities.

Looking ahead, we are now moving into the delivery phase of our Three-Year Plan. The ambition is clear and delivering it will require us to build on that foundation and to be more consistent in how we work across our services and sites.

As set out in the Acting Chief Executive's report, we have a clear plan and a more structured approach to delivery, our focus now is on making that real in practice and reflecting a theme within our recent DBTH Leadership Conference, making it stick.

Working together across our services

A key theme in our conversations over recent months has been how we work together as one organisation, particularly across different services and sites.

There is a clear opportunity to be more consistent in how we deliver care, to learn from where things work well, and to strengthen areas where we have seen fragility at times. This is not about asking colleagues to work harder, but about improving how we do things, making better use of our collective experience, and working in a more joined up way to achieve the outcomes we all want for our patients and communities.

This aligns closely with the focus described in the Acting Chief Executive's report. If we are to deliver the improvements we have set out, we will need to be more consistent and more connected in how we work across the organisation.

Alongside this, we have had further discussions with partners across our system, including community organisations and neighbouring providers, about how we work more closely together, recognising that many of the challenges we face are shared.

Line in the sand

As the Acting Chief Executive reflects, how we work together will be as important as what we deliver over the coming years.

Over recent months, we have taken time to listen carefully to feedback from colleagues and our communities, through the Staff Survey, DBTH into Action, and conversations across our sites.

The message has been consistent. Where expectations are clear, where people feel able to speak up, and where leaders respond, teams work well and care improves. Where this is not the case, variation can emerge and the experience for colleagues and patients is not as strong as it should be.

In response, we have taken the opportunity to be clearer about how we work together. Later this month, we will share a short film with colleagues across the Trust, featuring over 50 colleagues from all sites, which sets out what we have described as a line in the sand, something we are proud to lead as a Board.

This is about clarity and our values of compassion, kindness and inclusion remain fundamental, but they must be matched by consistent expectations and action.

In practice, this means being clear about how we treat one another, especially when under pressure, being willing to speak up when something is not right and to listen when others do, and supporting leaders to act early, fairly and consistently when issues arise.

This is not about blame, and it is not about one off moments of pressure. It is about addressing patterns of behaviour that affect colleagues, teams and ultimately patient care.

Put simply, compassion and accountability go hand in hand, and being clear is an important part of being kind.

I am looking forward to sharing the final film with colleagues and see how this work progresses in future.

Listening and our role in the community

This theme of listening will remain central as we move forward.

We receive feedback in many ways, through colleagues, patients, partners and our communities, and our Council of Governors plays an important role in ensuring that local voices are heard and reflected in our work.

I look forward to the upcoming Governor elections this month, which provide an opportunity for both colleagues and members of the public to contribute to the future direction of our Trust (details on our website, www.dbth.nhs.uk).

We are also continuing to strengthen our role within our communities. In Doncaster, this has included discussions with the Chamber of Commerce and with university and college leaders, focused on promoting skills, supporting local people into health careers, and working with businesses on health and wellbeing.

I hope to share more on the above in future papers.

Looking ahead

We have a clear plan and a strong foundation to build on. The focus now is on delivery, in a way that reflects our values, strengthens how we work together, and supports colleagues to do their best work.

There will be challenges ahead, but there is also a real opportunity to do things better. To organise ourselves more effectively, to be more consistent in how we deliver care, and to put in place the foundations that will support our services for the long term.

If we approach this in the right way, working together and being clear about what we expect of one another, we will not only deliver our Three-Year Plan, but continue to improve the care we provide for our patients and communities.

2605 - D2 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

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

10 minutes

REFERENCES

Only PDFs are attached

D2 - Chief Executive's Report including Partnership Update.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Chief Executive's Report including Partnership Update**			
Executive Sponsor:	Zara Jones, Acting Chief Executive			
Authors:	Adam Tingle, Deputy Director of Communication & Engagement			
Appendices:				
Purpose of the report	~~Assurance~~	~~Decision required~~	**Information**	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1 - 7			

Executive Summary – Key messages and Issues
This report provides an overview of the Trust's key achievements, developments, areas of strategic focus and associated risks.

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 continued focus on patient safety, experience and continuity of care.
People	This report recognises support and development opportunities for colleagues.
Partnerships	The report highlights the ways in which the Trust works in partnership to support service delivery.
Pounds	The report recognises the delivery of 2025/26's financial plan and the need for recurrent efficiency and productivity improvements to deliver future plans.
Health Inequalities	The Trust considers its activities through the health inequalities lens, taking action to support access to care.
Legal/ Regulation:	This report has no impact on legal or regulatory practice. The latest regulator visit is referenced in the report.
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 Report - May 2026

Organisational position and Board takeaways

My overall assessment is that the Trust is making progress, but performance remains inconsistent and in some areas below the standard we expect, with further improvement required.

I am seeing tangible progress in operational delivery, including recent improvements in urgent and emergency care performance, supported by our adoption of national improvement initiatives.

We are awaiting confirmation of funding to support further development of our Emergency Department at Doncaster Royal Infirmary and Same Day Emergency Care, which will be important enablers of sustained improvement.

Alongside this, direct engagement on the ground remains an important part of how I assess performance, including regular Emergency Department visits to speak with colleagues, understand pressures in real-time and test whether our data reflects the lived experience of teams.

At the same time, I remain concerned about the number of patients waiting over 52 weeks and the need to secure more rapid improvement over the year ahead, particularly in our most challenged specialties. We have deliberately set a stretching trajectory for improvement and have a number of actions in train to support delivery. The focus now is on delivery and seeing these translate into tangible reductions in long waits over the coming months.

Alongside this, we are strengthening how we understand performance. We are undertaking deeper dives in areas where our triangulation of data and insight indicates a need for further scrutiny, including our work to improve mortality rates following the Board's recent discussion on Learning from Deaths.

Performance will be covered in more detail by the Executive Team through the Integrated Quality and Performance Report. Alongside this, we are continuing to strengthen our governance and assurance processes to ensure we have earlier visibility of risk and clearer grip on delivery, aligned to our Well-Led improvement actions.

Financially, we have delivered our 2025/26 position, including a £31m Cost Improvement Programme, but this is supported by non-recurrent funding. The underlying deficit remains and requires sustained delivery of our Three-Year Plan and Reset Programme.

There is a strong national focus on productivity, and we will continue to deliver improvements, as reflected in our implied productivity metric which showed positive movement last year.

I welcome NHS England regional oversight and support in relation to our Oversight Framework metrics and wider quality improvement plans, alongside positive discussions with Integrated Care Board (ICB) leaders on how we best meet the needs of our population and deliver consistent outcomes across our sites and services.

We have shared clear communication with colleagues on our Three-Year Plan and will be engaging directly with teams across our sites to set out these plans in more detail.

My judgement is that we have established a credible foundation for improvement, but the scale of the challenge remains significant.

We are clear that we need to reset how we work in order to become a sustainable organisation and we own this challenge collectively as a leadership team.

In summary, I would like the Board to take the following from this report:

- We are making progress, but performance remains inconsistent and requires further improvement.
- Delivery of the Reset Programme and Three-Year Plan is now the critical priority.
- Current financial position is not sustainable without recurrent change.
- Variation in performance, including long waits and quality indicators, continues to limit progress.
- We are strengthening grip through deeper performance scrutiny, triangulation and governance.
- The next phase requires disciplined delivery, consistency and clear leadership accountability.

Progress against our strategic priorities

Patients: Continued focus on safety, experience and continuity of care, including a more person-centred approach for vulnerable patients and better information sharing with primary care following Emergency Department and Minor Injuries Unit attendance. The Blood 360 bedside app is now live at Doncaster Royal Infirmary and Montagu Hospital, improving the safety and tracking of blood products, with rollout to Bassetlaw planned. Our Quality Priorities for 2026/27 include pain management, antibiotic use, end of life care and the safe handling of controlled drugs.

People: As reflected in the Chair's report, ensuring colleagues feel supported, listened to and clear on expectations remains central to how we work together and deliver improvement. This commitment can be seen in the recognition of our workforce through World Admin Day and upcoming Nurses' and Midwives' Days, alongside the expansion of Professional Nurse Advocate and Professional Midwifery Advocate roles and our annual Leadership Conference. Appraisal Season is also underway, providing an opportunity for colleagues to reflect on their performance, discuss development and set clear expectations for the year ahead, supporting both individual growth and organisational priorities.

Partnerships: Partnership working continues to support service improvement and patient experience, including the Audiology Action Day in Doncaster, which brought together over 160 local people, colleagues and partners. Work with ConvoAccess and Language Empire is improving access for Deaf patients and those who use British Sign Language, while contributions to the Armed Forces Covenant workshop support a more joined-up approach to care for veterans and their families.

Pounds: The Trust has received £4.2 million in additional funding for the final quarter of 2025/26, enabling delivery of a breakeven position and reflecting progress made alongside a £31 million Cost Improvement Programme. Reducing the underlying deficit remains essential to achieving financial sustainability and creating headroom for future investment.

What this looks like in practice: selected examples

These examples illustrate areas of progress, development and learning since the last report to the Board:

Three-Year Plan: We are now moving into delivery of our Three-Year Plan, supported by a structured Reset Programme to drive pace, clarity and oversight, alongside a continued focus on consistent behaviours and expectations. The plan sets out how we will improve performance, redesign services and deliver around £90 million in recurrent savings over time.

MEOC accreditation: The Montagu Elective Orthopaedic Centre of Excellence has achieved national GIRFT accreditation, recognising high-quality care and providing protected elective capacity to reduce cancellations and support shorter waiting times.

Pharmacy automation: The upgrade to the Inpatient Pharmacy at Doncaster Royal Infirmary is now complete, improving the speed and accuracy of dispensing while releasing colleague time for direct patient care.

Car parking improvements: A new 103-space car park has opened at Doncaster Royal Infirmary, with further expansion planned, increasing overall capacity by around 25 percent over time.

CQC activity and learning: An unannounced CQC inspection of paediatric services took place in April, following a recent CQC unannounced visit to the Emergency Department at Doncaster Royal Infirmary. This has provided important feedback and learning, which we are actively reviewing and responding to. A more detailed update on this CQC feedback and will be provided to the Board by the Chief Nurse.

Health devolution: National developments in health devolution, particularly in South Yorkshire, will increase local influence over health services, with a greater focus on prevention, integration and locally led decision making.

Looking ahead: Risks and priorities

The next phase of our improvement work is focused on delivery and consistency.

Key risks:

- Current financial position is not sustainable without recurrent change.
- Variation in performance across services and sites.
- Pace of delivery of workforce and service redesign.
- Risk of slippage in delivery of consistent care and improvement without strong grip and early warning.
- Continued long waits in challenged specialties if actions do not translate into sustained reductions.
- Inconsistent leadership behaviours and colleague experience if the culture reset is not embedded.

Key priorities:

- Delivery of the Reset Programme as the single vehicle for improvement.
- Reduction of the underlying deficit through productivity and redesign.
- Strengthening governance, grip and early warning.
- Embedding consistent leadership behaviours and expectations.
- Translating performance actions into measurable improvements through IQPR oversight, deep dives and executive scrutiny.

- Continuing direct engagement with colleagues across sites as part of the Three-Year Plan and culture reset.

Culture, leadership and organisational effectiveness

Feedback from the Staff Survey, Well-Led Review and engagement highlights both strengths and the need for greater clarity and consistency in behaviours, expectations and leadership.

In response, we are undertaking a significant reset of our approach to culture and leadership, grounded in the DBTH Way. This includes increased executive and senior leadership visibility, clearer expectations of behaviours, stronger support for speaking up and greater consistency in how issues are addressed.

Over the coming year, this will be supported by targeted work on priority behaviours shaped by colleague feedback, alongside clearer accountability at all levels. As the Chair describes in more detail in his paper, this forms part of our wider "Line in the Sand" approach, creating clarity on how we work together in practice and reinforcing consistent standards across teams and services.

Alongside this, we continue to review and refine our governance systems and processes to support delivery and provide clearer assurance. This aligns with the Well-Led review recommendations, with progress updates reflected elsewhere on this agenda.

We are also progressing our leadership arrangements to support delivery, including the recruitment of a substantive Chief Medical Officer, Non-Executive Directors and a number of public and staff Governors.

Summary

We have made progress and established a stronger foundation across performance, finance and infrastructure, but performance remains inconsistent and our financial position is not yet sustainable.

The priority now is delivery. We need to see our plans translate into consistent performance and measurable improvement for patients and colleagues.

My focus, and that of the executive team, is on disciplined delivery, underpinned by strong oversight and early visibility of risk.

2605 - D3 INTEGRATED QUALITY & PERFORMANCE REPORT (INCLUDING FINANCE REPORT)

Discussion Item | Executive Directors | 11:30

20 minutes

REFERENCES

Only PDFs are attached

- D3 - Integrated Quality & Performance Report.pdf
- D3 - Appendix 1 IQPR March 2026.pdf
- D3 - Appendix 2 Finance and Activity Report 25-26 Month 12.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	Integrated Quality & Performance Report			
Executive Sponsor:	Zara Jones, Acting 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:	Appendix 1 - IQPR March 2026 Appendix 2 - Finance & Activity Report 25-26 Month 12			
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

This report presents the Trust's integrated performance across Access, Quality, People and Finance, highlighting the current pressures and the implications for delivery of safe, timely and sustainable care.

Overall, the Trust continues to face sustained operational pressures across urgent and elective care pathways. Performance against national access standards remains challenging, reflecting high demand, flow constraints and system pressures. The report highlights ongoing actions to manage emergency department performance, ambulance handover delays and elective waiting times, including the 18-week referral-to-treatment standard and the 62-day cancer pathway. Elective challenges are heavily concentrated in Trauma and Orthopaedics, which represents a disproportionate share of both the overall waiting list and the longest waits.

Challenges continue across quality metrics including SHMI, hospital-acquired infections and compliance with the sepsis one-hour antibiotic standard. Patient safety remains a central focus during periods of operational pressure.

People indicators including sickness absence and statutory and essential training compliance remain important enablers of sustainable performance. There is continued reliance on bank and agency staffing, particularly in high-pressure areas such as the Emergency Department. While a range of actions are in place to improve attendance management, strengthen rostering controls, and reduce agency usage, the workforce model remains under strain and not yet fully sustainable.

<u>1 Financial Risks</u>
There are no remaining risks for 25/26. New risks have been added to the risk register and will be reported as part of Month 1 26/27.

<u>2 Delivering financial sustainability by addressing our underlying deficit over time</u>
The current underlying deficit is estimated at £47.5m (vs £46.2m last month), the movement results from increased reliance on non-recurrent measures.

Latest published data (to November 2025) shows that Implied productivity is 5.5% (per £) and 2.6% (per WTE) **below** pre-COVID levels, placing the Trust in the second-best quartile of performance nationally on each measure.

Efficiency schemes implemented during the year will yield recurrent full year savings of £22.3m going forward and a 65.8 WTE recurrent reduction.

3 Delivering the 2025/26 committed plan

In Month 12 the Trust reports the Group financial position to NHS England (with the Group made up of the Trust, the Chairty and the Wholly Owned Subsidiary). The Trust's reported deficit YTD at Month 12 was £0.2m, £0.2m adverse to budget. This was offset by a favourable variance of £0.2m for the Wholly Owned Subsidiary, bringing the Group position to be in line with plan.

Within the month 12 position, there were one-off entries for notional pensions uplift, where £23.4m has increased both income and pay expenditure, resulting in a nil effect to the bottom line. Also, as a result of the year end land and buildings revaluation, there has been an impairment cost of £5.1m.

Activity was below plan for New and Follow Up Outpatients and Elective in the month. However, activity remains above plan in the year to date across all 4 points of delivery (elective, new and follow up outpatients and day-cases).

Analysis of agency costs versus the required 40% year on year reduction is included within the pack. Agency costs in month were £0.9m, similar to the previous month. Latest available benchmarking data (month 10) shows the Trust's year to date agency spend amounted to 2.5% of total pay spend. This level is in the worst quartile of performance nationally.

The funded establishment has reduced by 20.2 Whole Time Equivalents (WTE) in month 12. Based on the number of contracted staff, there is a 'vacancy' rate of 6.7% gross (down from 7.1% last month) or 0.1% net of temporary staffing (down from 1.2% last month). These figures reflect a number of roles being 'held' rather than actively recruited to in order to support efficiency savings.

Latest published data (month 8 year to date) shows that Implied productivity is 8.0% (per £) and 8.1% (per WTE) **better** than in the corresponding period for 2024/25, placing the Trust in the best quartile of performance nationally for each measure.

In-year and YTD efficiency savings (which include non-recurrent efficiencies) are in line with plan in-month (£2.3m) and across the full year (£31.4m).

The cash balance is £53.4m against a plan of £15.8m. The increase is as a result of receiving £38.4m of capital PDC monies, not all of which have been paid out as yet.

Capital spend in month is £29.2m and year to date capital expenditure of £65.4m in line with plan.

Recommendations
The Board is asked to receive the report for assurance.

Healthier together – delivering exceptional care for all	
Patients	Regular review and assessment of Trust performance support the delivery of safe and effective services.
People	Regular review and assessment of Trust Performance, support our people to deliver safe and effective care.
Partnerships	This paper has no positive or negative impact on partnerships.
Pounds	Regular review and assessment of Trust Performance, supports delivery of the strategic priority to be sustainable and spend money wisely.

<table>
<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><td colspan="2">Assurance Route</td></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>
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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

March 2026

We care

NHS Oversight Framework 2025/26 Key performance indicators - Access

Access to Services — 8 KPIs — Mean Score: 2.17

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q4 25/26	75.00%	**74.95%**			2.00
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q4 25/26	80.0%	80.2%			1.00
Community Services - Patients waiting over 52 weeks	Jan 26	-	0.00%	H		1.00
ED - Attendances managed within 4 hours QTD	Q4 25/26	78.00%	**69.19%**	H		2.96
ED - Attendances over 12 hours in department QTD	Q4 25/26	-	6.5%			1.52
RTT - Patients waiting 18 weeks or less	Jan 26	-	59.46%	L		2.89
RTT - Patients waiting over 52 weeks	Jan 26	1.00%	**1.98%**			3.04
RTT - Planned v actual 18 week performance	Q3 25/26	0.0%	**-2.4%**			2.96

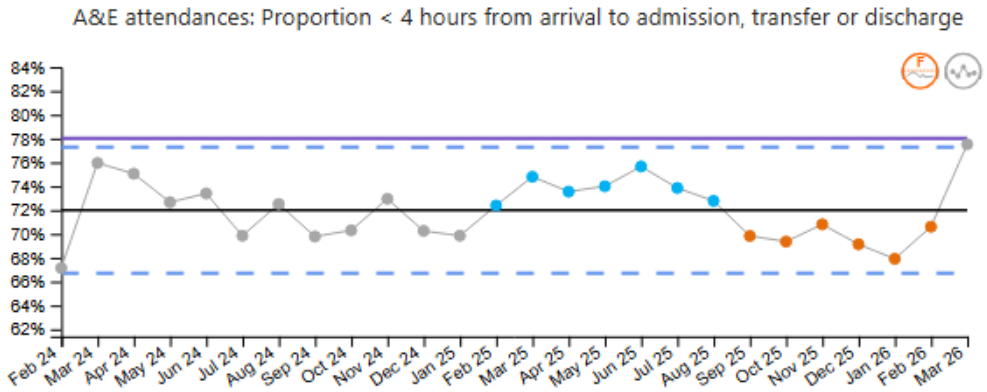
Key performance indicators - Access

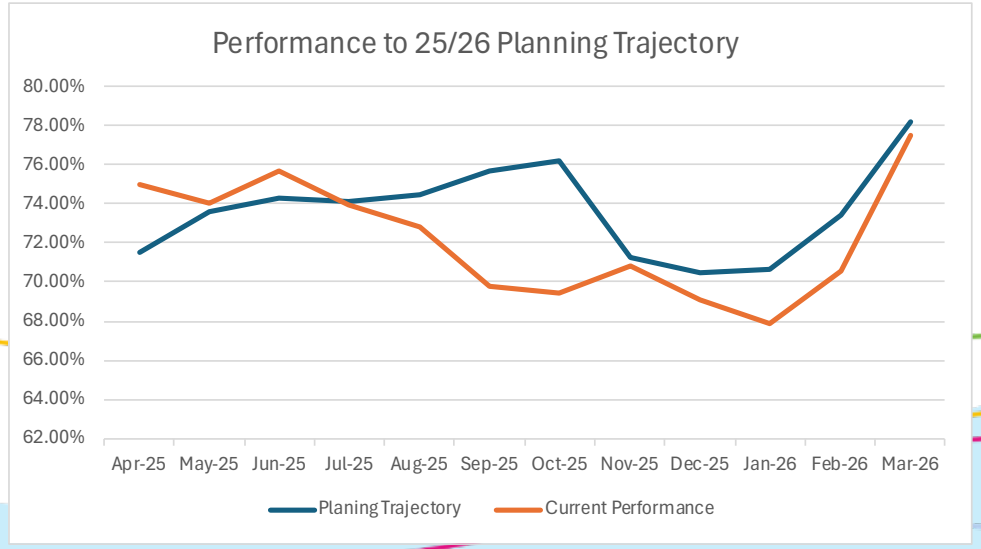
				Current month		
Metric	**Standard 25/26**	**Source & Description**	**Latest month reported**	**Plan**	**Actual**	**Variance**
4 hour in A&E department	78%	NHS Oversight Framework 25/26	Mar-26	78.2%	77.5%	-0.7%
12 hours in A&E department	No more than 2%	NHS Oversight Framework 25/26 NHS Standard Contract 2025/26	Mar-26	2.9%	2.5%	-0.3%
Ambulance handovers within 15 minutes	65%	NHS Standard Contract 2025/26	Mar-26		56.8%	-8.2%
Ambulance handovers within 30 minutes	95%	NHS Standard Contract 2025/26	Mar-26		91.7%	-3.3%
Ambulance handovers over 60 minutes	0%	NHS Standard Contract 2025/26	Mar-26		0.4%	0.4%
Diagnostic waiting times	95%	NHS Oversight Framework 25/26/ NHS Standard Contract 2025/26	Mar-26	40.8%	73.8%	33.0%
Percentage of patients waiting less than 18 weeks from referral to treatment	63.6%	NHS Oversight Framework 25/26	Mar-26	65.8%	61.1%	-4.7%
Under 18s Percentage of patients waiting less than 18 weeks from referral to treatment		NHS Oversight Framework 25/26	Mar-26		69.9%	
Referral to treatment percentage waits over 52 weeks for incomplete pathways	< 1%	NHS Oversight Framework 25/26	Mar-26	1%	2.0%	1.0%
28 day Faster Diagnosis Standard	80%	NHS Oversight Framework 25/26/ NHS Standard Contract 2025/26	Feb-26	81.4%	83.3%	1.8%
31 day decision to treatment for all cancer patients	96%	NHS Standard Contract 2025/26	Feb-26	96.0%	97.8%	1.8%
62 day referral to treatment for all cancer patients	75%	NHS Oversight Framework 25/26/ NHS Standard Contract 2025/26	Feb-26	75.3%	73.9%	-1.5%
Cancelled operations not rebooked within 28 Days	0	NHS Standard Contract 2025/26	Mar-26		4	4
Mixed Sex Accommodation - nationally reported breaches in month	0	NHS Standard Contract 2025/26	Mar-26		0	0

Assurance report

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

Summary of challenges & risks	In March 2026, **77.5%** of patients in ED > 4 hours from arrival before admission, discharge or transfer, against the plan of **78.2%**. The Trust ranked 68th out of 150 acute providers. Attendances were 18,713, against the plan of 18,202 (2.8% above plan). Performance in March 2026 showed a 6.9% improvement compared to February 2026 and was as a result of the UEC Sprint Re-set actions. The improvement actions focussed on improving wait time to senior decision maker and the non-admitted pathways led to an improvement in non-admitted performance from 78.5% in February to 84.1% in March. At site level, the most significant improvement in non-admitted performance was seen at Doncaster, where performance in March was 79.5%, compared to 69.7% in February. The operational oversight and focus on Length of say 0-7 days also led to improvements on the admitted pathway, with overall admitted performance improving from 21% in February to 33.1% in March. At site level, admitted performance at Doncaster improved from 21.9% to 36.6% and at Bassetlaw admitted performance improved from 19% in February to 24.5% in March. **Key challenges:** maintaining consistent wait times to see a senior decision maker over the 24/7 period and specialty reviews taking place outside of the Emergency Department **Risks:** the key risks to performance demand continuing to be above plan, peaks in non-elective admission and delays to discharge
Actions to address risks, issues and emerging concerns relating to performance and forecast	**Key actions** 1. **Wait to be seen time to senior decision maker-** increasing the proportion of patients seen within 60 minutes of arrival, focusing on Early Senior Assessment on arrival and early management plans. 2. **Non admitted pathway** – most patients are discharged from ED therefore a focus on improving the non admitted pathway, reducing delays to assessment / diagnostics / treatment, has a significant impact on overall performance 3. **Operational oversight -** regular touchpoints and tracking all patients over 3 hours with improved escalation / action planning 4. **LoS 0-7 days-** MDT review of care plans / discharge plans for patients in the first 7 days supports earlier discharge and improves patient flow
Action timescales and assurance group or committee	Monthly Reporting to the Finance and Performance Committee The Trust is forecasting to be on track
Risk register	Risk 3437 Timely Access to Emergency Care

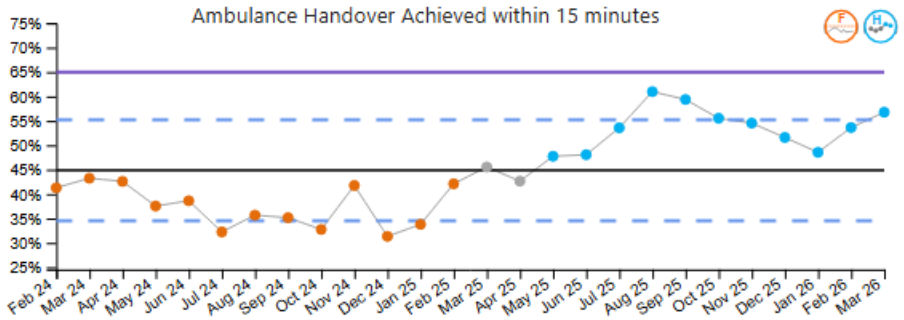


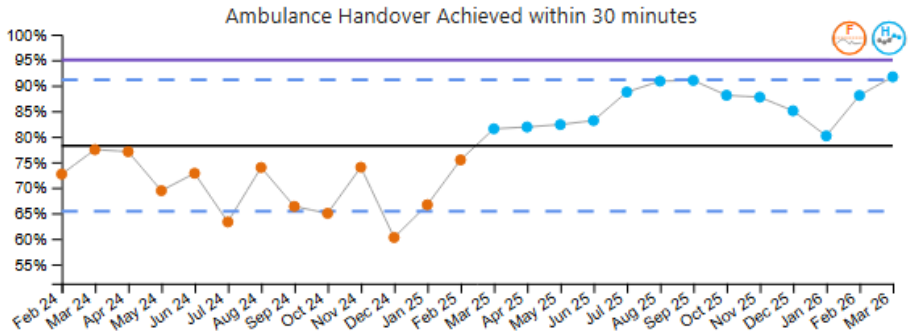


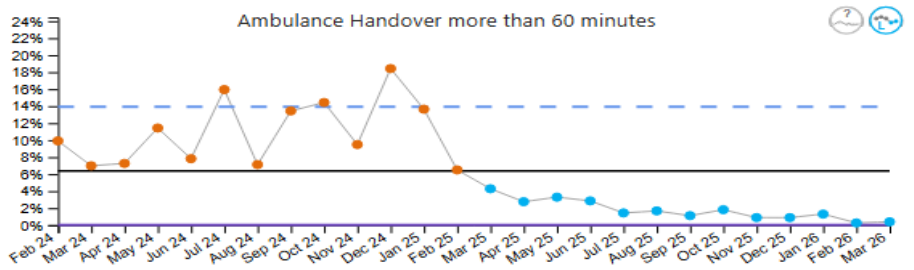
Assurance report

Ambulance handover within 15/30/60 mins

Summary of challenges & risks	In March 2026, there were 3,869 ambulance arrivals to Doncaster and Bassetlaw in total, representing an increase of 267 compared with the previous month. Improvements in ambulance handover performance are noted overall and the Trust is above plan for average handover time. However, the contractual standards for 15 minute, 30 minute and 60 minutes are not yet achieved. Performance in March against contractual standards are summarised below: • 56.8% of handovers were completed within 15 minutes, against the contractual standard of 65% • 91.7% of handovers were completed within 30 minutes, against the contractual standard of 95% • 99.6% of handovers were completed within 60 minutes, against the contractual standard of 100% **Key challenges:** limited capacity at both Emergency Departments for ambulance handover, which is exacerbated when the department is already crowded. The majority of ambulances continue to present to ED with limited options in place currently to present to an alternative location **Risks:** A sustained high rate of ambulance conveyance
Actions to address risks, issues and emerging concerns relating to performance and forecast	1. **Direct access to medical SDEC** – continued improvement work with Acute Medicine / Emergency Medicine and YAS to facilitate direct transfer for patients presenting with respiratory and chest pain symptoms. 2. Increase in **ambulance handover capacity –** escalation capacity remains in place to support peaks in demand 3. **Daily validation of >45-minute** ambulance arrivals, with feedback provided to ambulance trusts where data quality issues are identified
Action timescales and assurance group or committee	Elimination of handovers > 45 minutes - Monthly reporting to the Finance and Performance Committee
Risk register	Risk 3437



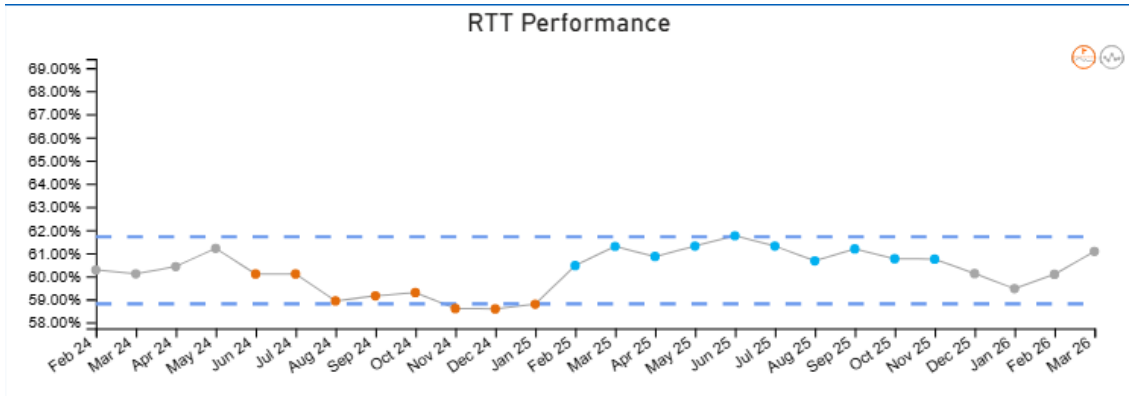


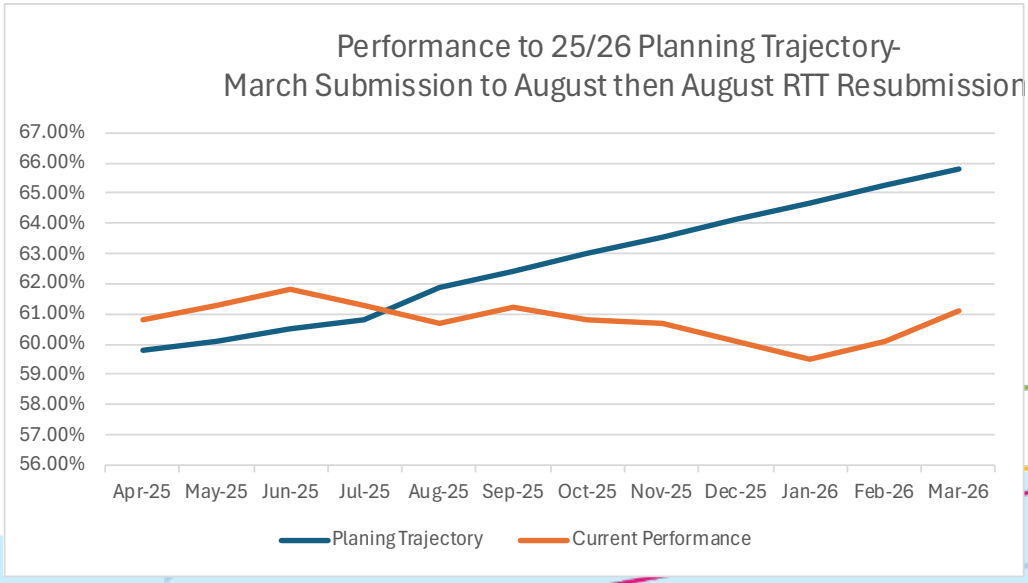


Assurance report

Percentage of patients waiting less than 18 weeks from referral to treatment

Summary of challenges & risks	In March 2026, 61.1% of patients were treated within 18 weeks from referral to treatment, against the plan of 65.8%. The Trust ranked 105th out of 152 acute Trusts. Referral to Treatment (RTT) performance is comprised of admitted and non-admitted pathways, with notable performance variation between the two. Admitted performance in March 2026 was 36.4% and non-admitted performance was at 64.9%. Performance also varies significantly by specialty and the Trust level under performance is largely driven by Trauma and Orthopaedics (T&O), a high volume specialty with c.23% of the total waiting list and a third of all patients waiting > 18 weeks. T&O RTT performance in March was 46%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Key actions to improve performance include: • Completion of demand and capacity modelling in all specialties. T&O is complete and an elective recovery plan developed. Due to be presented April 2026. Gastroenterology, Respiratory, Gynaecology and Ophthalmology modelling has been completed, recovery action plans are to be developed. • **Non-admitted RTT** performance improvement is focussed on outpatient transformation. Key priorities include expanding Advice and Guidance (A&G) and Single Point of Access (SPoA) provision in 2026/27, improving booked clinic utilisation and reducing DNA rates. These actions will support a reduction in waiting times to first appointment. • **Admitted RTT** performance improvement is focused on optimising theatre booking and scheduling, redesign of the pre-op assessment process and reducing on the day cancellations. These actions will support a reduction in waiting times for surgery.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee
Risk register	Risk 3435 Timely access to elective care

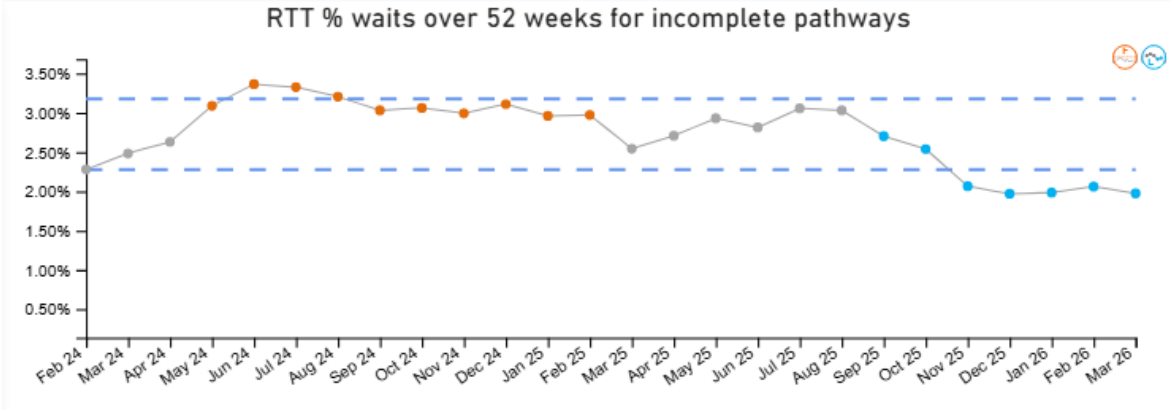


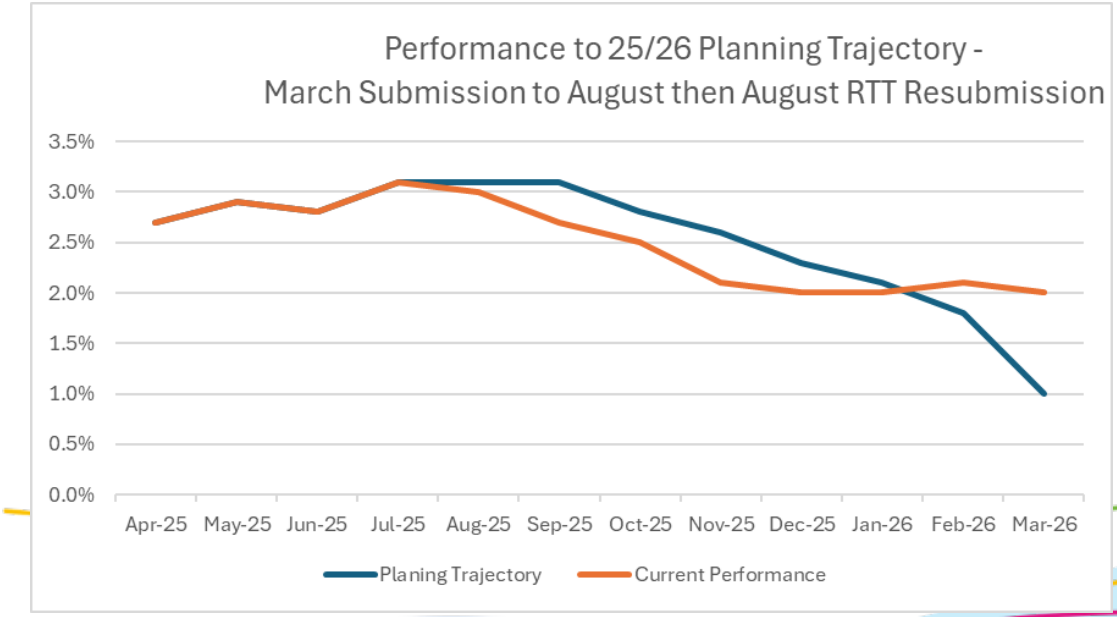


Assurance report

Referral to treatment percentage waits over 52 weeks for incomplete pathways

Summary of challenges & risks	In March 2026, 2.0% of patients on incomplete RTT pathways had been waiting over 52 weeks, exceeding the annual planning trajectory of 1%. A total of 995 patients were waiting longer than 52 weeks at month-end, with Trauma and Orthopaedics (T&O) accounting for c. 80% of these Trauma & Orthopaedics remains the Trust's highest-risk specialty, and without improvement in this speciality is required in order to deliver on the Trust overall performance.
Actions to address risks, issues and emerging concerns relating to performance and forecast	The Trust has a number of recovery actions in place, applicable to all specialties, as well as an elective recovery action plan specific to T&O. The T&O recovery action plan is structured around seven key priority areas, each designed to address the underlying drivers of long waits and improve overall pathway performance. These focus areas target capacity, demand management, productivity, and pathway efficiency, with the aim of reducing 52-week breaches and supporting delivery of the Trust's RTT trajectory: • **PTL Validation:** Twice weekly PTL meetings to review and manage overall size and shape of the T&O PTL . PTL validation to understand the key themes and bottlenecks driving the increasing PTL size • **Capacity Management:** Management and full utilisation of admitted and non admitted capacity to support time to first appointment and time to TCI **Demand Management:** Management of the volume of patients on PTL through appropriate clinical triage. Management of patient pathways to support with discharge initiatives such as one stop clinics and PIFU • **Backlog Recovery:** Enhanced focus on patients 65 weeks and above with twice weekly PTL meetings. Core capacity currently marked and matched against long wait patients. Additional weekend sessions and outsourcing • **Internal Support Teams:** PASS, DQ, Preop and Radiology teams engaged. Capacity and resources required to support action plan delivery discussed and agreed in principle • **Pathway development and redesign:** Exploring pathway redesign schemes to support demand management and improved patient pathways • **Management Team and Delivery:** Identifying the right skills mix to drive forward delivery of the T&O recovery action plan. Identifying the right skills mix to support Orthopaedic elective recovery. Understanding resource challenges within the team
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee continues.
Risk register	Risk 3435 Timely access to elective care

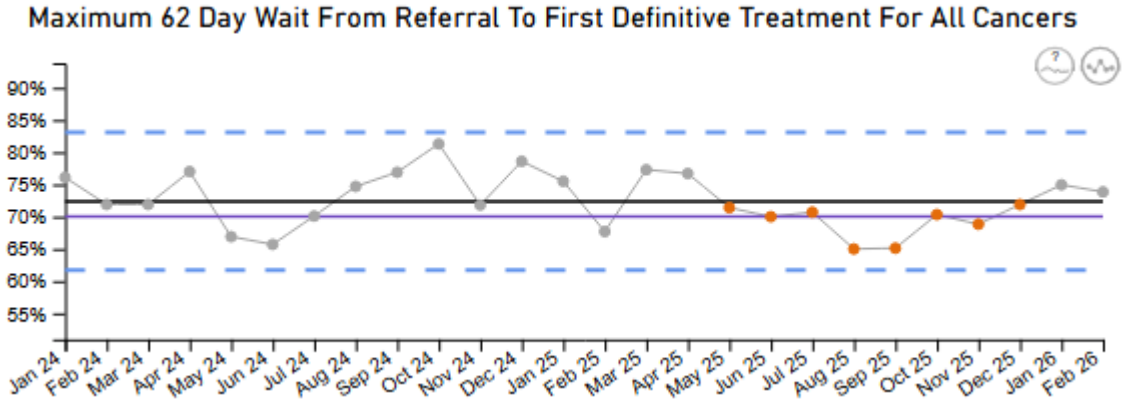


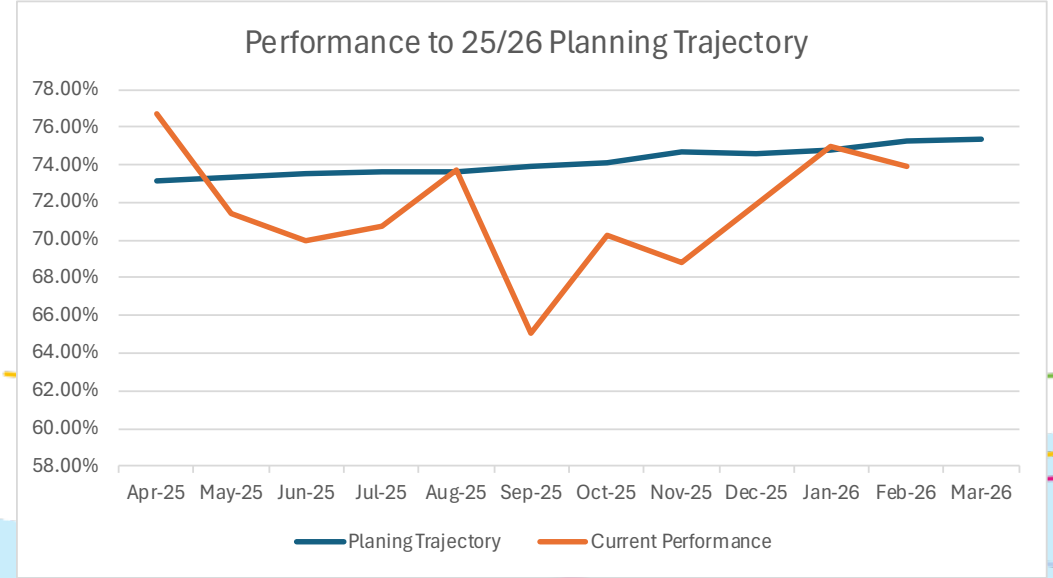


Assurance report

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

Summary of challenges & risks	In February 2026, **73.9%** of patients had a maximum wait of 62 days from referral to first definitive treatment for all cancers against the annual planning trajectory / contractual standard of 75%. The Trust ranked 52 out of 136 acute trusts. There were 208.5 treatments in month, with 54.5 of these taking place > 62 days from referral to treatment. Of the 54.5 breaches, 37.5 occurred within the following tumour sites: prostate (14), breast (9), Lower GI (7.5) and lung (7)
Actions to address risks, issues and emerging concerns relating to performance and forecast	The Trust continues to experience internal delays (radiology) and external delays (histopathology). These delays impact on diagnostic turnaround times and subsequent clinical decision-making. A number of targeted actions are being progressed with the SY Pathology Network. These include strengthening IT infrastructure and system interoperability to improve access, supporting flexible and efficient reporting arrangements. In parallel, a centralised recruitment approach is being undertaken to increase histopathology workforce capacity, with a particular focus on appointing additional histologists to support demand and reduce backlog pressures. Internally, further work is required to understand and address any changes to the demand and capacity profile for radiology. An improvement action plan has been developed and implemented for each tumour site.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee continues
Risk register	

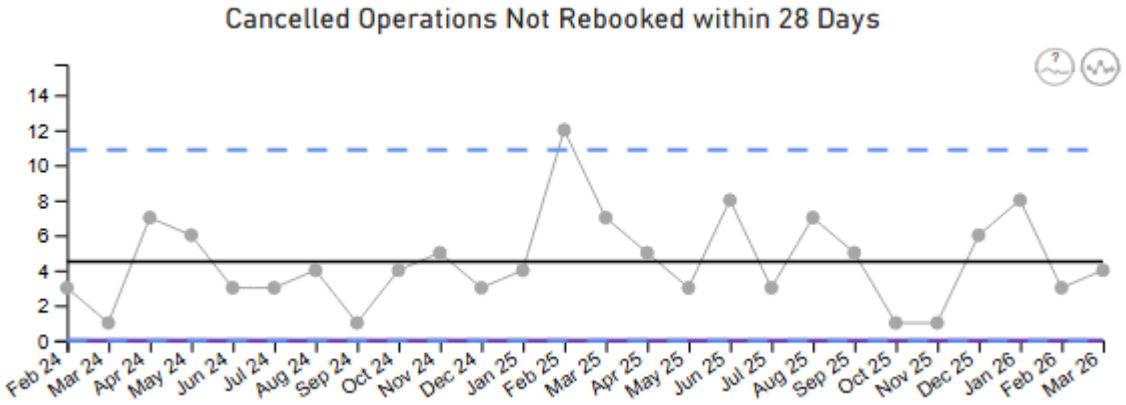




Assurance report

Cancelled operations not rebooked within 28 days

Summary of challenges & risks	There were 4 breaches of the 28-day guarantee in March 2026 against the standard of 0. The SPC chart shows typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	There were 4 breaches of the 28-day guarantee in March 2026, against the annual plan trajectory of zero. The breaches were in the following specialties: 1 x Ophthalmology Cancelled due to lack of time in theatre, re-booked in 28 days and then surgeon sickness resulted in further delay to reappoint 1 x Trauma & Orthopaedics Cancelled due to lack of time in theatre, re-booked in 28 days and then surgeon sickness resulted in further delay to reappoint 2 x General Surgery Cancelled and insufficient capacity to re-book within 28 days Oversight of cancelled operations and re-booking within 28 days is included in the Trust Access Group, chaired by the Head of Elective Care. This will be strengthened through the development of a Standard Operating Procedure (SOP) to formalise a consistent, Trust-wide approach to the management of all cancelled procedures.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	Risk 3435 Timely access to elective care



NHS Oversight Framework 2025/26 Key performance indicators - Quality

Effectiveness & Experience

3 KPIs Mean Score: 2.31

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Avg Days Ready Date to Discharge (inc 0 day delays)	Jan 26	-	0.3			1.40
CQC inpatient survey satisfaction rate	2024	-	4.0			2.00
Summary Hospital Mortality Indicator	Oct 25	-	1.14			3.54

Patient Safety

5 KPIs Mean Score: 2.63

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC Safe inspection score	2026	-	2.0		No Data	3.00
Number of MRSA bacteraemia cases	Jan 26	0	**4**			2.92
Proportion of C-Difficile infections against threshold	Jan 26	1.00	**1.25**			3.03
Proportion of E-Coli bacteraemia against threshold	Jan 26	1.00	**1.05**			2.14
Staff Survey - Raising Concerns sub-score	2024	-	6.53			2.08

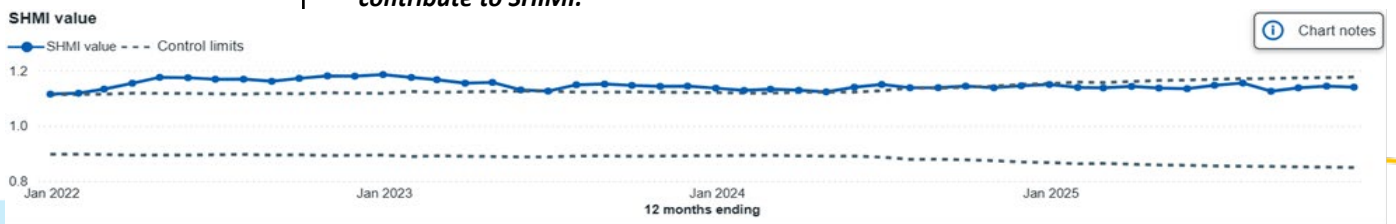
Key performance indicators - Quality

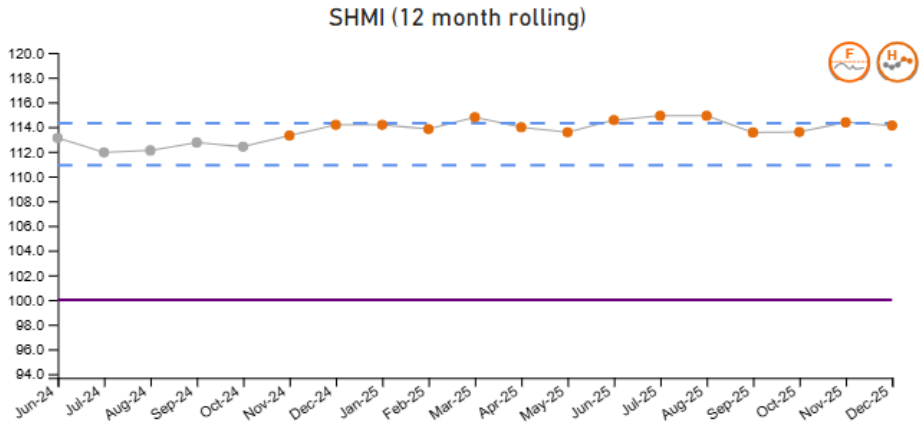
		Current Period			Year to date		
Metric	Month	**Threshold**	**Actual**	**Variance**	**Threshold**	**Actual**	**Variance**
Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling	Dec-25	100	114.1	14.1	100	114.1	14.1
Summary Hospital - Level Mortality Indicator (SHMI) - Monthly	Dec-25	100	104.7	4.7	100	104.7	4.7
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month	Mar-26	1	2	1	14.0	28	14
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month	Mar-26	0	1	1	0	4	4
Number of Hospital Onset Healthcare associated (HOHA) Clostridioides difficile cases in month	Mar-26	4	5	1	64	89	25
Number of Community Onset Healthcare associated (COHA) Clostridioides difficile cases in month							
Overall Number of HAPUs / 1000 bed days	Mar-26		0.96			1.21	
Escherichia coli	Mar-26	6	9	3	94	110	16
Complaints Not Signed Off In Agreed Timeframe	Mar-26	0	0	0	0	1	1
Percentage over 18 in-hospital deaths scrutinised by Medical Examiner Team	Mar-26	100%	100.0%	0.0%	100%	100.0%	0.0%
Venous Thromboembolism - percentage of patients having a Risk Assessment	Mar-26	95%	95.0%	0.0%	95%	96.8%	1.8%
National Institute for Health and Care Excellence (NICE) Guidance Response Rate Compliance	Mar-26	90%	98.9%	8.9%	90%	98.1%	8.1%
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	Mar-26	90%	55.3%	-34.7%	90.0%	49.2%	-40.8%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	Mar-26	90%	40.7%	-49.3%	90.0%	54.2%	-35.8%
Emergency readmissions within 30 days of discharge from hospital (Rolling 12 month)	Mar-26		11.56%				

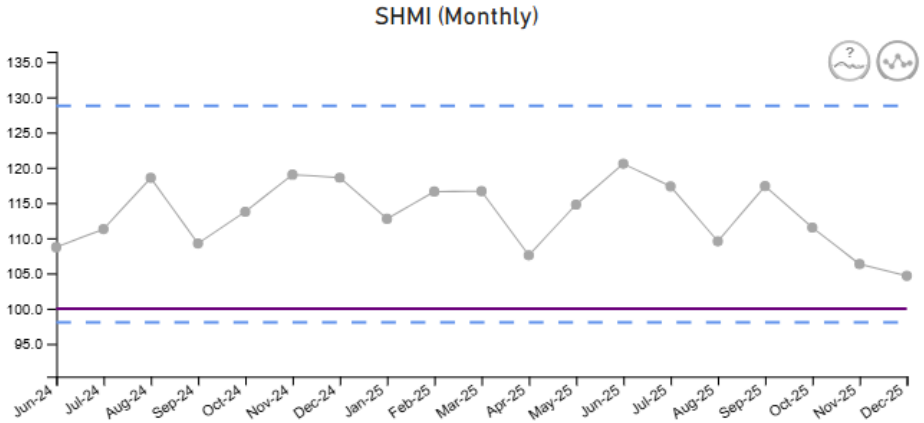
Assurance report

Summary Hospital - Level Mortality Indicator (SHMI)

Summary of challenges & risks	The 12 month rolling SHMI in December 2025 was 114.1 against a trajectory of 100. Monthly SHMI in December 2025 was 104.7 against a trajectory of 100. **SHMI (12 month rolling)** The SPC chart shows results outside the expected range and below the expected level — and in a concerning direction. **SHMI (Monthly)** The SPC chart shows typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Trust is now within the national control limits for SHIMI and have been for >1 year, as shown in graph below taken from the national SHIMI dashboard, also in the limits on Model hospital and HED data. • Further scrutiny on divisional level mortality through PRMs and a dashboard in development which will display SHMI by speciality to identify hotspots for intervention as needed. • ***It should be noted that SHMI does not control for deprivation and we have a large number of patients that are in the highest deprivation quintile. This is nationally recognised to contribute to SHIMI.***
Action timescales and assurance group or committee	Mortality Data Assurance Group and Mortality Governance Group report into Effective Assurance Group and Quality Committee.
Risk register	



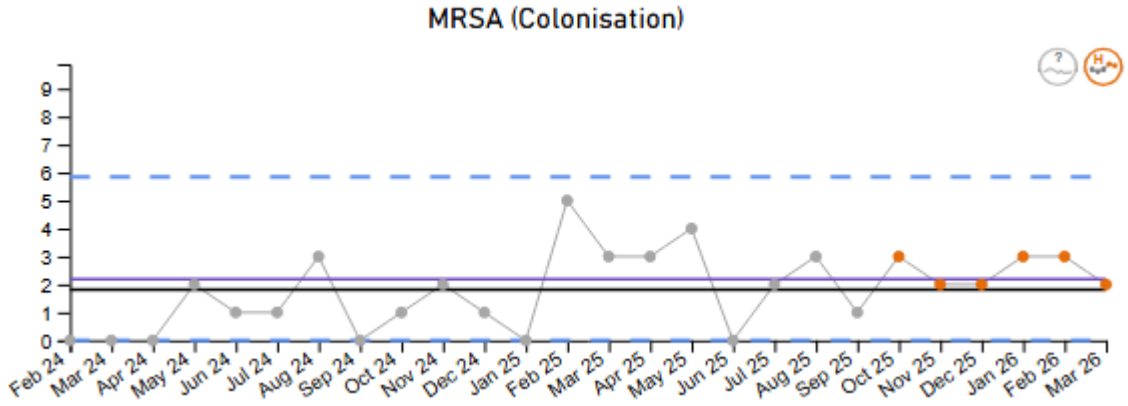


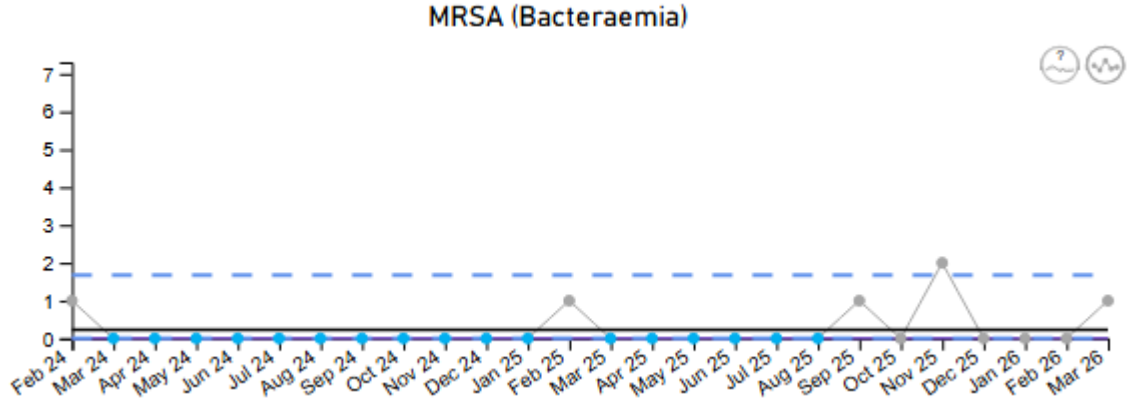


Assurance report

Hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) cases reported in month

Summary of challenges & risks	In March 2026 there were 2 cases of Hospital Acquired MRSA – Colonisation against a trajectory of 1 and 1 case of Hospital Acquired MRSA – Bacteraemia against a trajectory of 0 reported in Month The SPC charts show results outside the expected range, but performance naturally moves around the expected level for MRSA colonisation and for MRSA Bacteraemia typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Promotion of Hand Hygiene through World Hand Hygiene day scheduled for May. IPC team to continue to perform monthly hand hygiene audits. Gloves off campaign. Promotion of Prontoderm Foam use, monitoring compliance through IPC weekly alert reviews. Weekly PICC line surveillance, including Renal/Femoral lines. Strengthened PSIRF process and learning response with all cases presented via Divisional Safety Panels. Continued AMS work with reduction in blood culture contamination rates, working with ED, AMU and paediatrics. Deep cleaning schedule ongoing and monitored by IPC and facilities team. Monitor MRSA screening in admission areas, AMU, FAU, G5 and SAW.
Action timescales and assurance group or committee	HCAI reviews at TWIG and ICOG. Divisional Safety Panels – PSIRF process. Divisional Governance, divisions receiving feedback. IPC dashboard shared with Divisional Nurses monthly.
Risk register	3834

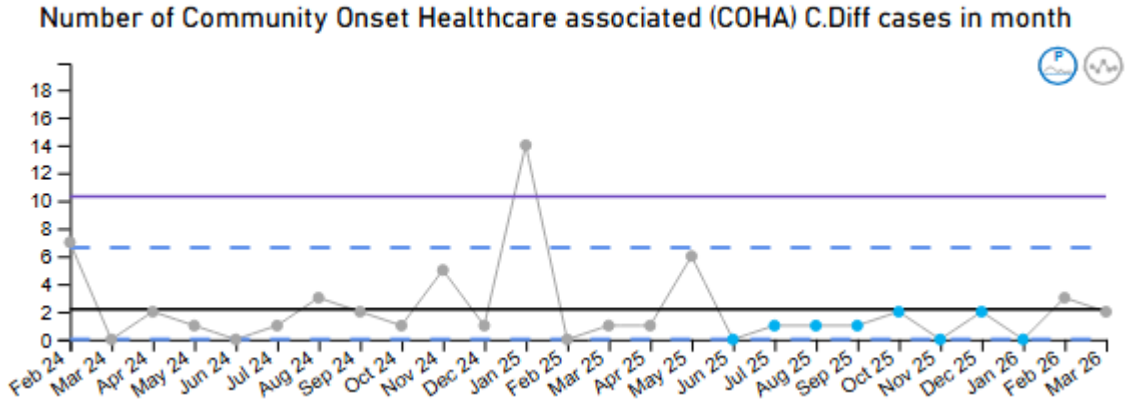


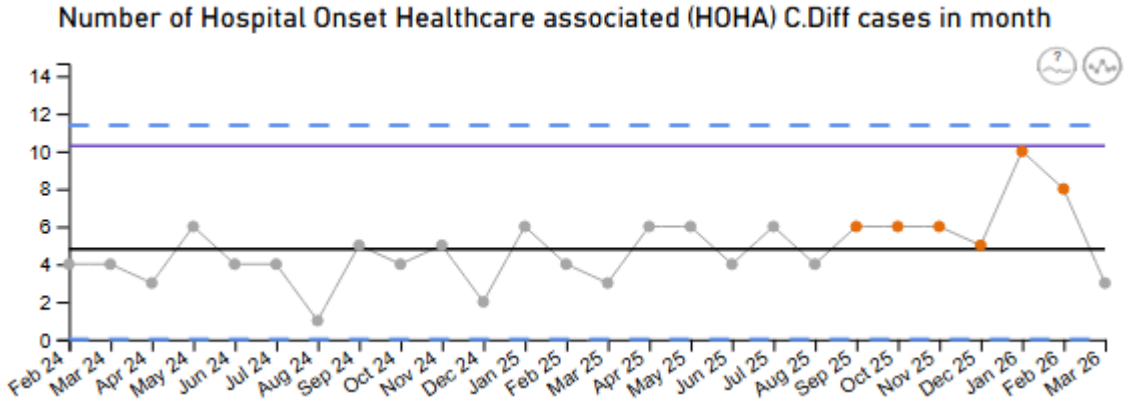


Assurance report

Number of Hospital Onset Healthcare associated (HOHA) and Community Onset Healthcare associated Clostridioides difficile cases in month

Summary of challenges & risks	In March 2026 there were 5 cases of Hospital Onset Healthcare associated (HOHA) and Community Onset Healthcare associated (COHA) Clostridioides difficile cases combined in month, against a target of 4. The SPC charts show typical month-to-month variation, with performance consistently better than the expected level for COHA and for HOHA typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Strengthened antimicrobial stewardship oversight, weekly AMS ward rounds on AMU, PADL, blood culture improvement work which supports good AMS practice. Quarterly antibiotic audits in draft to improve engagement and ownership within divisions. AMS quality priorities identified, reduction of consumption and duration of antibiotics, improve diagnostic stewardship and blood culture pathway. Purchase of Sanondaf equipment to improve bed turnaround times by facilitating faster HPV treatment. Development of a real time dashboard to monitor trends and ward level performance. Health Innovation Project for AMU- reduction in C.Diff rates.
Action timescales and assurance group or committee	Monthly HCAI Review at TWIG and ICOG. Refreshed PSIRF process. All CDI cases to be discussed at Divisional Safety Panels. Divisional level accountability, with divisions receiving feedback.
Risk register	3517

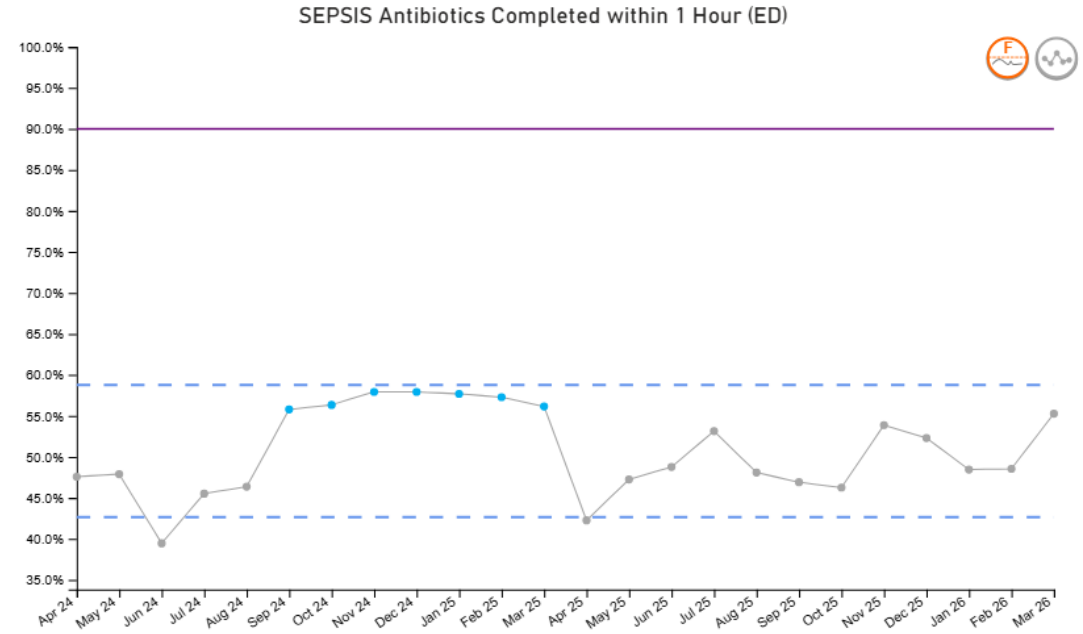


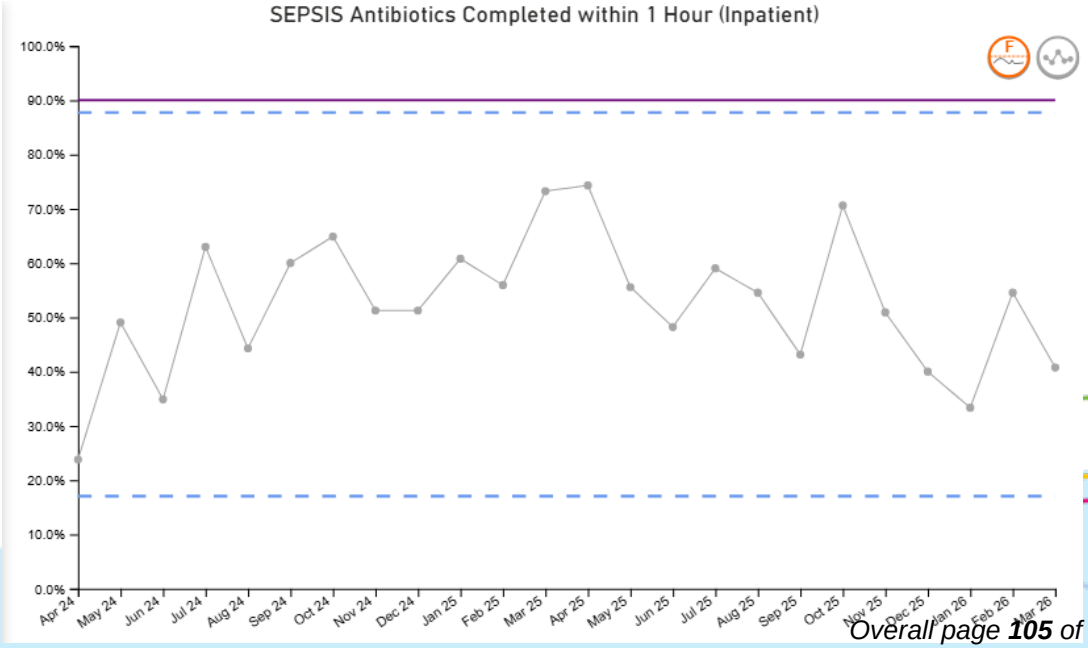


Assurance report

Sepsis antibiotics completed within 1 hour

Summary of challenges & risks	For March 2026, 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 55.3% against a trajectory of 90%, as an Inpatient performance was 40.7% against a trajectory of 90% The SPC charts show typical month-to-month variation, consistently performing below the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Recognition of sepsis remains good however time to first antibiotic continues to fall below the standard. • There is a lot of ongoing education with a recent Sepsis Summit being held. • We have a focus on neutropenic sepsis and are increasing monitoring, as well as reviewing the Sepsis Action Group's actions through the Patient Safety Assurance Group. • SHMI for Sepsis is 1.03 in the month ending November 2025 (last period for national sepsis reporting) this is within the national control limits
Action timescales and assurance group or committee	Sepsis Action Group reports into Mortality Governance Group



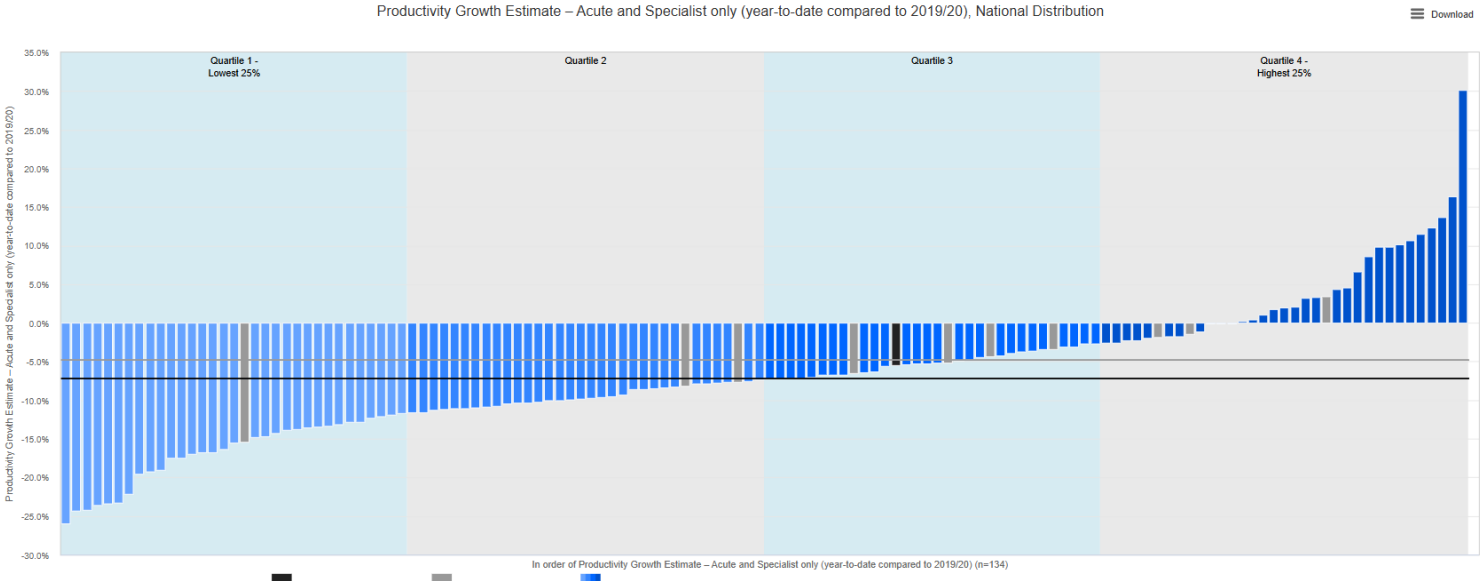


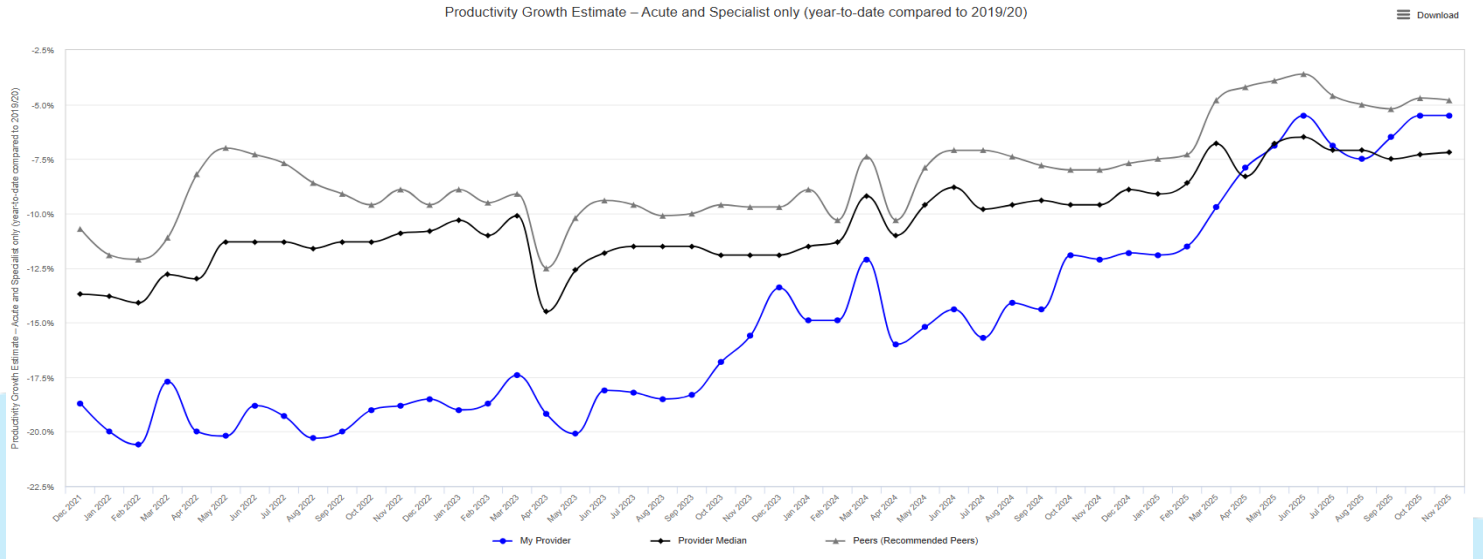
Key performance indicators - Finance

Metric	Basis for plan	Latest month reported	Plan £'000	Actual £'000	Variance £'000
YTD Surplus/(Deficit)		Mar-26	0	17	17
YTD ERF Income earned		Mar-26	122,340	127,845	5,505
YTD CIP delivery		Mar-26	31,397	31,397	0
YTD Total pay spend		Mar-26	441,645	446,390	4,745
Included within above overall pay position:					
YTD Bank pay	*10% reduction on 24/25 spend*	*Mar-26*	*16,153*	*17,229*	*1,076*
YTD Agency pay	*40% reduction on 24/25 spend*	*Mar-26*	*8,054*	*11,752*	*3,698*
YTD Capital Investment		Mar-26	65,391	65,391	0
Cash balance		Mar-26	15,815	53,438	37,623
YTD Payment policy (BPPC metrics) (1)	To pay 95% of invoices by the due date	Mar-26	95.0%	79.6%	-15.4%

(1) This covers both NHS and Non NHS invoices and is calculated on a value basis

Implied Productivity (per £ compared to pre-COVID levels)





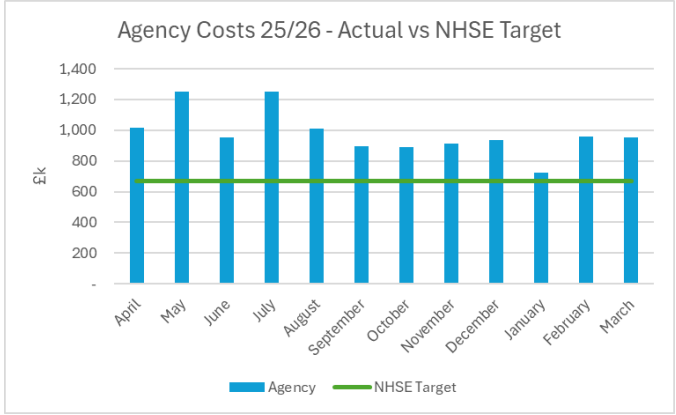
The most recently published data (M8 YTD) shows DBTH implied productivity is 5.5% below pre-covid (2019/20) levels (last month: 5.5%). This places the Trust in the second-best quartile of performers nationally and is better than the national median (-7.2%) but worse than the median of the group of peer Trusts selected by NHS England (-4.8%).

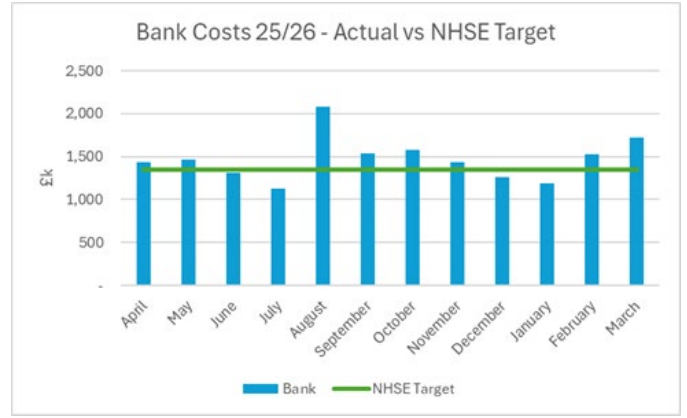
The peer includes:
Bradford Teaching Hospitals (-15.4%)
Barnsley Hospital (-8.2%)
Sherwood Forest Hospitals (-7.6%)
Bolton Hospital (-6.5%)
Wrightington, Wigan and Leigh Hospitals (-5.2%)
North Tees and Hartlepool (-4.3%)
Northern Lincolnshire & Goole (-3.4%)
Wirral University Hospital (-1.8%)
County Durham & Darlington (-1.4%)
East Sussex (+3.4%)

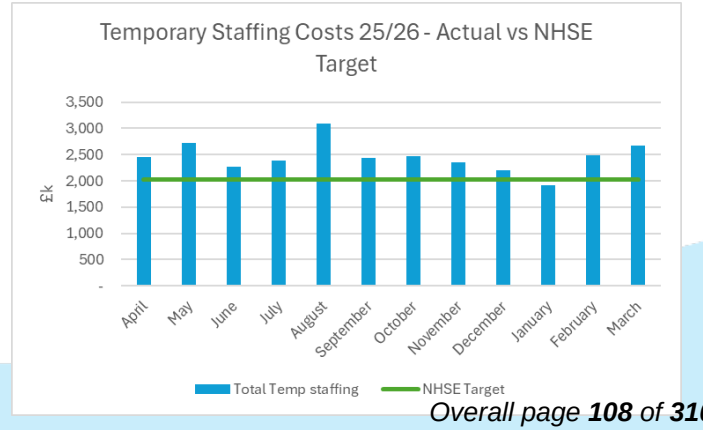
Assurance report

Pay spend

Summary of challenges & risks	Winter pressures – requests for additional cover plus increased sickness Bank - pay awards have increased spend although there has been a reduction in volumes CQC recommendations actioned immediately in ED Timescale to implement NMNC Direct Engagement Model Continued high demand of bank and agency against sickness and vacancy
Actions to address risks, issues and emerging concerns relating to performance and forecast	Maintaining tight vacancy control Improving attendance management Rostering tighter controls in line with the Rostering Road Map – implementation of two-tier approval now complete across all divisions, review of HCA bank request controls, review of controls related to roster finalisations, improve interface usage between roster and NHSP for NMNC Data interrogation between bank and agency request reasons and actual sickness and vacancy rates Tighter controls on budget approval for medics to reduce requests outside of system approval Implementation of Holt/ Health Rota interface in ED with plans to expand to Division of Medicine New approach to filling medical vacancies – review of hard to fill vacancies and consideration of engaging with Holt as master vendor for permanent recruitment. Implementation of direct engagement model for Agenda for Change NMNC agency workers, working with other SY trusts Internal control process on usage and spend being re-reviewed – SOP review completed, awaiting final sign off Joint working with system partners, temporary staffing reduction joint working group held with common actions/ themes identified for further investigation Standardisation of internal locum rates in year, to have a follow up review later in the year Collaborative medic rate card established with a 3-year incremental reduction plan Reinstatement of Nursing and Medical Check and Challenge Meetings in all areas Review ED budget and roster templates in response to changes related to CQC recommendations
Action timescales and assurance group or committee	Ongoing efficiency workplan throughout the year Monthly Pay Efficiency Workstream Steering Group feeding into DBTHi Executive Accountability Meeting Monthly tracking of all actions via Monday.com F&P monthly updates F&P Deep Dive (23/1/26)
Risk register	







Assurance report

Payment policy

Summary of challenges & risks	Trusts are monitored on the value of invoices paid within 30 dates of being received. The Trust has to balance maintaining cash levels and good supplier relations.
Actions to address risks, issues and emerging concerns relating to performance and forecast	On weekly payment run meetings, supplier relationships are discussed and payment terms are reviewed. The level of cash balance and detailed cash flow is reviewed.
Action timescales and assurance group or committee	Daily review of cash balances. Item continues to monitored at Cash Committee on a monthly basis and reported in the monthly Finance Report at Finance and Performance Committee.
Risk register	

Invoice Turnaround

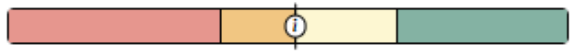
Average days	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Between date of invoice and date available on system	13.5	19.8	16.6	12.6	16.3	18	16.5
Between being available on system and approval	8.2	8.1	13.4	12.1	25.7	12.7	10.85
Between approved date and payment date	21.2	20.6	18.8	16.5	18.6	18.9	23.39
Total	42.9	48.5	48.8	41.2	60.6	49.6	50.74
Total that the Trust has control over	**29.4**	**28.7**	**32.2**	**28.6**	**44.3**	**31.6**	**34.24**
Number of invoices	*6,901*	*7,468*	*10,728*	*7,054*	*7,474*	*9,726*	*8,392*

Better Payment Practice Code (In month)

Average days	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
NHS - %age based on invoice count	77.48%	86.83%	85.85%	59.09%	86.61%	90.34%	84.37%
NHS - %age based on invoice value	74.98%	78.40%	92.50%	50.37%	88.02%	86.94%	82.88%
Non NHS - %age based on invoice count	39.42%	41.96%	34.23%	40.95%	34.95%	39.08%	38.22%
Non NHS - %age based on invoice value	78.31%	79.68%	80.47%	65.41%	78.77%	79.04%	77.11%
Overall - %age based on invoice count	40.05%	43.42%	36.01%	41.18%	36.50%	40.15%	39.49%
Overall - %age based on invoice value	78.01%	79.59%	82.79%	64.97%	79.92%	79.63%	77.56%

NHS Oversight Framework 2025/26 Key performance indicators - People

People & Workforce — 2 KPIs — Mean Score: 2.77

Key Performance Indicator	Period	Target	🏆	SPC	Segment Position	Score
Sickness Absence Rate QTD	Q3 25/26	-	5.42%			2.40
Staff Survey - Engagement Theme Score	2024	-	6.74			3.14

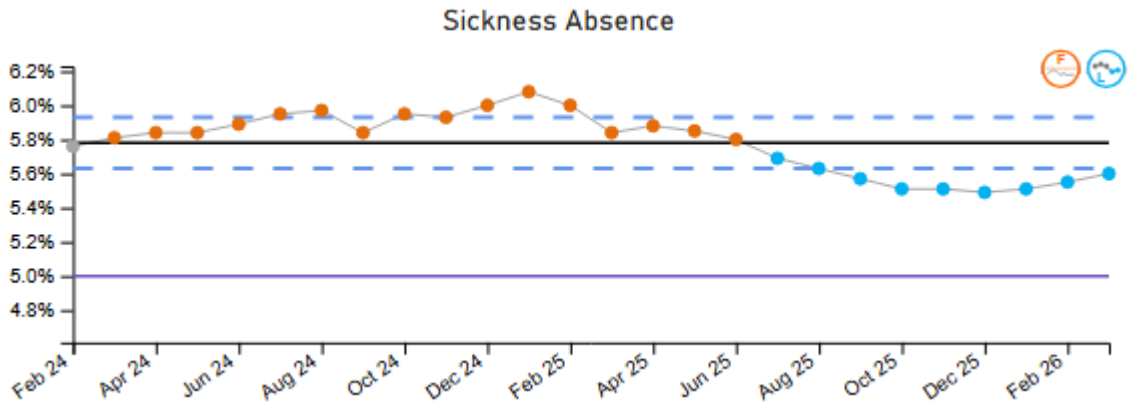
Key performance indicators - People

				Current month		
Metric	**Standard 25/26**	**Source & Description**	**Latest month reported**	**Local trajectory**	**Actual**	**Variance**
Employee Turnover	10%	NHS Long Term workforce plan	Mar-26	10.0%	9.3%	-0.7%
Overall Sickness Absence	5%	DBTH Trust agreed	Mar-26	5.0%	5.6%	0.6%
Completed Statutory and Essential Training (SET)	90%	DBTH Trust agreed	Mar-26	90.0%	84.1%	-5.9%
Medical Appraisals completed	90%	NHS England	Mar-26	90.0%	100.0%	10.0%

Assurance report

Sickness Absence

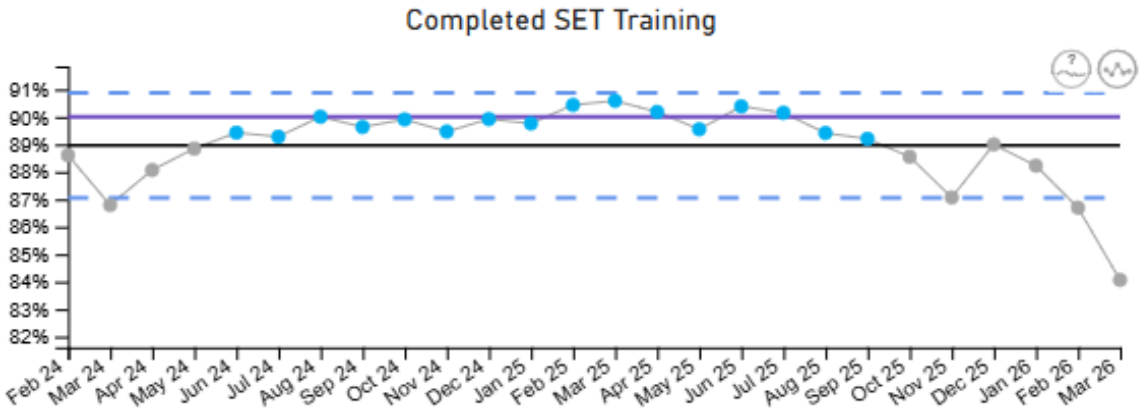
Summary of challenges & risks	Trust wide Sickness absence in March 2026 was 5.6% against at target of 5% The SPC chart shows results outside the expected range but still below the expected level. The trend continues to show an improving position and shows a reduction.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Continued work to revise the sickness absence policy with a move to Supporting Attendance at Work, ongoing engagement with Staff Side colleagues during Q3/4 to agree changes. Plan to go back to Policy Formulation Group in Q1. • Number of changes to the approach and detail in the policy to build on improvements to absence management achieved in past two years • Suite of training and managers briefings planned to promote and launch the policy once finalised • Regular KPI clinics for managers being provided through People & OD. • Overall rates reviewed with Exec oversight at the Performance Review Meetings • Improvement work ongoing supporting absence management for medical colleagues with input from medical leaders
Action timescales and assurance group or committee	• Policy due for discussion and ratification at Policy Formulation Group (PFG) in May 2026 • All actions with deadlines 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
Risk register	2554



Assurance report

Completed Statutory and Essential Training (SET)

Summary of challenges & risks	In March 2026 Trust SET training compliance was 84.1% against a trajectory of 90% The SPC chart shows typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• Commissioned a deep dive 360 audit – feedback due end of April • New Mandatory and Learning Oversight Group (MLOG) introduced from June (aligning to the national timelines) • Concluded the Resus deep dive work – actioned due to this being an area of lower compliance. Findings and recommendations to be shared with Exec Team in Q1 • Executive oversight of compliance rates at Performance Review Meeting agenda • Included within the appraisal documentation to assist in improving engagement and monitoring during appraisal season • 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	• Education report presented to People Committee meeting in April 2026 and at every meeting • NHSE project work in line with national timescales during 2025/26. • Workforce & Education Group reports – every meeting • 360 Assurance audit – Q4 commencement, Q1 completion
Risk register	16



Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Finance And Activity Report

March 2026

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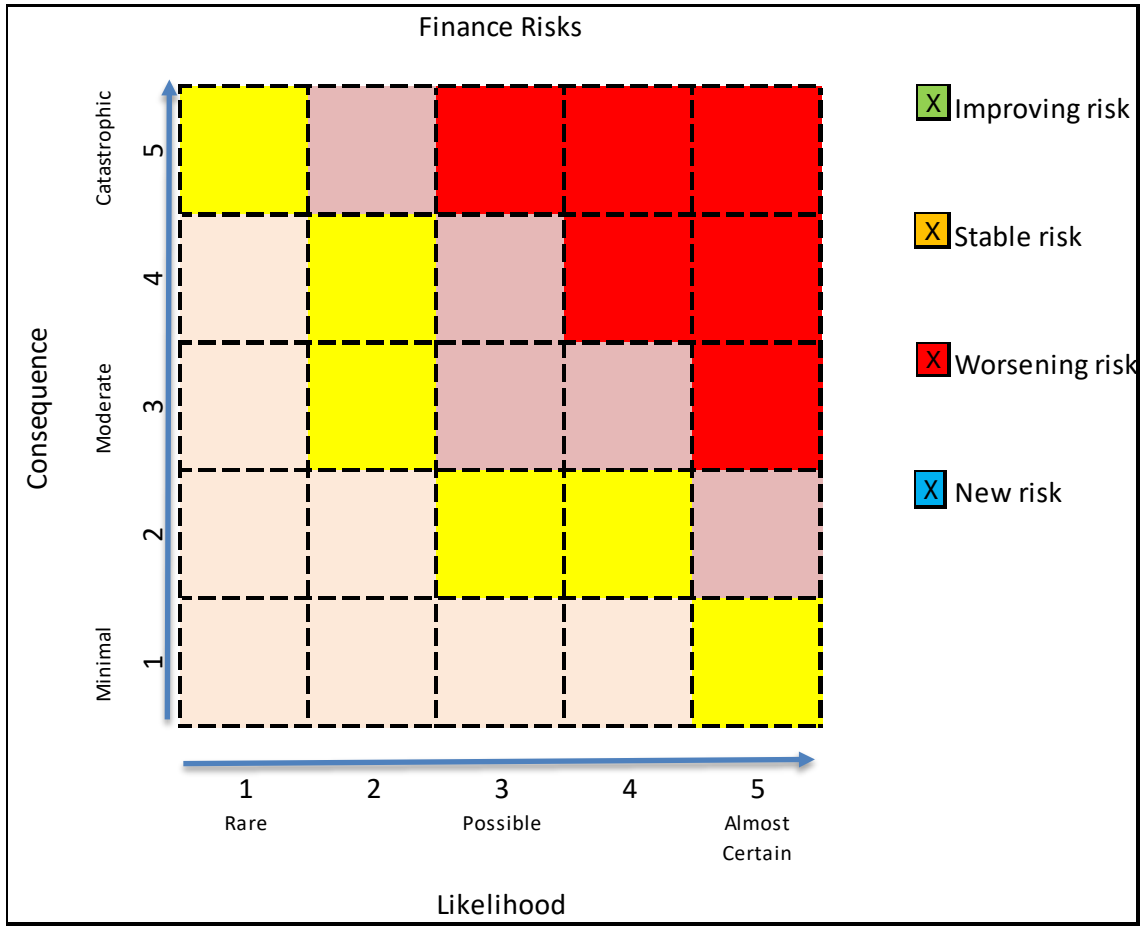
SECTION 1
Financial Risks

Financial Risks



Ref	Title
A	25/26 PMO2 Financial services don't complete financial analysis of identified schemes within agreed timescales delaying schemes
B	25/26 PMO3 - Monday.com system failure resulting in the loss of project information
C	25/26PMO1 Lack of engagement/capacity from operational services to deliver project objectives/CIP schemes not delivering savings
E	Failure to achieve compliance with financial performance and achieve 25/26 financial plan
F	Failure of Overseas Team Database to ensure accurate recording of 25/26 overseas patients by ensuring the database is supported
G	Failure to capture all 25/26 NHS revenues may result in reduction in payments by commissioners
H	Failure to deliver 25/26 Capital Programme including inability to meet Trust's needs for capital investment
I	Failure to deliver 25/26 Cost Improvement Plans impact on the Trust's deliver of financial targets
J	Failure to provide accurate and timely 25/26 financial information to Board and other stakeholders
K	Insufficient cash funds in 25/26 to pay staff, suppliers and replace/invest in capital
L	Non-delivery of 25/26 activity targets impacting on levels of income received by the Trust
M	Poor performance of Shared Business Services may lead to non-payment of invoices 25/26 and reputational damage
O	Incomplete counterfraud checks may lead to hiring unsuitable staff, risking financial and reputational harm
P	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust

Updates

- Removed risks – All risks greyed out in the table have been removed following the completion of the 2025/26 year.

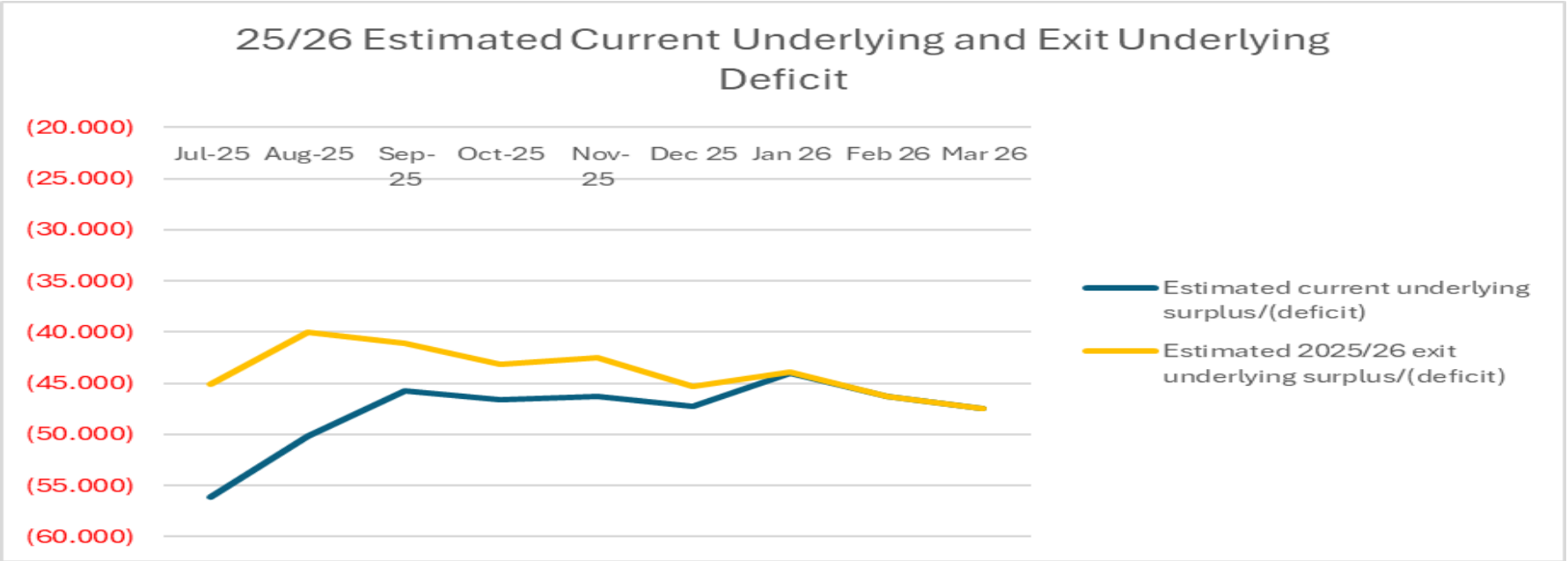
- The risks for 2026/27 are currently being worked on and will be updated for the April 2026 report.

SECTION 2
Delivering financial sustainability by addressing our underlying deficit over time

Underlying Deficit

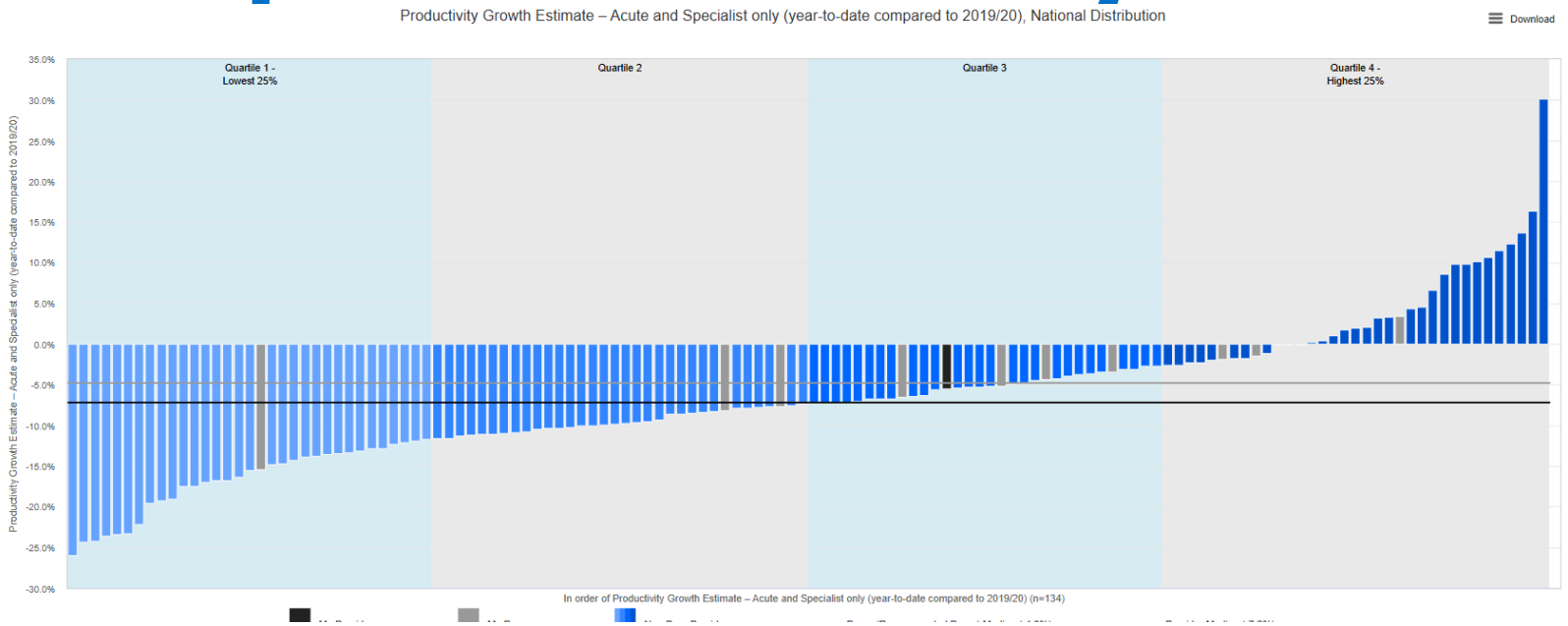
The table provides the estimated underlying deficit as well as the exit rate.

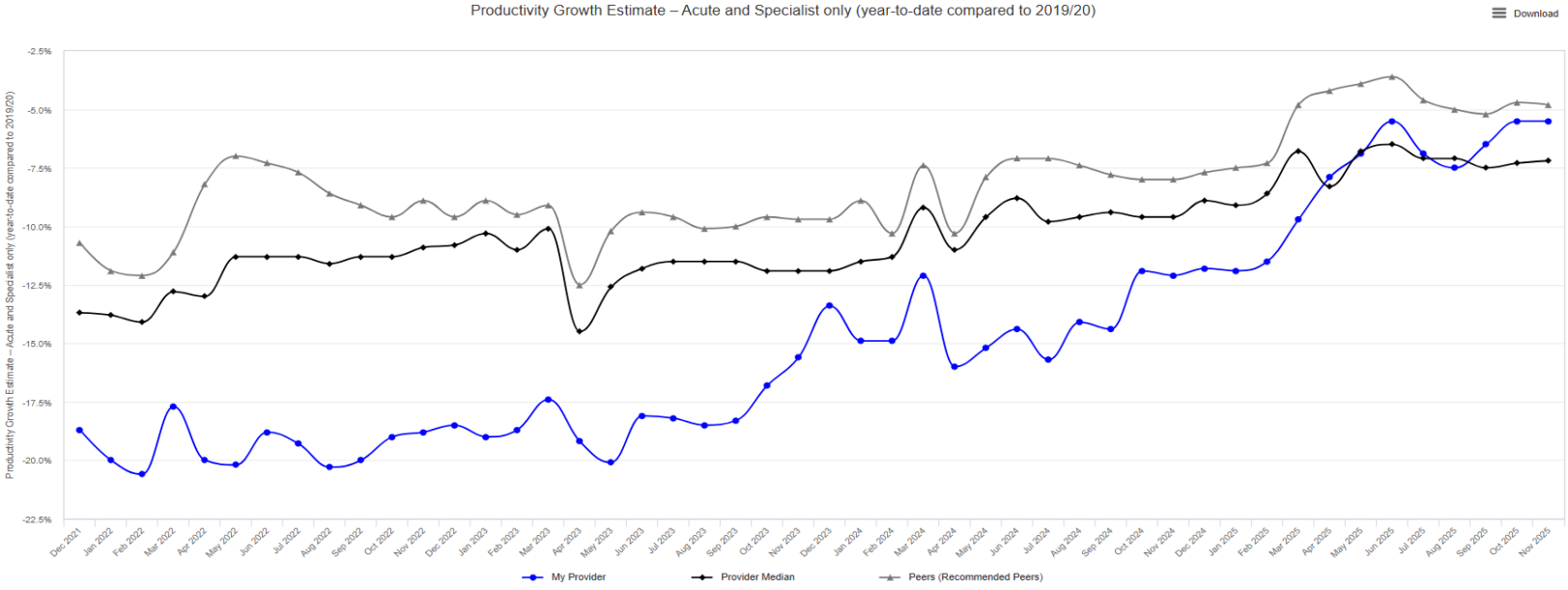
The underlying deficit is estimated at £47.5M.



Estimated Underlying surplus/(deficit)	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec 25	Jan 26	Feb 26	Mar 26
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
YTD reported adjusted surplus/(deficit)	(1.856)	(1.708)	1.182	1.737	1.368	1.070	(0.625)	(2.360)	0.017
Less YTD DSF (£17M)	(5.667)	(7.083)	(8.500)	(9.917)	(11.333)	(12.750)	(12.750)	(12.750)	(17.000)
Less YTD NHSE 24/25 brokered support (£10M)	(5.502)	(6.063)	(6.624)	(7.184)	(7.745)	(8.305)	(8.866)	(9.426)	(9.986)
Less YTD CIP	(9.349)	(12.826)	(16.181)	(19.383)	(22.117)	(24.426)	(26.730)	(29.056)	(31.397)
Less Other Non-Recurrent Support	(0.146)	(0.510)	(2.429)	(4.247)	(5.023)	(7.507)	(7.507)	(9.273)	(11.393)
Subtotal	**(22.520)**	**(28.190)**	**(32.552)**	**(38.994)**	**(44.850)**	**(51.918)**	**(56.478)**	**(62.866)**	**(69.760)**
Extrapolated to full year	(67.559)	(67.657)	(65.104)	(66.846)	(67.275)	(69.224)	(67.774)	(68.581)	(69.760)
Add Recurrent CIP FYE (implemented already)	11.400	17.500	19.300	20.200	21.000	22.000	23.800	22.300	22.300
Estimated current underlying surplus/(deficit)	**(56.159)**	**(50.157)**	**(45.804)**	**(46.646)**	**(46.275)**	**(47.224)**	**(43.974)**	**(46.281)**	**(47.460)**
Remove Recurrent CIP FYE (implemented already)	(11.400)	(17.500)	(19.300)	(20.200)	(21.000)	(22.000)	(23.800)	(22.300)	(22.300)
Add Recurrent CIP FYE (full year forecast)	22.438	27.627	23.968	23.682	24.719	23.916	23.874	22.333	22.300
Estimated 2025/26 exit underlying surplus/(deficit)	**(45.121)**	**(40.030)**	**(41.136)**	**(43.164)**	**(42.556)**	**(45.308)**	**(43.900)**	**(46.248)**	**(47.460)**

Implied Productivity (per £ compared to pre-COVID levels)





The most recently published data (M8 YTD) shows DBTH implied productivity is 5.5% below pre-covid (2019/20) levels (last month: 5.5%). This places the Trust in the second-best quartile of performers nationally and is better than the national median (-7.2%) but worse than the median of the group of peer Trusts selected by NHS England (-4.8%).

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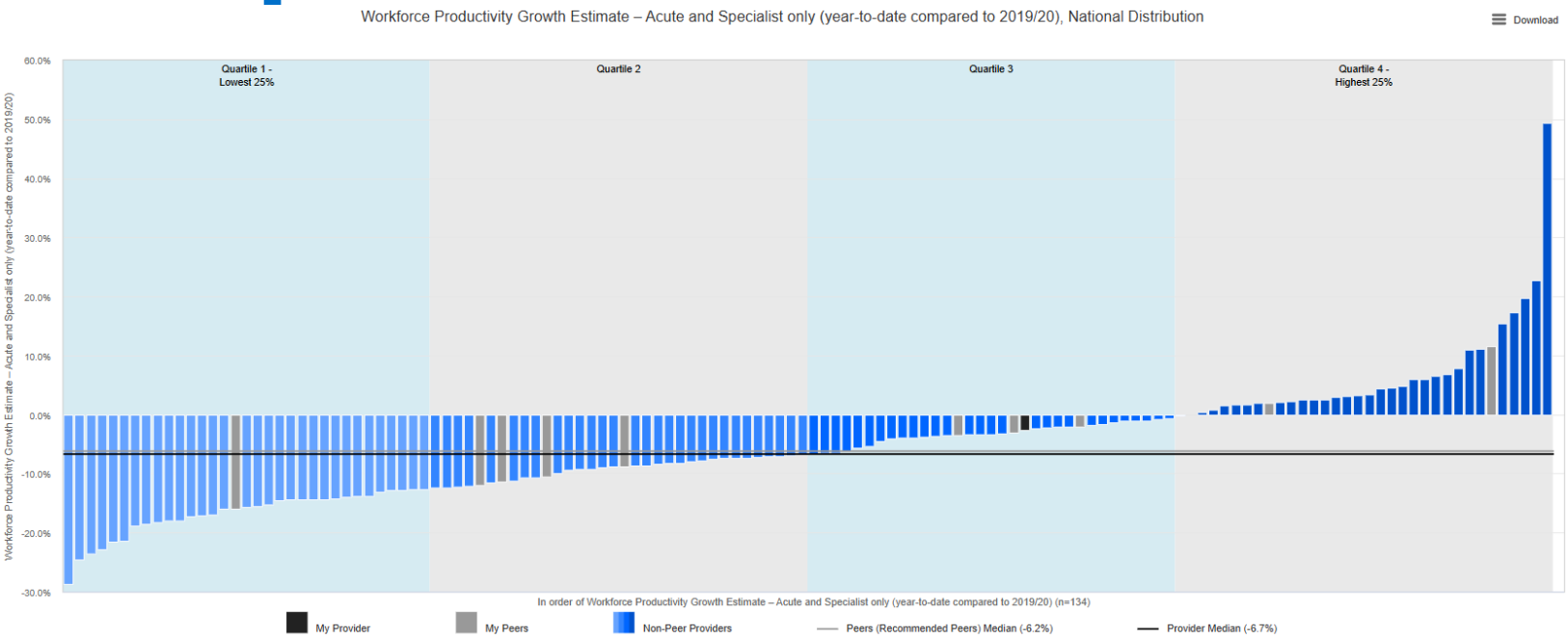
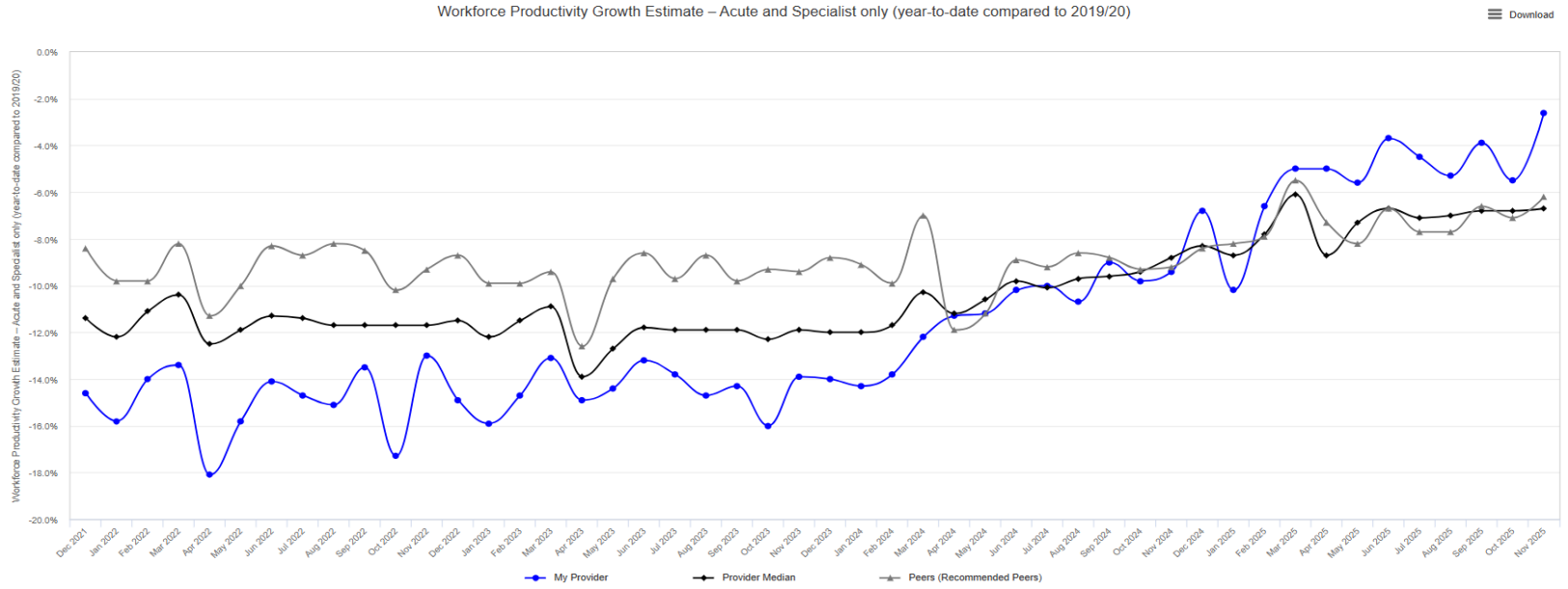
Sherwood Forest Hospitals (-7.6%)
Bolton Hospital (-6.5%)
Wrightington, Wigan and Leigh Hospitals (-5.2%)
North Tees and Hartlepool (-4.3%)
Northern Lincolnshire & Goole (-3.4%)
Wirral University Hospital (-1.8%)
County Durham & Darlington (-1.4%)
East Sussex (+3.4%)

Implied Workforce Productivity (per WTE compared to pre-COVID levels)





The most recently published data (M8 YTD) shows DBTH implied workforce productivity 2.6% below pre-covid (2019/20) levels (previously -5.5%). This places the Trust in the second-best quartile of performers nationally and is better than both the national median (-6.7%) and the median of the group of peer Trusts selected by NHS England (-6.2%).

The peer group includes:
Bradford Teaching Hospitals (-15.9%)
Barnsley Hospital (-11.9%)
County Durham & Darlington (-11.3%)
Sherwood Forest Hospitals (-10.5%)
Wrightington, Wigan and Leigh Hospitals (-8.8%)
North Tees and Hartlepool (-3.5%)
Northern Lincolnshire & Goole (-3.0%)
Wirral University Hospital (-2.1%)
Bolton Hospital (+2.0%)
East Sussex (+11.5%)

Efficiency Programme

In terms of recurrent full year effect:

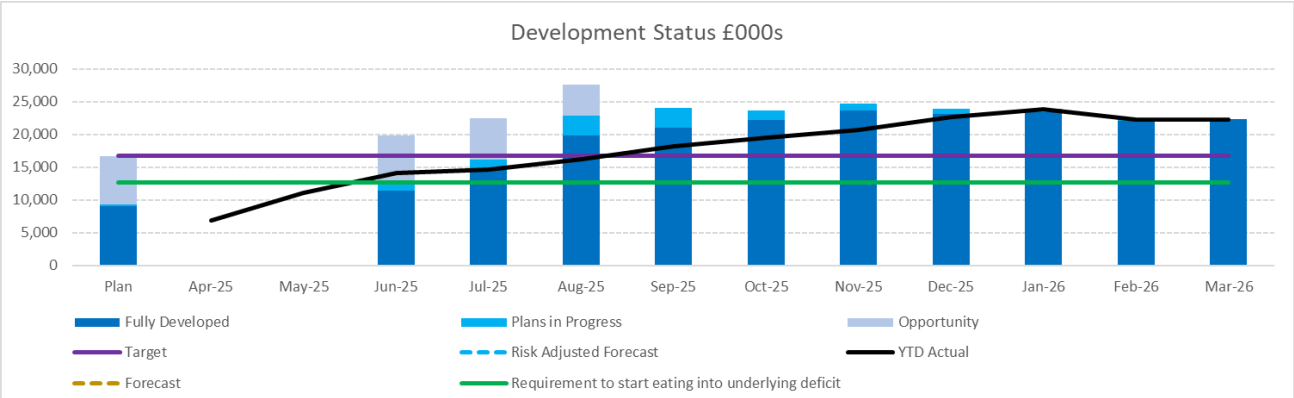
- Savings beyond £12.7m will start to eat into the Trust's underlying deficit, planned delivery was £16.7m.
- Schemes implemented in year have a recurrent full year effect of £22.3m which exceeds plan and addresses £9.6m of the Trust's underlying deficit.
- The committed plan is to reduce recurrent establishment by 252.1 WTE recurrently, at the end of month 12 we have delivered a recurrent reduction of 65.8 WTE.

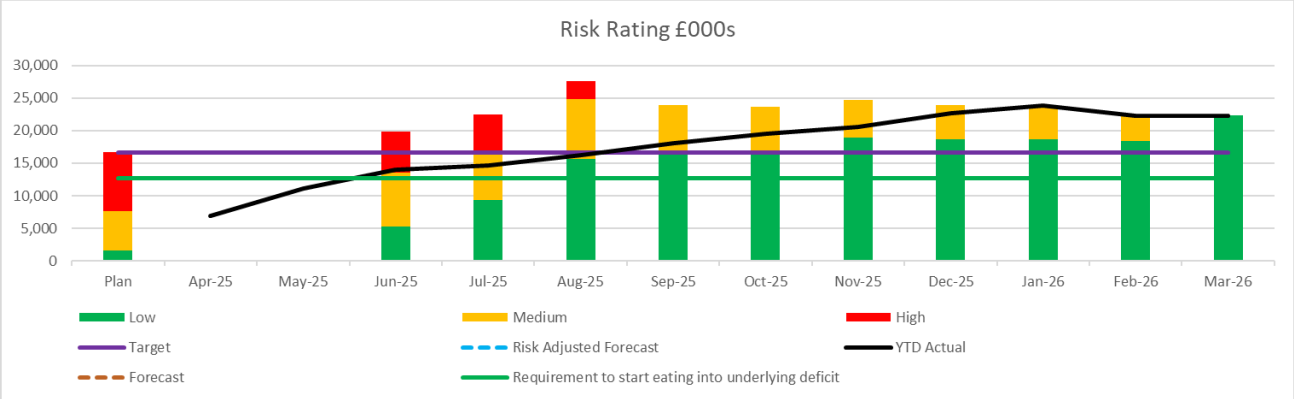
Efficiency Schemes – Recurrent FYE (£)

Recurrent FYE £000's	April Plan Submission	Month 10	Month 11	Month 12	Increase (Decrease)
Fully Developed	9,008	23,366	22,101	22,287	186
Plans in Progress	278	508	232	0	(232)
Opportunity	7,402	0	0	0	0
Unidentified	0	0	0	0	0
Total	**16,688**	**23,874**	**22,333**	**22,287**	**(46)**

Recurrent FYE £000's	April Plan Submission	Month 11	Month 12	Increase (Decrease)
High	9,083	0	0	0
Medium	5,973	3,880	0	(3,880)
Low	1,632	18,453	22,287	3,834
Total	**16,688**	**22,333**	**22,287**	**(46)**

The NHSE recurrent Plan (53% of the total target) is £16.7m. At the end of month 12 we have delivered a recurrent FYE of £22.3m.



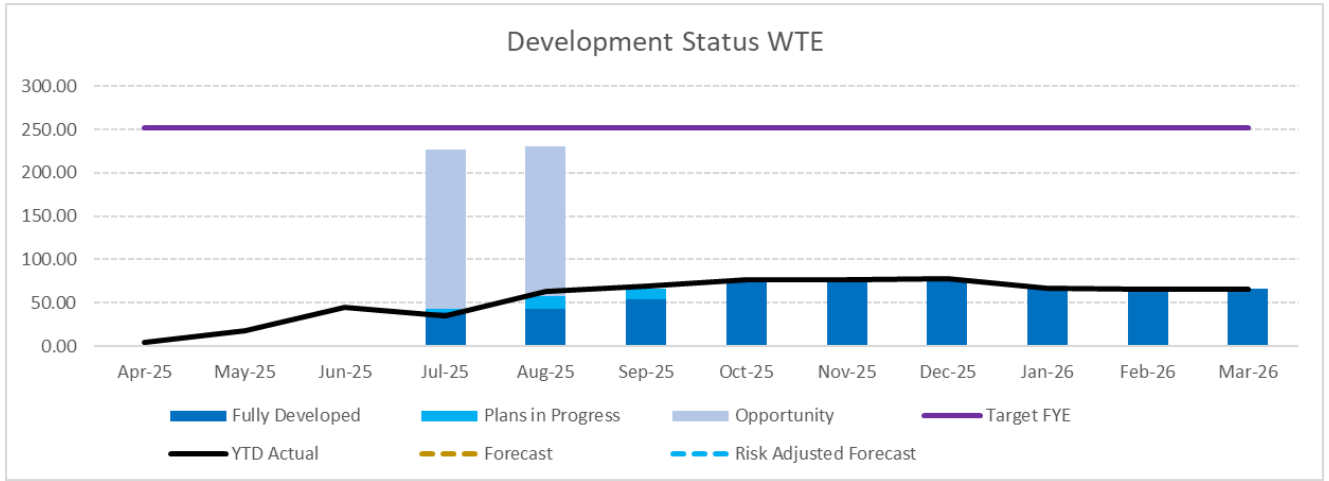


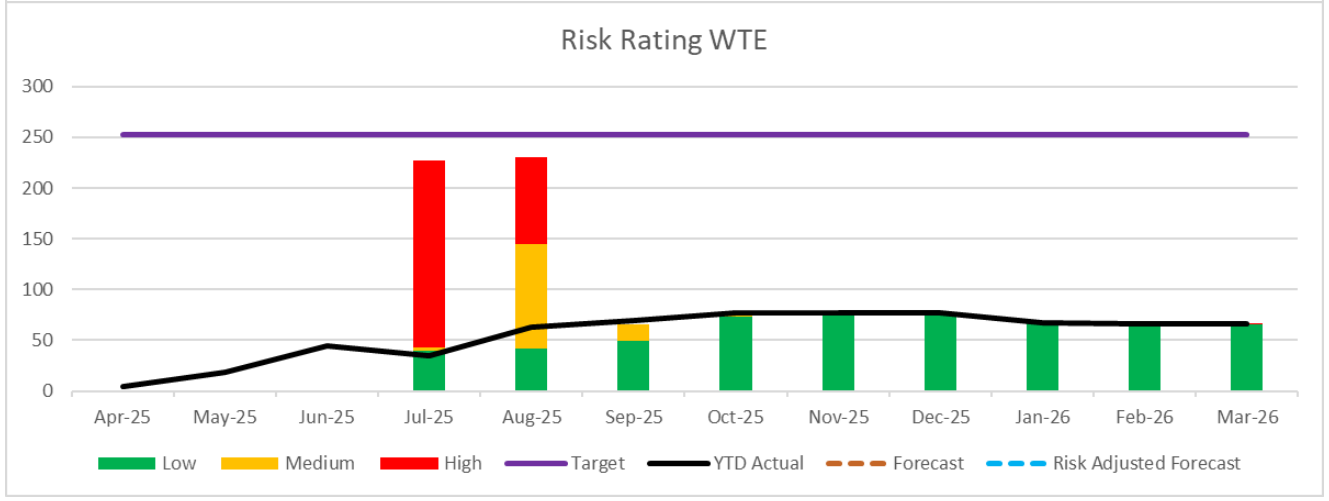
Efficiency Schemes – Recurrent FYE (WTE reduction)

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 12 we have delivered a recurrent FYE WTE reduction of 65.8.

WTE - FYE	April Plan Submission	Month 10	Month 11	Month 12	Increase (Decrease)
Fully Developed	0.0	68.4	65.8	65.8	(0.0)
Plans in Progress	0.0	0.0	0.0	0.0	0.0
Opportunity	114.7	0.0	0.0	0.0	0.0
Unidentified	137.3	0.0	0.0	0.0	0.0
Total	**252.1**	**68.4**	**65.8**	**65.8**	**(0.0)**

WTE - FYE	April Plan Submission	Month 10	Month 11	Month 12	Increase (Decrease)
High	252.1	0.0	0.0	0.0	0.0
Medium	0.0	0.0	0.0	0.0	0.0
Low	0.0	68.4	65.8	65.8	(0.0)
Total	**252.1**	**68.4**	**65.8**	**65.8**	**(0.0)**





SECTION 3
Delivering the 2025/26 committed plan

Executive Summary

Annual surplus/deficit (March 2026)
The Group's reported deficit for the full year is £17.0M in line with plan.

Activity
Outpatient New, Outpatient Followup and Elective were all below plan in month, but all points of delivery remain above plan for the full year.

Efficiencies
Schemes implemented in the year yielded a recurrent full year effect of £22.3m. In-year savings (which also include non-recurrent) are in line with plan, in-month (£2.3m) and across the full year (£31.4m).

Income and Expenditure vs. Budget								
Performance Indicator	Monthly Performance				YTD Performance			
	Budget £'000	Actual £'000	Variance to budget £'000		Annual Budget £'000	YTD Actual £'000	Variance to budget £'000	
Income	(80,971)	(87,004)	(6,033)	F	(657,197)	(663,045)	(5,848)	F
Pay	62,529	58,814	(3,715)	F	441,645	446,390	4,745	A
Non Pay	18,132	29,498	11,366	A	206,383	215,338	8,954	A
Financing Costs	805	1,194	389	A	9,660	7,172	(2,488)	F
(Surplus)/Deficit for the period	**495**	**2,503**	**2,008**	**A**	**492**	**5,855**	**5,363**	**A**
Donated Asset Adjustment	(41)	201	242	A	(492)	(592)	(100)	F
Impairment Adjustment	0	(4,897)	(4,897)	F	0	(5,096)	(5,096)	F
WOS surplus for year	0	(183)	(183)	F	0	(183)	(183)	F
Adjusted (Surplus)/Deficit for the purposes of system achievement	**454**	**(2,376)**	**(2,830)**	**F**	**0**	**(17)**	**(17)**	**F**
Remove Deficit Support Funding	***1,417***	***1,417***	*0*	***F***	***17,000***	***17,000***	*0*	***F***
Adjusted Financial Performance Excluding Deficit Support Funding	***1,871***	***(960)***	***(2,830)***	***F***	***17,000***	***16,983***	***(17)***	***F***

Cash
The cash balance is £53.4m and is favourable to plan by £37.6m. The increase is as a result of receiving £38.4m of capital PDC monies.

Capital
Capital spend for the year is in line with plan at £65.4m.

Key Risks and Mitigations to delivery of in-year plan

Key Risks	Risks (R)					Key Mitigations	Mitigations (M)					Net (R/M)	(Increase) Decrease
	25/26 Plan	M10	M11	M12	(Increase) Decrease		25/26 Plan	M10	M11	M12	Increase (Decrease)		
	£'000	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Additional cost risk	(2,000)	0	0	0	0	Additional cost control	2,000	0	0	0	0	0	0
Additional cost risk (inflation)	(6,178)	0	0	0	0	Additional income	6,178	0	0	0	0	0	0
Efficiency risk	(22,817)	(96)	(68)	0	68	Efficiency mitigation	2,322	96	68	0	(68)	0	0
Impact of potential further industrial action	0	0	0		0	Unmitigated	0	0	0		0	0	0
Over 65 week waits	(1,000)	(4,600)	0	0	0	Additional income	1,000	4,600	0	0	0	0	0
Total	**(31,995)**	**(4,696)**	**(68)**	**0**	**68**	**Total**	**11,500**	**4,696**	**68**	**0**	**(68)**	**0**	**0**

- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans were added to the corporate risk register and were monitored and reviewed throughout the year.
- Following the completion of the 2025/26 financial year, the risks have been managed appropriately within the position
- The risks and mitigations for the 2026/27 year end are being compiled and will be included within the April 2026 Report..

Surplus/Deficit – Graphs M12

In month/Annual

- In month £2.4m surplus as a result of the achievement of the Quarter 4 Deficit Support Funding.
- Year to date £17k surplus in line with plan for the Group.

Income

- The Clinical Income position is showing a favourable position YTD of £5.8m. The main driver is ERF performance at £5.5m.

Pay

- Pay is £3.7m favourable to budget in month mainly due to additional non recurrent funding received.
- £4.7m adverse YTD due to operational pressures and premium costs.
- Bank/agency and additional medical sessions spend in month is £4.5m (previous month: £3.9m) due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

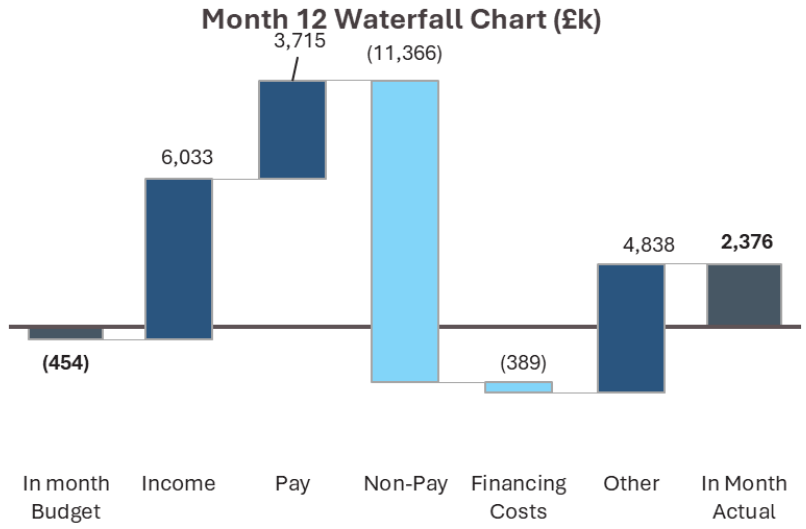
- Non pay is £11.4m adverse to budget in month and YTD mainly due to impairments £4.9m (which does not count towards achievement of financial targets), clinical supplies, HEE expenditure, year end stock and non recurrent items.

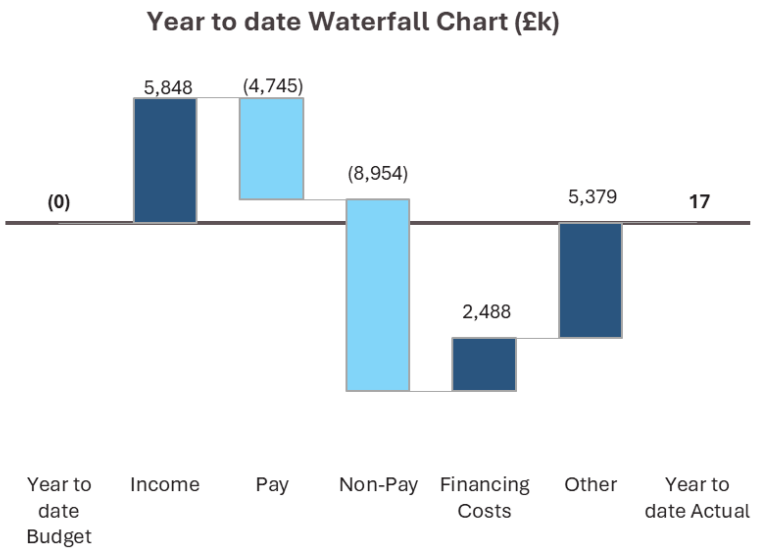
Other

- Adjustments for the impairment, WOS and donated assets

Financing Costs

- Higher cash balance than planned has created increased interest income year to date.





Financial Performance – Income

Clinical Income Position Month 12

	Plan - M12 YTD	Actuals - M12 YTD	Variance
	£'000	£'000	£'000
ICB			
NHS South Yorkshire ICB	(401,546)	(402,172)	(626)
NHS Nottingham and Nottinghamshire ICB	(110,390)	(110,374)	15
NHS Humber and North Yorkshire ICB	(8,335)	(8,331)	4
NHS Derby and Derbyshire ICB	(6,063)	(5,925)	137
NHS West Yorkshire ICB	(4,058)	(4,060)	(2)
NHS Lincolnshire ICB	(2,310)	(2,310)	(0)
LVA	(1,244)	(1,236)	8
ERF	0	(5,505)	(5,505)
API variable	(87)	(87)	0
ICB sub total	**(534,033)**	**(540,001)**	**(5,968)**
NHS England			
Specialised Commissioning	0	0	0
Public Health	(4,559)	(4,726)	(167)
Offender Health	(1,657)	(1,656)	1
Drugs and Devices	(11,243)	(11,243)	0
NHSE sub total	**(17,459)**	**(17,625)**	**(166)**
CDC	(9,896)	(8,281)	1,615
Clinical Income - misc	(2,050)	(3,346)	(1,296)
RTAs, PPs, OSV, CIP target	(5,265)	(5,165)	101
Notional Employers Pension Uplift	-23,384	-23,384	0
	(592,087)	(597,801)	(5,715)

In Month

The Clinical Income position in month 12 is favourable by £4.7m (M11 £0.5m – adverse). The main driver was the reinstatement of deficit support funding £4.25m. Other clinical income is adverse by £0.2m to plan.

Year to Date

The Clinical Income position is showing a favourable position YTD of £5.8m and other income adverse to plan by £0.1m. The main driver is ERF performance at £5.5m, partially offset by CDC underperformance of £1.6m. Miscellaneous Clinical Income items at £1.3m favourable mainly due to non recurrent benefits. Rapid diagnostic funding £0.4m and validation sprint funding £0.1m made up the additional £0.6m from South Yorkshire ICB.

ERF Performance

The activity has not yet been fully coded and includes estimates. Below is a table showing the ERF position at Month 12 by Commissioner. This reflects the month 12 agreements made by Commissioners.

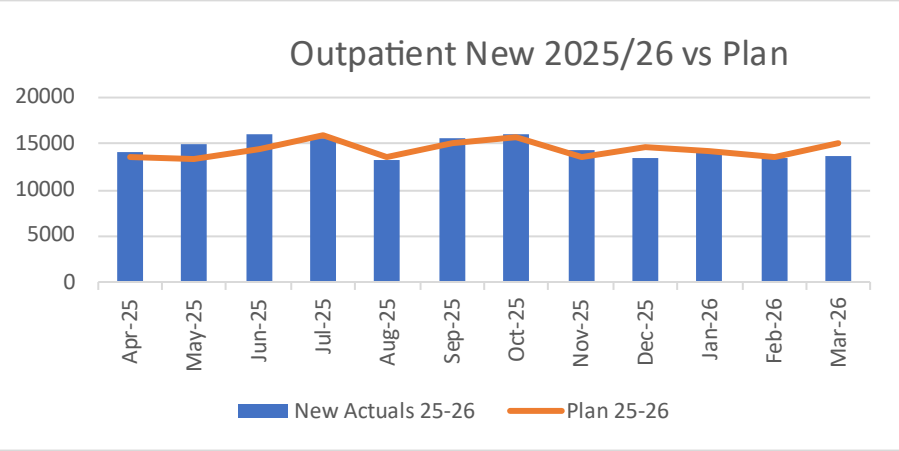
Commissioner	Plan YTD M12	Actual YTD M12	Variance YTD M12
NHS Derby and Derbyshire ICB	(953)	(1,205)	(252)
NHS Humber and North Yorkshire ICB	(1,850)	(2,168)	(318)
NHS Lincolnshire ICB	(746)	(616)	130
NHS Nottingham and Nottinghamshire ICB	(27,106)	(30,631)	(3,525)
NHS West Yorkshire ICB	(752)	(625)	127
NHS South Yorkshire ICB	(88,486)	(90,153)	(1,667)
NHS England - Offender Health & Armed Forces	(544)	(544)	(0)
NHS England - Specialised Commissioning	(1,903)	(1,903)	0
Total	(122,339)	(127,843)	(5,505)

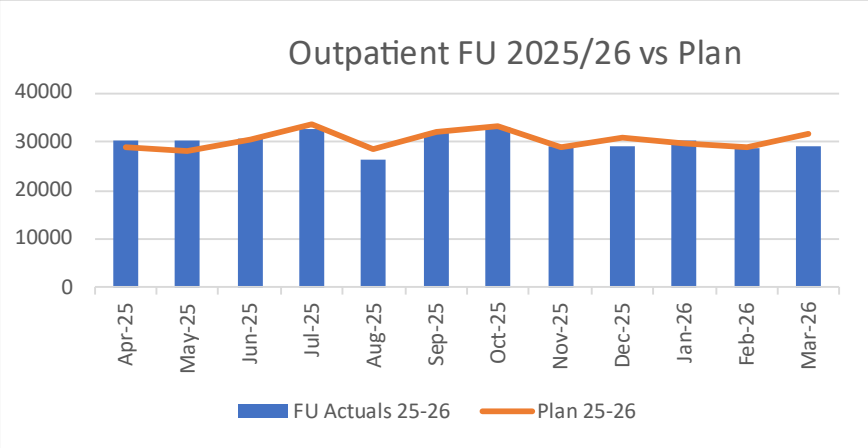
Activity Against Plan 2025/26

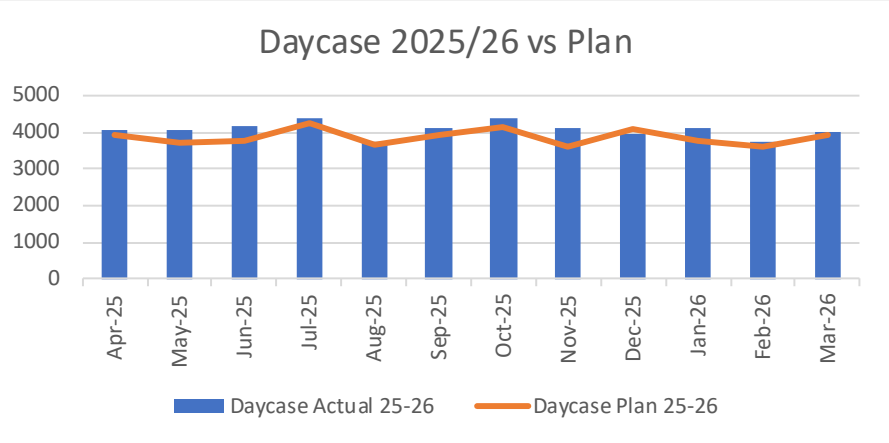
Data as at 02/04/2026

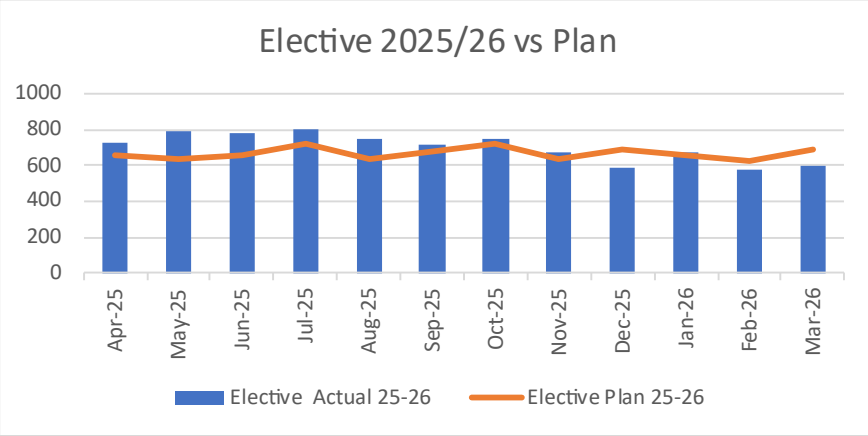
Point of Delivery	Activity vs Plan (March 2026)
Outpatients New	90.2%
Outpatient Follow up	91.7%
Daycase, excluding MEOC	102.4%
Elective, excluding MEOC	87.6%

- OP New, OP (FU) and Elective were all below plan in month but all points of delivery remain above plan YTD.
- OP (New) was -1,474 below plan in month and is 3,634 above plan YTD (102.1%).
- OP (FU) was -2,655 below plan in month and 5,960 above plan YTD (101.6%)
- Daycases were above plan by 95 cases in month and remain above plan by 2,725 cases YTD (105.9%)
- Electives were below plan by -85 cases in month but remain above plan by 454 cases YTD (105.7%)







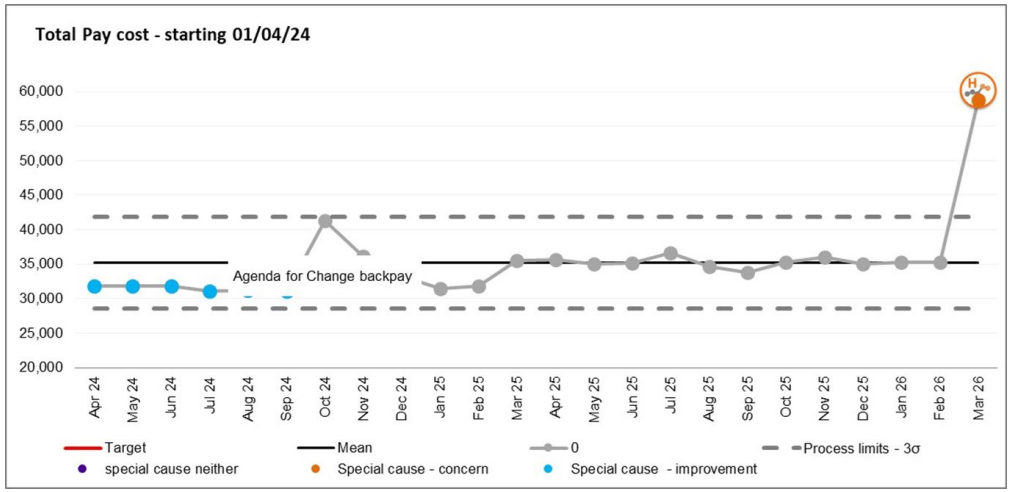


Financial Performance - Pay

In Month - £3.7m favourable to budget
Annual - £4.8m adverse to budget

- Pay expenditure in month is ahead of plan due to additional funding received.
- Additional sessions and bank increased in month mainly in CSS and UEC whereas agency remained in line with Month 11. Spend in both month 12 was £4.5m for all three areas combined compared to £3.9m in month 11.
- Increase in additional sessions and bank spend linked to mainly sessions covering vacancies and service pressures in Clinical Divisions.
- Special Cause - Substantive pay increased by £22.9m in month due to notional pension contributions of £23.4m offset by temp staffing.
- The adverse variance in the year to date is driven by operational pressures and premium costs of medics.

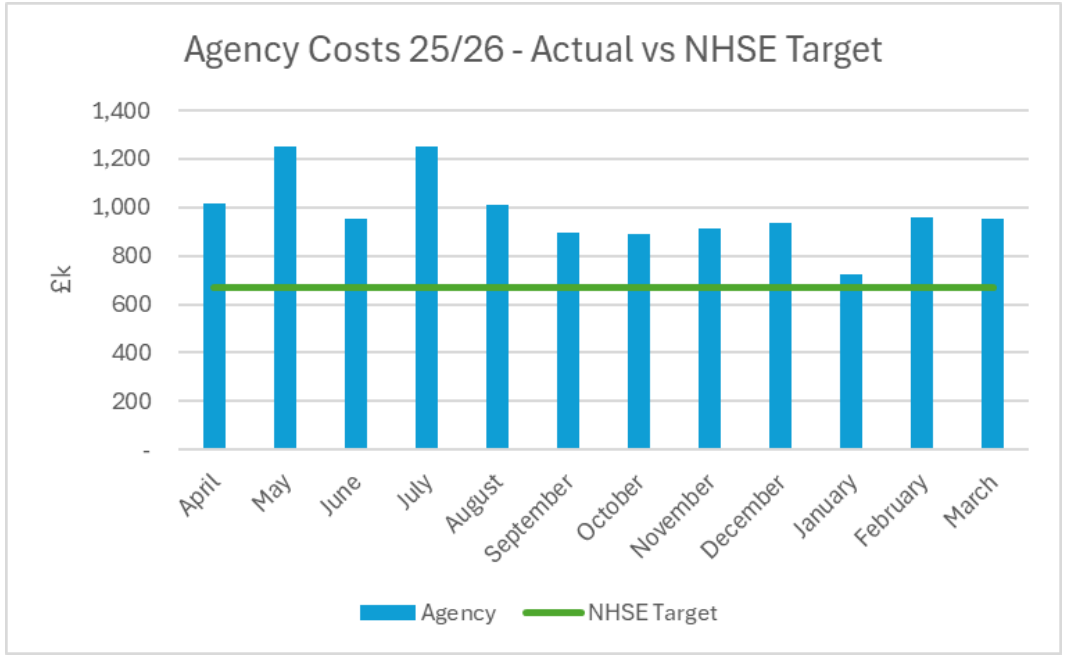
Total Pay Spend by Staff Group	In month budget £'000	In month actuals £'000	In-month variance vs budget		YTD variance vs budget	
Administration and estates	6,307	5,974	(334)	F	(1,624)	F
Ambulance staff	-	-	-			
Apprenticeship Levy	131	130	(1)	F	(24)	F
Allied health professionals	3,306	2,991	(316)	F	(807)	F
Healthcare science staff	21	31	10	A	(10)	F
Medical and dental	10,815	11,972	1,157	A	9,866	A
Non Medical Non Clinical	-	-	-	A		A
Nursing & midwifery	13,518	13,635	117	A	1,465	A
Comprising:	-	-	-			
Registered nursing	10,202	9,995	(207)	F	(2,327)	F
Unregistered nursing	3,316	3,629	314	A	3,777	A
Scientific, therapeutic and tech	842	898	56	A	323	A
Reserves & Technical Adjustments	27,589	23,184	(4,405)	F	(4,443)	F
Total Trust	**62,529**	**58,814**	**(3,715)**	F	**4,745**	A



Financial Performance - Agency

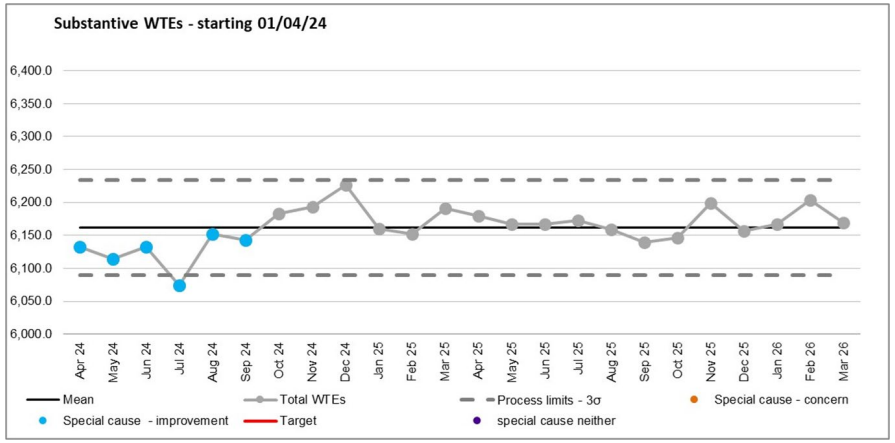
In Month - £1.0m
Annual- £11.8m

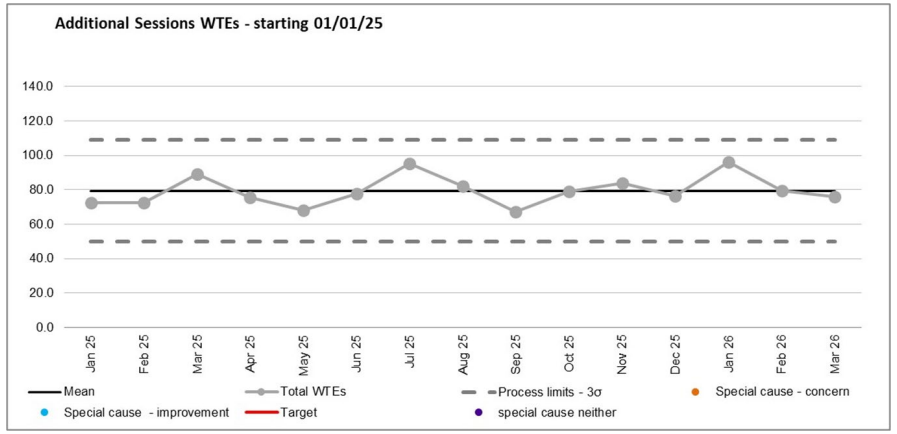
- The NHSE target is based on 24/25 actuals with a 40% reduction.
- Agency costs in month are £0.9m, in line with YTD average. The previous month was in line with current month (£0.9m).
- The majority of agency spend is within Medical/Dental staff group and is throughout all Clinical Divisions.
- Initiatives within the Pay Efficiency Cross Cutting CIP Workstream (CPO as SRO) include medical substantive recruitment, deep dives into sickness and effective rostering in conjunction with the roll out of Healthrota.
- A, similar, 40% reduction in agency costs for 26/27 would lead to a reduction in costs of £4.7m
- Latest available benchmarking data (month 10) shows the Trust's year to date agency spend amounted to 2.5% of total pay spend. This level is in the worst quartile of performance nationally with the Trust ranking 177th of 195 providers

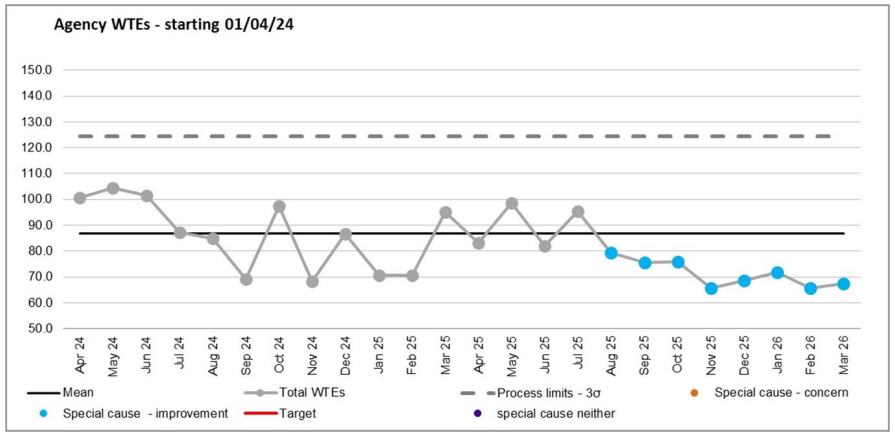


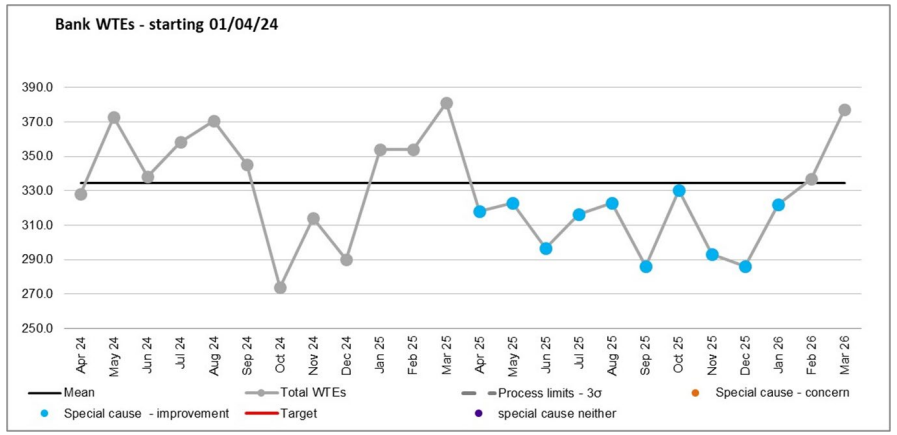
Financial Performance – Worked WTE

Workforce								
	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Additional Sessions	Total Temporary WTE	Total Worked WTE	Variance
Current Month	6,743.7	6,169.5	377.2	67.3	76.16	520.6	6,690.1	-53.6
Previous Month	6,764.0	6,203.6	336.8	65.6	79.70	482.1	6,685.7	-78.3
Movement	-20.2	-34.1	40.4	1.7	-3.5	38.5	4.5	24.7









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 have reduced in month across all Divisions mainly due to vacancies within Clinical Divisions covered by increase in temporary staffing.

Bank WTE increased mainly in UEC relating to A&E and Acute Medical Staff for winter pressures.

Additional sessions have reduced in month mainly in Medicine (4.45 wte).

Agency has increased slightly in February mainly in CSS to cover medic absences.

Financial Performance – WTE

	2025/26 Budget WTE												
Total Pay WTE by Cost Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Movement
2a. Substantive	6,732.0	6,771.3	6,776.0	6,748.5	6,742.4	6,736.0	6,707.6	6,695.7	6,693.3	6,662.2	6,680.3	6,658.6	-21.6
2b. Bank	4.8	5.0	5.0	5.0	3.9	1.4	1.4	0.4	0.4	0.4	36.6	35.6	-1.0
2c. Agency	77.3	78.3	76.8	76.8	76.8	62.5	60.4	48.3	48.3	45.3	47.1	49.5	2.4
2d. Reserves - Pay	88.7	88.7	88.7	88.7	88.7	88.7	88.7	88.7	88.7	88.7	0.0	0.0	0.0
Total	**6,902.7**	**6,943.2**	**6,946.5**	**6,919.0**	**6,911.8**	**6,888.6**	**6,858.1**	**6,833.1**	**6,830.7**	**6,796.6**	**6,764.0**	**6,743.7**	**- 20.2**

Table 1 – Budget WTE
Main movement movements in month 12 relate to a paediatrics skill mix in Women's and Children's (10.4 wte) and CIP in Medicine (11.7 wte).

WTE Vacancies											
Table 2	Budget WTE	Substantive Contracted WTE	Gross Substantive Contracted Vacancies WTE	Gross Substantive Vacancies %	Bank Worked WTE	Agency Worked WTE	Additional Sessions	Total Temporary WTE	Total Contracted WTE & Worked Bank/Agency WTE	Vacancies Net of Temporary Staffing WTE	Vacancies Net of Temporary Staffing %
Current Month	6,743.7	6,291.3	452.4	6.7%	377.2	67.3	0.0	444.4	6,735.7	8.0	0.1%
Previous Month	6,784.0	6,301.3	482.7	7.1%	335.8	65.6	0.0	401.4	6,702.7	81.3	1.2%
Movement	-40.3	-10.0	-30.3	-0.4%	41.4	1.7	0.0	43.1	33.1	-73.3	-1.1%

Table 2 - Vacancies are calculated as per national guidance on Contracted WTE and are submitted by Workforce to NHSE on a monthly basis.

Additional sessions WTE are excluded in this return as they are not contracted WTEs.

Payroll Overpayments By Value

Division/Directorate	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Number of Transactions
Chief Executive Directorate	-	-	-	-	-	-	-	-	-	2
Chief Operating Officer	20	-	459	1,246	-	397	434	371	-	6
Clinical Specialties Division	2,466	3,435	3,408	2,221	625	380	232	3,046	21,622	33
272 DCEO									-	
Digital Transformation Directorate	-	-	8,133	-	-	2,035	1,070	218	-	2
Doncaster & Bassetlaw HC Services Ltd	-	-	-	-	-	-	-	-	-	1
Education and Research Directorate	-	-	2,697	94	-	-	-	-	558	2
Estates & Facilities	176	585	1,181	173	1,118	-	-	18	-	16
Executive Team Board	-	-	96	-	1,694	6,495	6,850	-	4,905	17
Finance & Healthcare Contracting Directorate	-	-	-	-	-	-	-	-	-	0
Medical Director Directorate	-	1,124	-	-	-	-	-	604	-	2
Medicine Division	2,482	287	991	2,557	1,787	-	4,706	5,577	4,307	27
Mexborough Elective Orthopaedic Centre	-	-	-	-	-	-	-	-	-	1
Nursing Services Directorate	-	-	-	-	-	-	-	-	-	3
People & Organisational Directorate	-	-	-	21	-	-	-	5,142	-	2
Performance Directorate	-	-	-	-	-	-	-	-	-	2
Restoration, Innovation and Transformation Division	-	-	-	-	-	-	-	-	-	3
Surgery Division	11,383	30,492	13,699	6,430	99	-	2,406	102,423	32,927	37
Urgent and Emergency Care Division	21,765	16	2,425	-	-	213	1,065	421	2,452	25
Women's & Children's Division	1,689	-	756	-	573	1,743	9,110	-	3,908	40
Grand Total	**39,980**	**35,939**	**33,843**	**12,742**	**5,896**	**11,263**	**25,873**	**117,821**	**70,679**	**221**

- The latest information available runs until the end of December 2025

Financial Performance – Non-Pay

In Month - £11.4 m adverse to budget
Annual- £9.0m favourable to budget

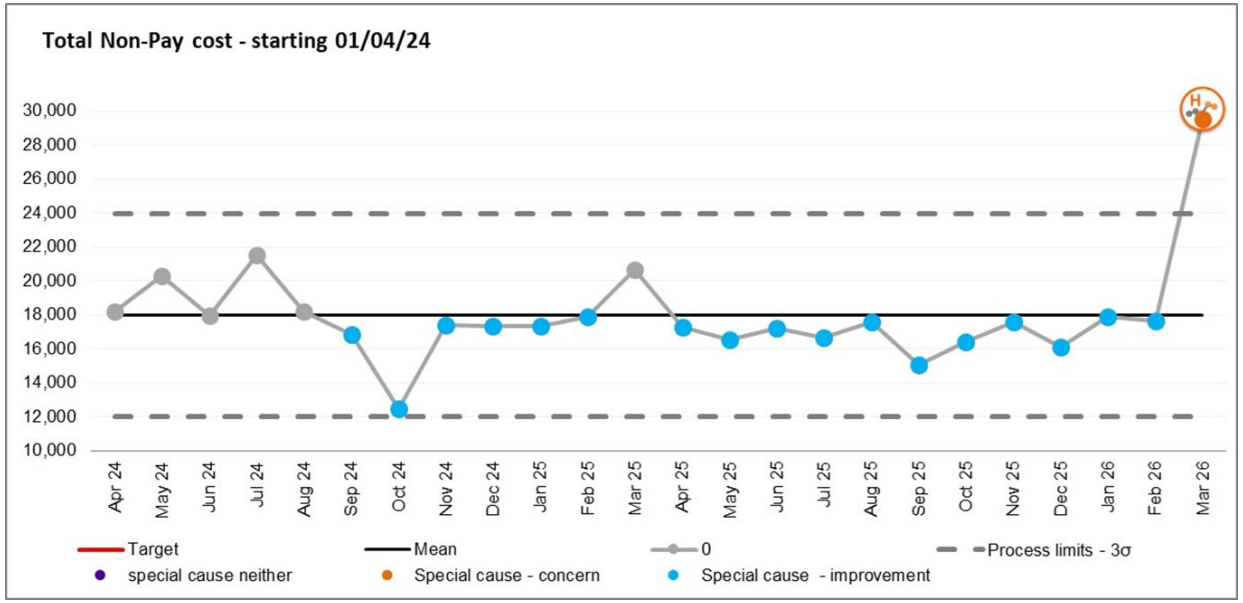
The main reasons for the adverse annual variance is due to:

- Impairments £5.1m
- Clinical supplies and services mainly due to increased activity £2.0m
- Depreciation £0.5m
- CIP - £1.4m

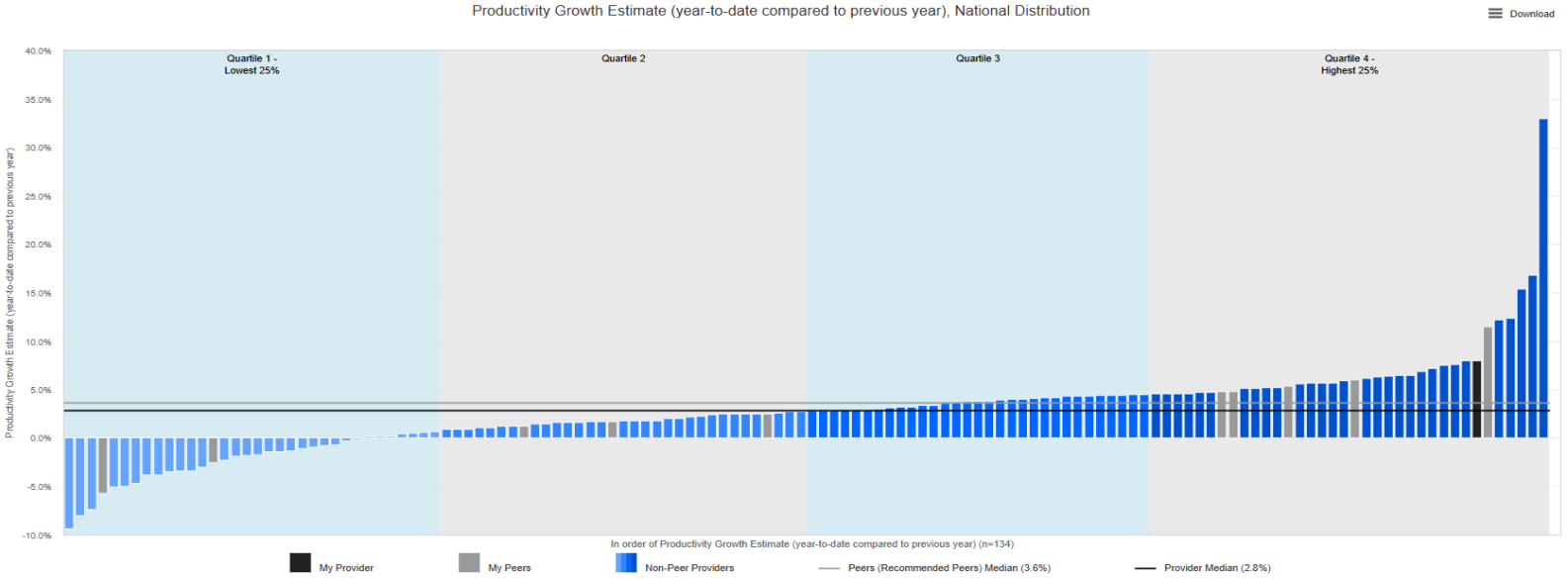
The in month movement of £11.7m and special cause mainly relate to the following:

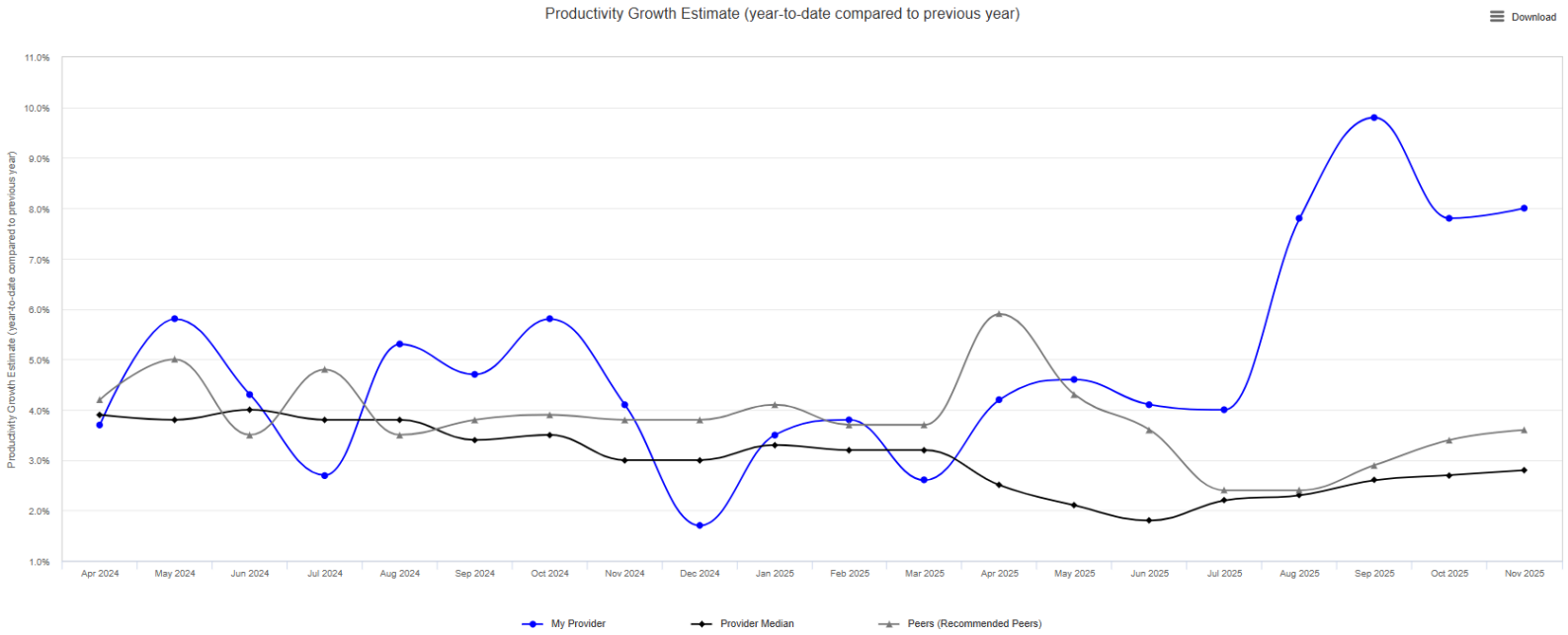
- Impairments £5.1m
- Clinical supplies and services/Drugs mainly due to increased activity £1.9m
- HEE CPD expenditure - £0.7m
- Reduction in CIP - £0.4m
- Year end stock - £1m
- Review of non recurrent benefits - £2.6m

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)	1,331	1,467	136	A	459	A
Drugs (non PBR)	2,431	2,226	(205)	F	(621)	F
Clinical Supplies and Services	3,467	4,291	824	A	2,003	A
Other costs	6,204	6,721	518	A	954	A
Non-Executive Directors	16	13	(3)	F	(17)	F
Depreciation	1,595	1,709	115	A	469	A
Reserves & Technical Adjustments	1,193	6,259	5,066	A	556	A
Recharges	1,861	1,861	-	A	-	A
Parkhill	35	53	18	A	56	A
Impairments	-	4,897	4,897	A	5,096	A
Total Trust	**18,132**	**29,498**	**11,366**	A	**8,954**	A



Implied Productivity (per £ compared to prior year)

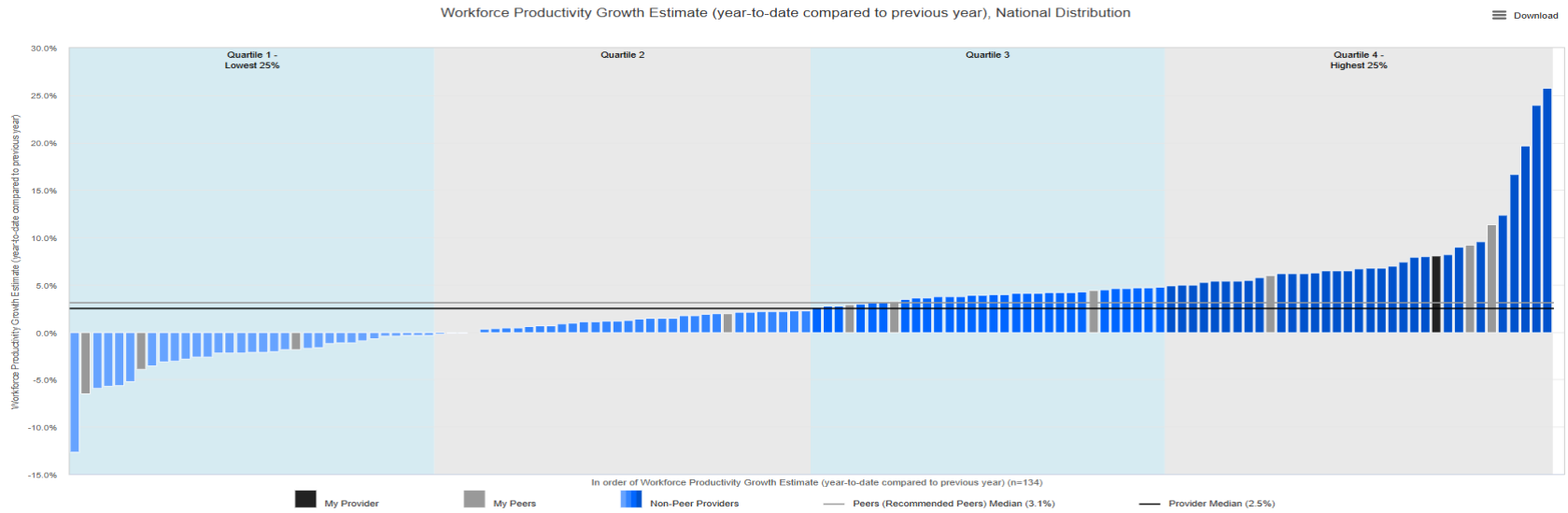


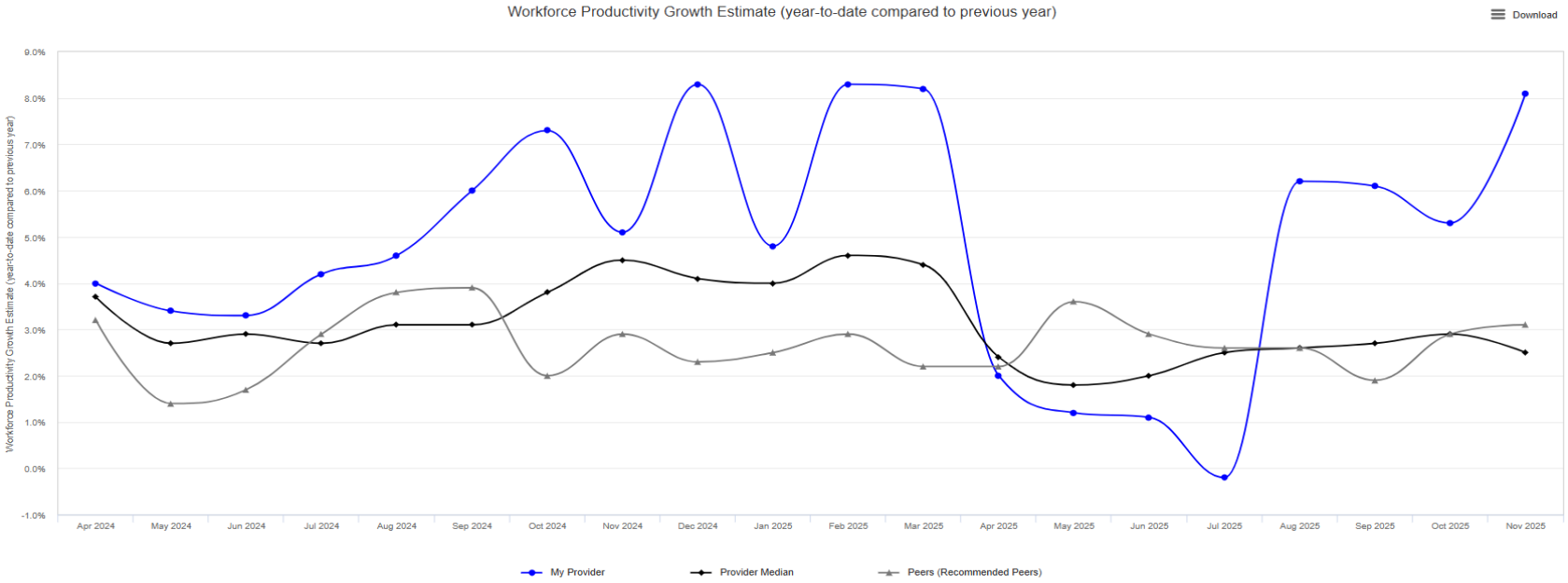


The most recently published data (M8 YTD) shows an 8.0% improvement in implied productivity for DBTH in comparison to the same period in the previous year (prior month: +7.7%). This places the Trust in the best quartile of performers nationally and is favourable against both the national median (2.8%) and the median of the group of peer Trusts selected by NHS England (3.6%).

The peer group includes:
Bradford Teaching Hospitals (-5.7%)
Barnsley Hospital (-2.5%)
Wirral University Hospital (+1.2%)
County Durham & Darlington (+1.7%)
Wrightington, Wigan and Leigh Hospitals (+2.5%)
North Tees and Hartlepool (+4.8%)
Bolton Hospital (+4.8%)
Northern Lincolnshire & Goole (+5.4%)
Sherwood Forest Hospitals (+6.8%)
East Sussex (+11.5%)

Implied Workforce Productivity (per WTE compared to prior year)





The most recently published data (M8 YTD) shows a 8.1% improvement in implied workforce productivity for DBTH in comparison to the same period in the previous year (prior month: +5.3%). This places the Trust in the top quartile of performers nationally and is better than both the national median (2.5% improvement) and the median of the group of peer Trusts selected by NHS England (3.1% improvement).

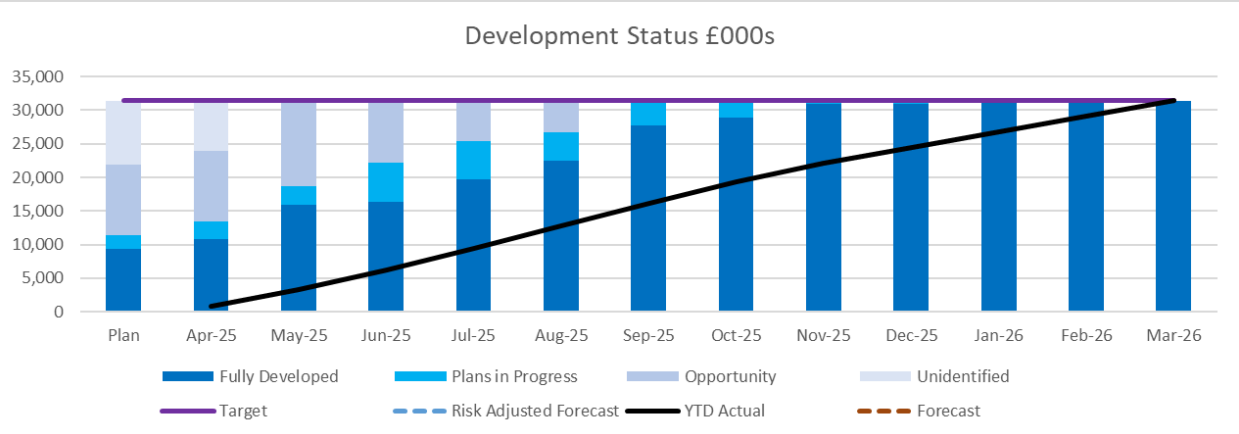
The peer group includes:
Barnsley Hospital (-6.5%)
Bradford Teaching Hospitals (-3.9%)
Wirral University Hospital (-1.8%)
County Durham & Darlington (+2.0%)
Wrightington, Wigan and Leigh Hospitals (+2.9%)
Sherwood Forest Hospitals (+3.3%)
North Tees and Hartlepool (+4.4%)
Northern Lincolnshire & Goole (+6.0%)
Bolton Hospital (+9.2%)
East Sussex (+11.4%)

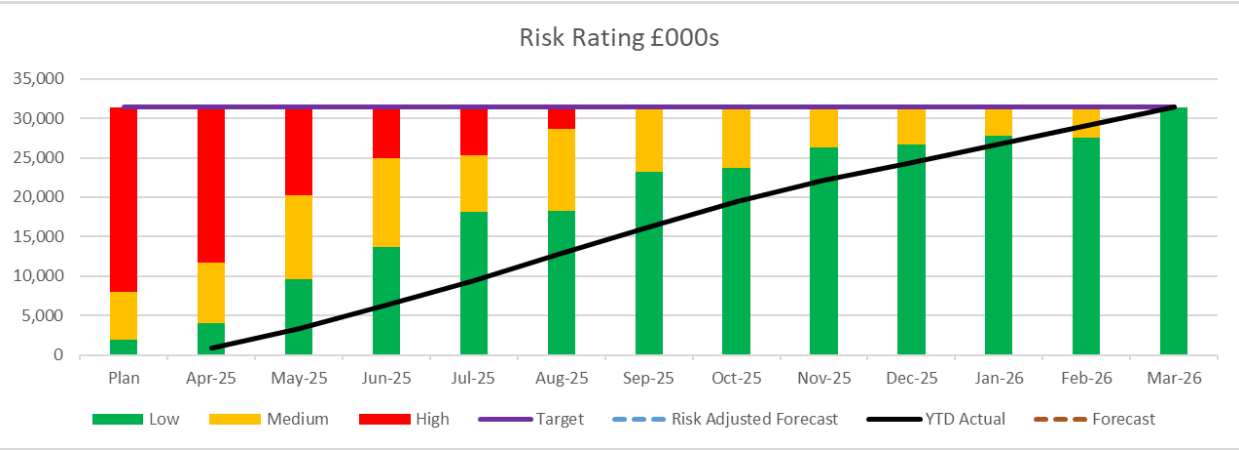
Efficiency Programme

In terms of 2025/26 in-year impact:

- In month 12 the Trust delivered £2.3m of savings in line with plan, bringing year end delivery to £31.4m, also in line with plan. This includes non-recurrent savings.
- The committed plan is to reduce by 252.1 WTE on average across the year, the average WTE reduction delivered in year is 103.4 WTE.

Efficiency Schemes – 2025/26 In Year Savings (£)





Efficiency Plan Status £000's	April Plan Submission	Month 8	Month 9	Month 10	Month 11	Month 12	Increase (Decrease)
Fully Developed	9,350	30,875	30,915	31,205	31,261	31,397	136
Plans in Progress	2,051	522	482	192	136	0	(136)
Opportunity	10,528	0	0	0	0	0	0
Unidentified	9,468	0	0	0	0	0	0
Total	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**31,397**	**0**

Efficiency Plan Risk £000's	April Plan Submission	Month 8	Month 9	Month 10	Month 11	Month 12	Increase (Decrease)
High	23,450	0	0	0	0	0	0
Medium	5,968	5,073	4,743	3,662	3,797	0	(3,797)
Low	1,979	26,324	26,654	27,735	27,600	31,397	3,797
Total	**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. As at month 12 this has been delivered in full, including non recurrent savings.

Workstream / Scheme	Movement	Value £000's	Risk as per Month 11	Risk as per Month 12	Status as per Month 11	Status as per Month 12
Corporate Services	Pay Underspends	300	Low	Low	Fully Developed	Fully Developed
Digital First	Decrease in coding income schemes	(62)	Low	Low	Fully Developed	Fully Developed
Medicines Management	Biosimilar reduction	(26)	Low	Low	Fully Developed	Fully Developed
Theatres	Improvement in HVLC List performance	283	Low	Low	Fully Developed	Fully Developed
Local	New schemes and improvement in existing schemes	85	Low	Low	Plans in Progress	Fully Developed
Local	Reduction in Reserves release	(580)	Low	Low	Fully Developed	Fully Developed
Pay Efficiency	Agency & Bank	(3,797)	Medium	Low	Fully Developed	Fully Developed

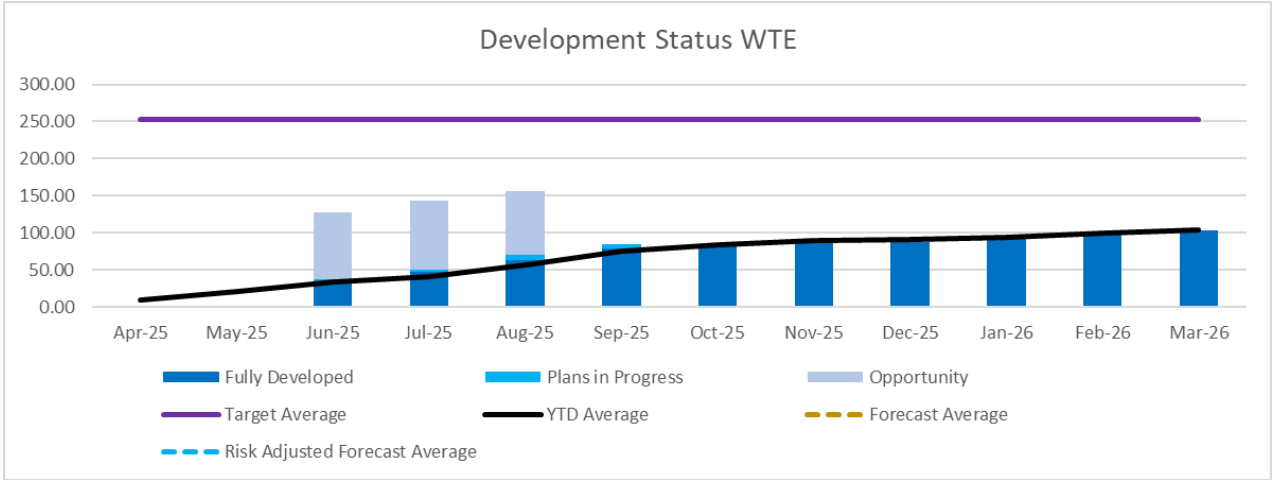
Efficiency Schemes – 2025/26 In-Year (WTE reduction)

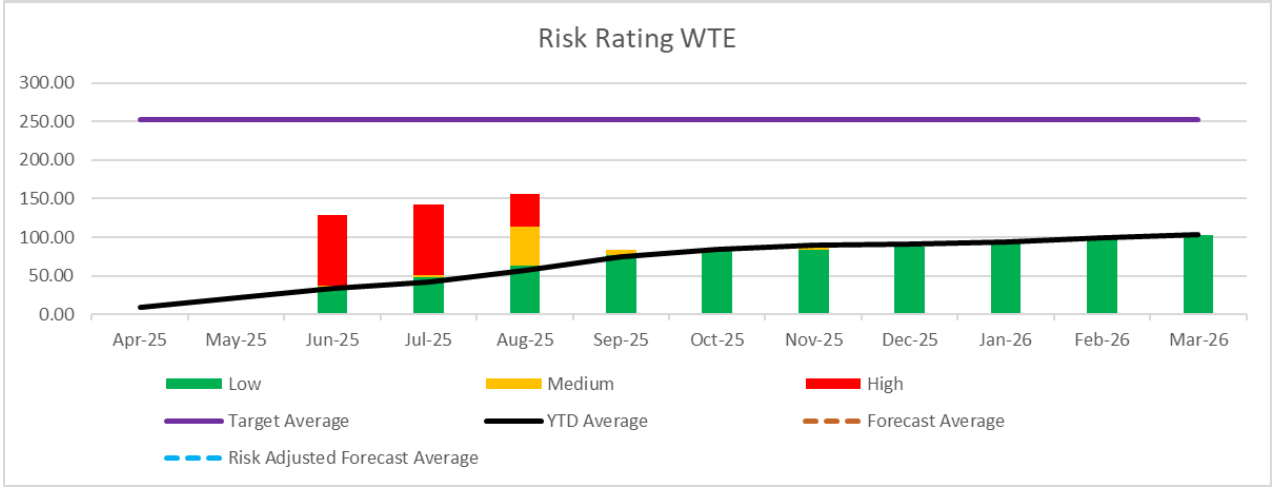
Our committed plan is to reduce by 252.1 WTE on average across the year. Tracking started in earnest in month 4, the average WTE reduction delivered across the year is 103.4 WTE.

WTE - in year	April Plan Submission	Month 10	Month 11	Month 12	Increase (Decrease)	FOT
Fully Developed	-	94.1	99.8	103.4	3.6	65.8
Plans in Progress	-	-	-	-	0.0	0.0
Opportunity	114.7	-	-	-	0.0	0.0
Unidentified	137.3	-	-	-	0.0	0.0
Total	**252.1**	**94.1**	**99.8**	**103.4**	**3.6**	**65.8**

WTE - in year	April Plan Submission	Month 10	Month 11	Month 12	Increase (Decrease)	FOT
High	252.1	0.0	0.0	0.0	0.0	0.0
Medium	0.0	0.0	0.0	0.0	0.0	0.0
Low	0.0	94.1	99.8	103.4	3.6	65.8
Total	**252.1**	**94.1**	**99.8**	**103.4**	**3.6**	**65.8**

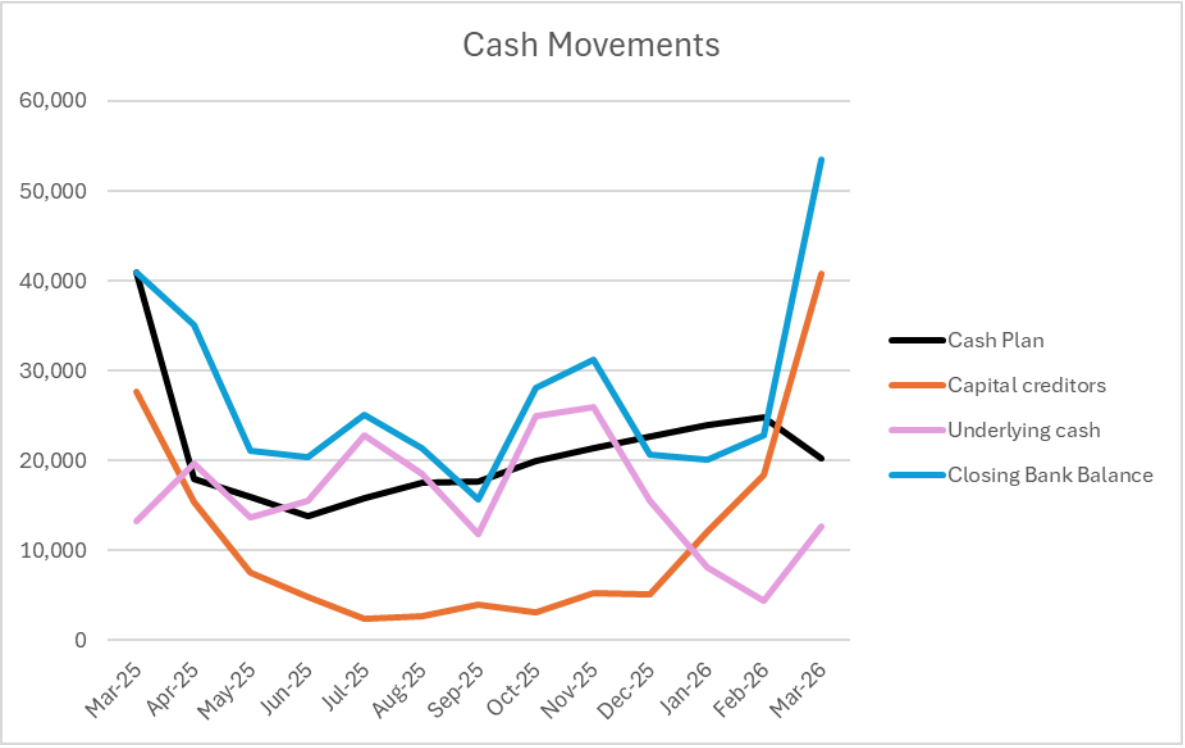
Workstream / Scheme	Movement	WTE	Risk as per Month 11	Risk as per Month 12	Status as per Month 11	Status as per Month
Corporate Services	Pay Underspends	4.8	Low	Low	Fully Developed	Fully Developed
Theatres	Improvement in HVLC List performance	1.1	Low	Low	Fully Developed	Fully Developed
Local	Reduction in WTE in month to forecast	(2.3)	Low	Low	Fully Developed	Fully Developed





Cash, Receivables and Payables

Cash increased by £30.7m to £53.4m as a result of the Trust receiving £38.4m of capital PDC monies in the month. Capital cash out in the month was only £6.8m with capital creditors at month end at £40.8m. These capital creditors will be paid out during Quarter 1 of 26/27. Better Payment Practice Code overall performance has remained relatively stable.



Invoice Turnaround

Average days	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Between date of invoice and date available on system	13.5	19.8	16.6	12.6	16.3	18	16.5
Between being available on system and approval	8.2	8.1	13.4	12.1	25.7	12.7	10.85
Between approved date and payment date	21.2	20.6	18.8	16.5	18.6	18.9	23.39
Total	42.9	48.5	48.8	41.2	60.6	49.6	50.74
Total that the Trust has control over	**29.4**	**28.7**	**32.2**	**28.6**	**44.3**	**31.6**	**34.24**
Number of invoices	*6,901*	*7,468*	*10,728*	*7,054*	*7,474*	*9,726*	*8,392*

Better Payment Practice Code (In month)

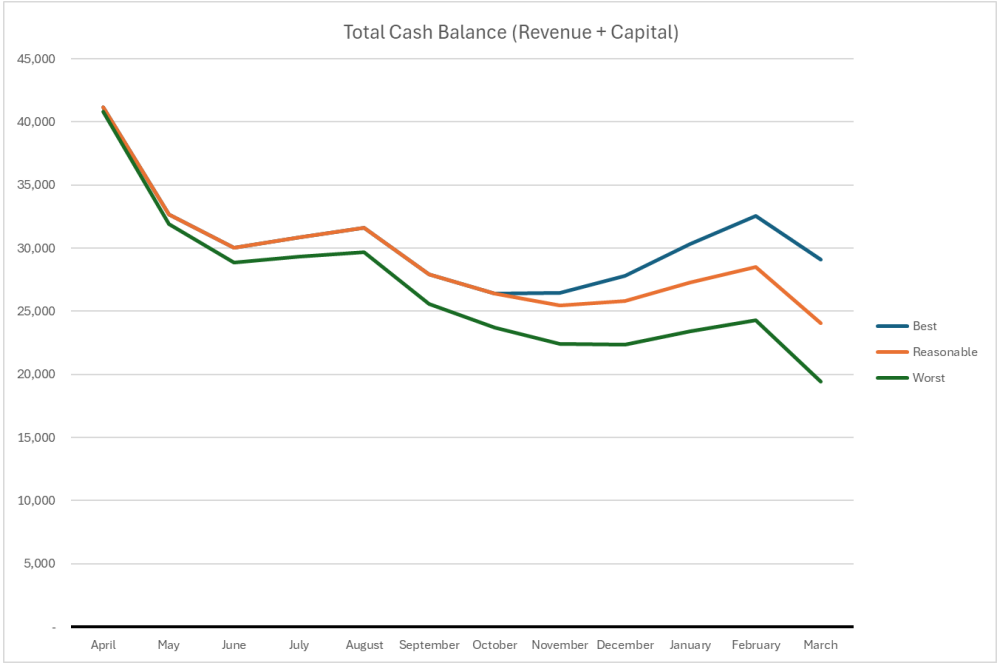
Average days	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
NHS - %age based on invoice count	77.48%	86.83%	85.85%	59.09%	86.61%	90.34%	84.37%
NHS - %age based on invoice value	74.98%	78.40%	92.50%	50.37%	88.02%	86.94%	82.88%
Non NHS - %age based on invoice count	39.42%	41.96%	34.23%	40.95%	34.95%	39.08%	38.22%
Non NHS - %age based on invoice value	78.31%	79.68%	80.47%	65.41%	78.77%	79.04%	77.11%
Overall - %age based on invoice count	40.05%	43.42%	36.01%	41.18%	36.50%	40.15%	39.49%
Overall - %age based on invoice value	78.01%	79.59%	82.79%	64.97%	79.92%	79.63%	77.56%

Cash Projections

The chart shows a scenario analysis of cash movements for the full 2026/27 year, following the finalisation of the financial plan. The cash position is supported by a significant level of capital creditors throughout the year and the revenue cash balance is between £5m-£10m throughout the year.

A key aspect underpinning the cash forecast is the achievement of efficiency schemes, particularly due to their size. It is important to note that such schemes will need to be cash releasing to ensure the achievement of the best and reasonable case scenarios.

As the risks and mitigations become more pronounced during 2026/27, the cash projections will become more granular.



Key variations in models	Best	Reasonable	Worse
Risks/Mitigations	Nil	Nil	10% of efficiencies not achieved
Cash Management pressures	Extension of creditor payment terms by £5m	Nil	Nil

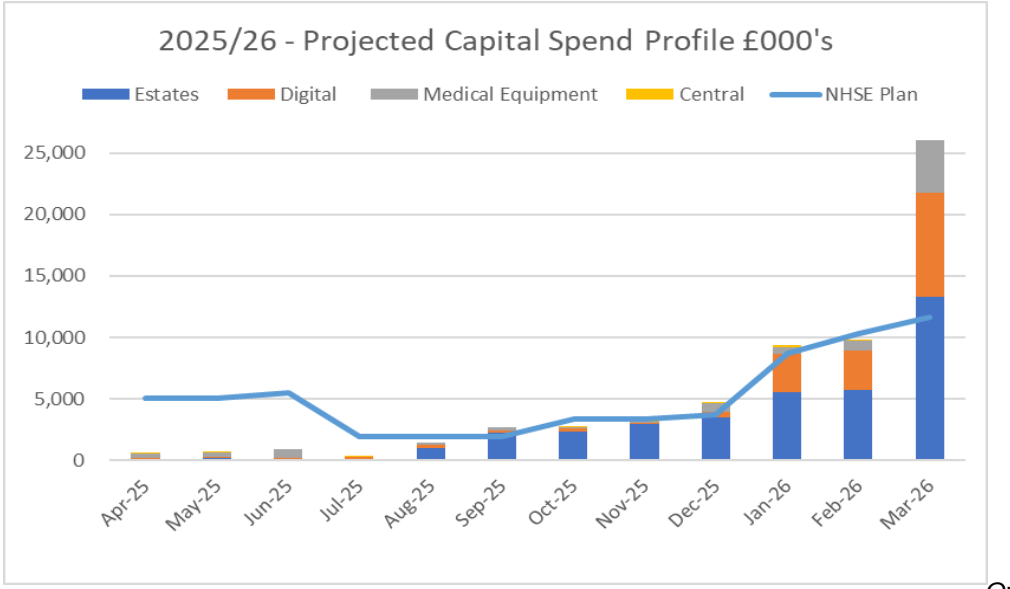
Capital

Capital spend in month is £29.2m and YTD is £65.4m in line with plan.

	Annual Plan Budget (£'000)	Annual Spend (£'000)	Annual Variance (£'000)		In Month Budget (£'000)	In Month Spend (£'000)	In Month Variance (£'000)
Estates Projects	37,050	36,860	(190)		3,628	13,254	9,626
Medical Equipment	10,366	10,348	(18)		1,860	6,152	4,293
Digital Transformation Projects	16,616	16,592	(24)		5,269	8,545	3,276
Central Capital	505	737	231		769	694	(76)
IFRS16 Leases	853	853	0		78	573	495
Total Capital Spend	**65,391**	**65,391**	**(0)**		**11,605**	**29,219**	**17,614**
Charitable Funds/Donated Assets	270	270	0		0	267	267
Total Capital Spend inc Charitable Funds/Donated Assets	**65,661**	**65,661**	**(0)**		**11,605**	**29,486**	**17,882**

There was significant spend across all areas in month 12, some of the larger schemes include main areas of in month spend include

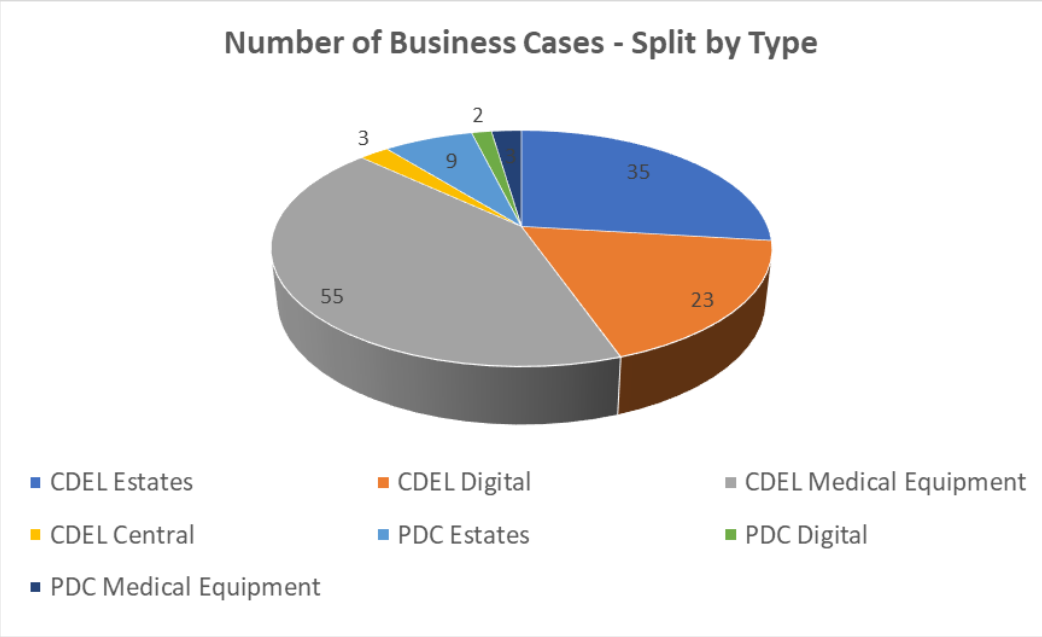
- DCC programme and a number of other Estates schemes including
- Fire Safety
- Electrical Infrastructure
- EPR
- DRI MRI Replacement

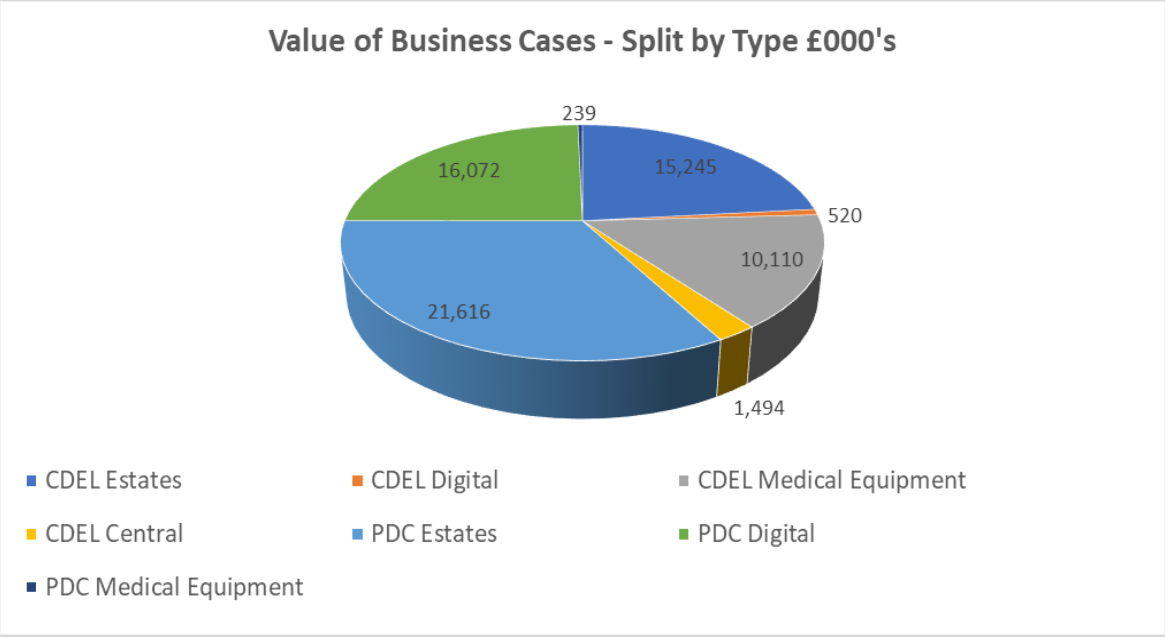


Capital – Business Cases

All cases have been approved through CIG or via Chair's action to support delivery.

Week Commencing	02/03/2026	09/03/2026	16/03/2026	23/03/2026	30/03/2026
Estates	38,362,946	35,765,884	36,366,172	37,138,874	37,138,874
Digital Transformation	10,424,723	13,325,567	14,202,960	12,670,643	12,670,643
Medical Equipment	9,696,175	9,844,668	10,263,557	10,263,557	10,263,557
Central	271,550	273,318	273,318	275,088	275,088
IFRS16	0	0	0	0	0
TotalCapital excluding Charity	58,755,394	59,209,437	61,106,007	60,348,163	60,348,163
Charitable Funds/ Donations Total	269,938	269,938	269,938	269,938	269,938
Total Capital including Charity	59,025,332	59,479,375	61,375,945	60,618,101	60,618,101
Weekly Order Value	1,825,872	454,043	1,896,569	-757,844	0





2605 - D3 MORTALITY REVIEW UPDATE

Discussion Item | Nick Mallaband, Acting Executive Medical Director | 11:50

10 minutes

REFERENCES

Only PDFs are attached

D3i - Mortality Review Update.pdf

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Mortality Review Update**			
Executive Sponsor:	Dr Nick Mallaband, Acting Executive Medical Director			
Authors:	Dr Nick Mallaband, Acting Executive Medical Director			
Appendices:				
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF1: If DBTH is not a safe trust which demonstrates continual learning and improvement then risk of avoidable harm and poor patient outcomes/experience and possible regulatory action.			

Executive Summary – Key messages and Issues

1. Purpose

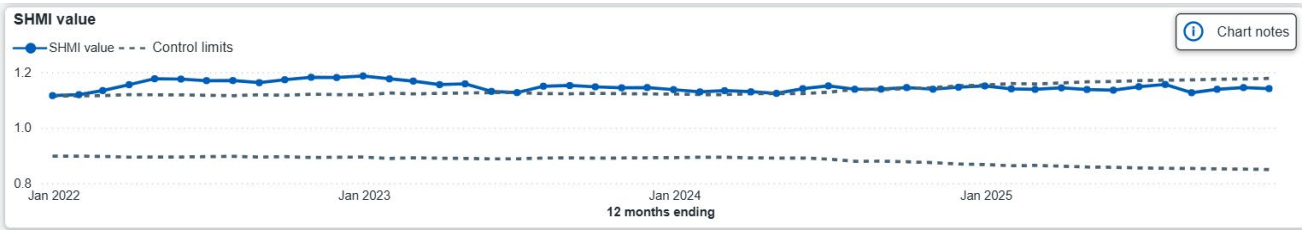
To provide an updated position to the Board of Directors in response to the agreed action for the Acting Executive Medical Director to address Board discussion points relating to the Trust's Summary Hospital-level Mortality Indicator (SHMI), the required improvement trajectory, and the assurance framework for reporting learning from deaths to the Quality Committee and Board.

2. Context

This report provides assurance to the Board of Directors on the Trust's mortality position, interpretation of SHMI, and the effectiveness of governance and improvement arrangements for learning from deaths.

Since the mortality improvement work commenced and the most recent mortality report to the Quality Committee in February 2026, the Trust has continued to demonstrate stable SHMI performance within national statistical control limits, with no sustained breaches of upper confidence limits across nationally published datasets, Model Hospital and Healthcare Evaluation Data (HED).

The Trust has now remained within national control limits for a prolonged period, providing assurance that mortality outcomes are not exhibiting special cause variation.



The above chart demonstrates that the Trust mortality performance was consistently above the upper control limit until July 2024, then has been consistently within the upper control limit from October 2024.

Whilst statistically within expected limits, the Trust's SHMI remains consistently above 1.0 close to the upper control limit, reflecting a combination of population complexity, case-mix, and wider determinants of health. Notably, SHMI does not adjust for deprivation, and the Trust serves a population with a high proportion of patients in the most deprived national quintile. This is a nationally recognised factor associated with poorer health outcomes and higher mortality rates and must be considered when interpreting SHMI data.

Robust mortality governance arrangements are in place, incorporating Structured Judgement Reviews, Medical Examiner scrutiny, diagnostic group analysis and targeted improvement where risks are identified. Specific thematic focus on sepsis demonstrates active risk management and alignment with national deteriorating patient safety priorities, including Martha's Rule.

3. Summary

Overall, the report provides assurance that mortality risks are understood, controlled, triangulated and actively managed, with a continued focus on learning-led improvement rather than reliance on metrics alone.

The Trust continues to emphasise learning rather than solely statistical performance, with triangulation of qualitative and quantitative data from:

- Structured Judgement Reviews (SJRs)
- Diagnostic group analysis
- Clinical coding and depth of coding

along with emphasis on clinical ownership forming the core of the improvement trajectory.

Recommendations

The Board is asked to:

- Take assurance from the report and that mortality remains within the statistical control limits.
- Triangulation with other systems, such as SJRs, Patient Safety Incident Response Framework (PSIRF) and Medical Examiner recommendations, is used to ensure patient safety and quality of care within the Trust
- Note a commitment to further reduce the headline SHMI indicator towards 1.0 from its current position of 1.14 noting that this may be hampered by the level of deprivation of our population served.
- Note ongoing risks and mitigations detailed in the report.
- Support continued focus on learning-led improvement alongside metric performance.

Healthier together – delivering exceptional care for all	
Patients	Mortality performance is a fundamental measure of patient safety and quality of care.
People	Engagement from clinical teams in order to review and understand mortality performance within their areas, to support learning and improvement.
Partnerships	Benchmarking against neighbouring trusts and the national position provides essential system context.
Pounds	Strengthening data quality, oversight of digital investments and routine performance review supports better use of resources and value for money across the organisation.
Health Inequalities	Mortality outcomes are influenced by population demographics, deprivation and long-term conditions. An underlying upward trend in predicted deaths, likely reflects changes in age profile, complexity and volume of admissions.
Legal/ Regulation:	Provides assurance that the Trust is delivering its legal and regulatory responsibilities
Partner ICB strategies	Transparent reporting and engagement with system partners support collective improvement and consistency of standards across the integrated care system.
Assurance Route	

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

Doncaster & Bassetlaw Teaching Hospitals NHS FT
Mortality Review Update

1. INTRODUCTION – OVERALL MORTALITY POSITION

Nationally published data (Summary Hospital-Level Mortality Indicator) and internal mortality analysis demonstrate that the Trust's actual mortality closely aligns with predicted mortality over time. Actual deaths consistently track the expected range generated by national modelling, providing reassurance that mortality outcomes remain statistically controlled rather than indicative of unexpected or special cause variation.

These outcomes are a result of continued improvement work, initiated following a deep dive into concerning mortality rates back in 2022.

1.1 Board Assurance

- National SHMI data and internal mortality analysis demonstrate that actual deaths align closely with predicted mortality over time.
- Mortality outcomes have remained within national statistical control limits for a sustained period, with no evidence of special cause variation.
- For the most recent three-month period, monthly mortality figures remain within established upper and lower confidence limits, confirming a stable position with no emerging deterioration.
- Observed seasonal variation (higher winter mortality, lower summer mortality) is expected, nationally consistent, and clinically explainable.
- While the Trust's rolling SHMI remains above 1.0, it is broadly stable and comparable with peer organisations operating in similar population contexts.

1.2 Key risks

- Continued proximity of SHMI to the upper control limit requires ongoing vigilance to ensure early identification of deterioration.
- Headline comparisons with peers risks misinterpretation if not viewed alongside population risk and statistical control.

1.3 Mitigations

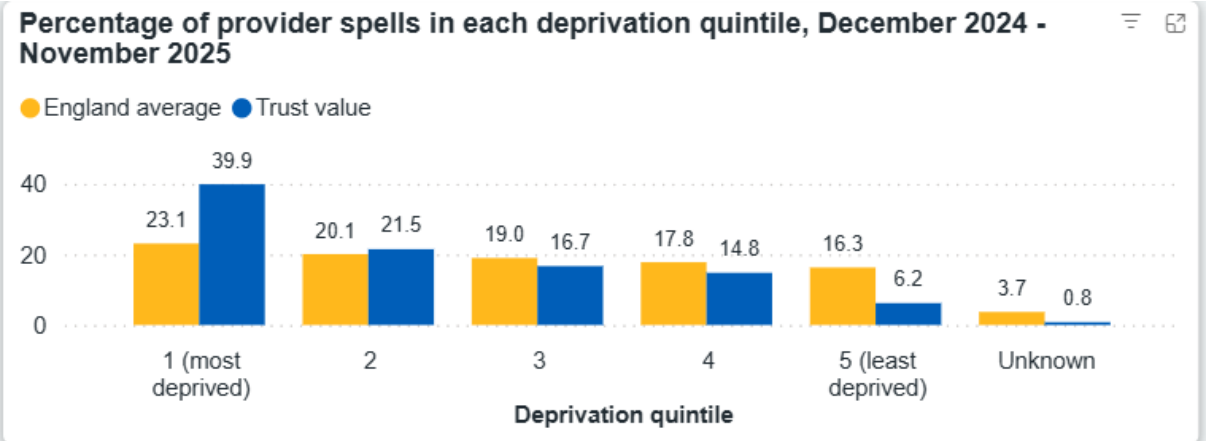
- Sustained mortality surveillance through national, internal and specialty-level data.
- Continued clinical scrutiny focused on learning and improvement rather than metric performance alone.
- Use of mortality intelligence to drive targeted quality improvement and specialty-level review.

2. INTERPRETATION AND CONTEXT

2.1 Deprivation and Population Risk

When interpreting SHMI performance, it is important to consider the broader population context in which the Trust operates. SHMI does not adjust for deprivation, despite the well-established relationship between socio-economic factors and health outcomes. The Trust serves a population with a high proportion of patients within the most deprived national quintile, a factor that is nationally recognised to influence mortality risk.

The below chart shows the percentage of provider spells for the Trust in each deprivation quintile for the period December 2024 to November 2025.

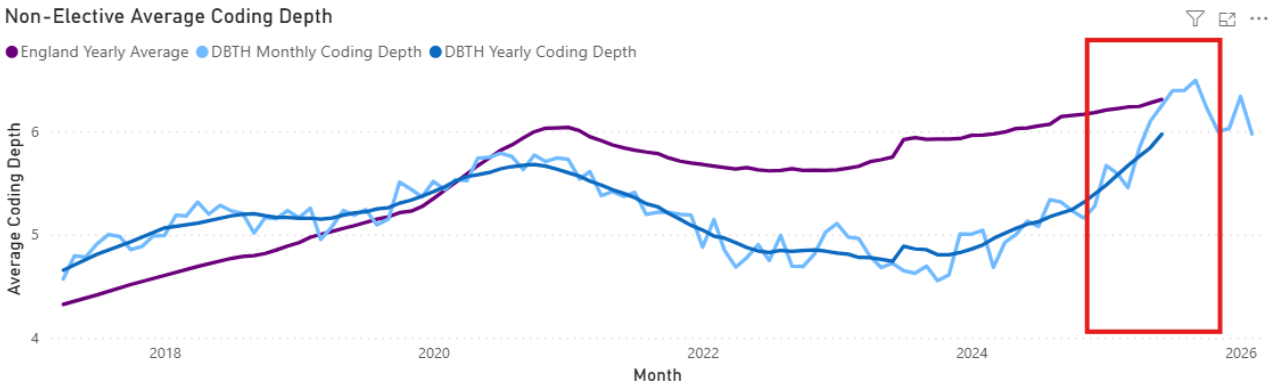


This context provides essential insight when interpreting the Trust's position relative to national benchmarks and peer organisations. It helps to explain why mortality indicators may remain above the national average despite statistically controlled performance and robust clinical governance.

Importantly, this context does not diminish the Trust's responsibility to scrutinise mortality outcomes, identify learning and continually improve care. Rather, it ensures that SHMI data are interpreted appropriately, balancing statistical performance with an understanding of population risk, clinical complexity and underlying health inequalities.

2.2 Clinical Coding and Depth of Coding

A key factor affecting the Trust's mortality indicator is depth of coding, which should reflect the levels of comorbidity within the patient population. A significant amount of improvement work has been undertaken within the clinical coding team over the past 2 years, which has ensured that case mix is coded correctly and that depth of coding now includes coding all comorbidities. The improvement change can be seen in the graph below.

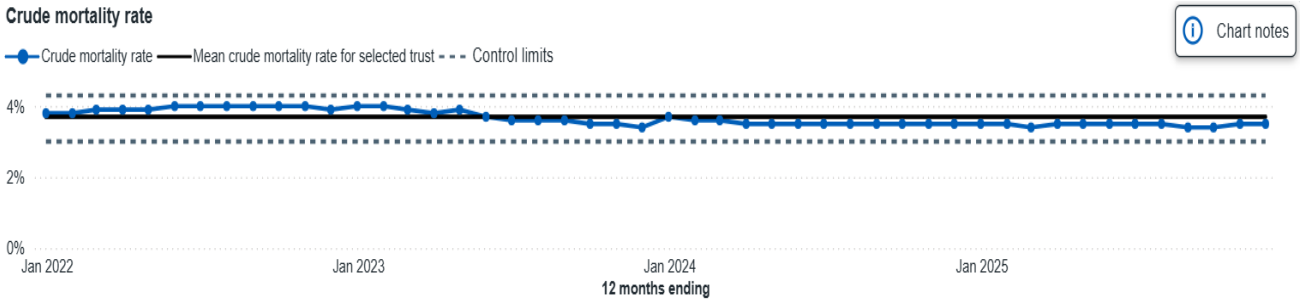


The red rectangle which denotes the latest national SHMI scoring which is the period December 2024 to November 2025.

This shows the lag in national SHMI reporting, from improvements made in either clinical coding or quality of care.

2.3 Crude Mortality

Crude mortality should be used with caution as it does not take account of the differences in case-mix, however it can act as a flag that indicates further investigation may be needed. The Trust's current crude mortality is now 3.4% down from a peak of 4% in October 2022, as seen in the below graph.



2.4 Board Assurance

- A high proportion of Trust activity relates to patients within the most deprived national quintile, who are more likely to present with:
    - Multi-morbidity and frailty
    - Advanced disease and increased clinical complexity
    - Reduced physiological reserve
- This context explains why SHMI may remain above the national average despite statistically controlled performance and robust governance.
- Crude mortality has improved materially, reducing to 3.4% from a peak of 4.0% in October 2022.
- The Trust operates within a population with high levels of socio-economic deprivation, which is a well-established determinant of increased mortality risk.
- SHMI does not adjust for deprivation and therefore does not fully reflect the underlying population risk faced by the Trust.
- A high proportion of Trust activity relates to patients from the most deprived national quintile, who are more likely to present with:
    - Multi-morbidity and frailty
    - Advanced disease at presentation

- Increased clinical complexity and reduced physiological reserve

- This population context provides essential insight when interpreting why the Trust's SHMI may remain above the national average despite statistically controlled mortality performance and robust clinical governance.
- Crude mortality has improved materially, falling to 3.4% from a peak of 4.0% in October 2022, indicating improvement in outcomes alongside stable risk-adjusted metrics.

2.5 Key risks

- There has been a recent change with some providers moving to coding Same Day Emergency Care (SDEC) admissions to the Emergency Care Data Set (ECDS) which removes them from the admitted data set from which SHMI is reported. This has led to an appeared increase in their mortality, which can be seen within Rotherham NHS Foundation Trust's data as a local example. We have not yet made this move as there is a national discussion on how to ensure consistency in metrics across providers.
- Risk of over-reliance on headline SHMI without appropriate population context.
- Potential lag between improvements in care or coding and appearance in national datasets.
- Misinterpretation of crude mortality without case-mix adjustment.

2.6 Mitigations

- Explicit deprivation-aware interpretation of mortality metrics at Board and Committee level.
- Triangulation of SHMI with crude mortality, specialty intelligence and SJR findings.
- Emphasis on trends, control limits and direction of travel rather than point estimates.

3. CLINICAL INSIGHT, STUCTURED JUDGEMENT REVIEWS AND LEARNING FROM DEATHS

3.1 Diagnostic group analysis and clinical coding

Diagnostic group analysis continues to support focused learning and improvement. Recent internal SHMI estimates demonstrate that a small number of high-volume clinical groups contribute disproportionately to excess deaths.

Latest 12 Months

Group Description	Total Spells	Predicted Deaths	LowerLimit	UpperLimit	Actual Deaths
Fluid and electrolyte disorders	692	39.2	27.5	51.0	61
Cardiac dysrhythmias	1145	15.8	8.2	23.4	27
Pulmonary heart disease	286	16.9	9.3	24.5	28
Cancer of breast	126	5.6	1.7	9.5	11
Pleurisy; pneumothorax; pulmonary collapse	264	19.4	11.4	27.4	30
Paralysis, Late effects of cerebrovascular disease	34	0.8	-0.9	2.5	3
COPD & bronchiectasis	1323	81.2	64.2	98.1	100
Nutritional, endocrine and metabolic disorders	404	11.1	4.9	17.3	18
Total	**79564**	**2,406.6**	**2,319.0**	**2,494.2**	**2539**

Conditions such as fluid and electrolyte disorders, urinary tract infections, congestive cardiac failure and renal failure remain areas of continued clinical scrutiny.

These findings are being addressed through targeted specialty-level review via divisional Performance Review Meetings (PRMs), clinical engagement and learning dissemination.

3.2 Structured Judgement Reviews (SJRs)

SJRs remain a central component of the Trust's approach to learning from deaths, providing structured, clinically-led insight into both the quality of care delivered and opportunities for improvement. During October–December 2025, there was a marked increase in SJR activity, reflecting a more targeted and risk-based approach to case selection.

A total of 11% (67) SJRs were requested and 46 completed during this period, which represents a significant upward trajectory in review activity, with the previous quarter seeing 33 cases reviewed (7%).

A dedicated team of 20 trained senior medical and nursing reviewers undertakes SJRs, ensuring clinical credibility and consistency. The reviews assess each phase of care and provide an overall quality rating, explicitly recognising good and excellent care as well as areas for improvement.

Case selection for SJR is robust and multi-factorial, led primarily by the Medical Examiner (ME) service, and includes:

- deaths of patients with learning disabilities, autism or significant mental health needs
- deaths following elective admission
- cases where staff or bereaved relatives raise concerns
- deaths with features not meeting Patient Safety Incident Response Framework (PSIRF) thresholds but warranting learning
- sepsis-related deaths identified from the Medical Certificate of Cause of Death
- specific diagnostic groups associated with higher-than-expected mortality contributing to SHMI, including anaemia, intestinal infection, electrolyte imbalance and urinary tract infection (UTI)

The outcomes from completed SJRs demonstrate that most cases are assessed as providing "good" or "excellent" care, with common examples including:

- timely recognition and escalation of sepsis
- exemplary documentation and communication
- early recognition of the dying patient and delivery of high-quality end-of-life care
- effective multidisciplinary working and early consultant involvement at critical points in the patient pathway

Importantly, SJRs are also used to provide positive assurance. Reviews of cases including learning disabilities, intestinal infection and anaemia frequently identified appropriate care, reinforcing confidence that elevated statistical signals do not necessarily equate to poor clinical practice.

3.3 Sepsis: Learning, Improvement Focus and Outcomes[1]

Sepsis continues to be a specific focus of SJRs due to its clinical significance and its contribution to mortality metrics. Predominantly identified through the Medical Examiner office where sepsis appears on the Medical Certificate of Cause of death, the reviews provide critical insight into both strengths and recurring opportunities for improvement.

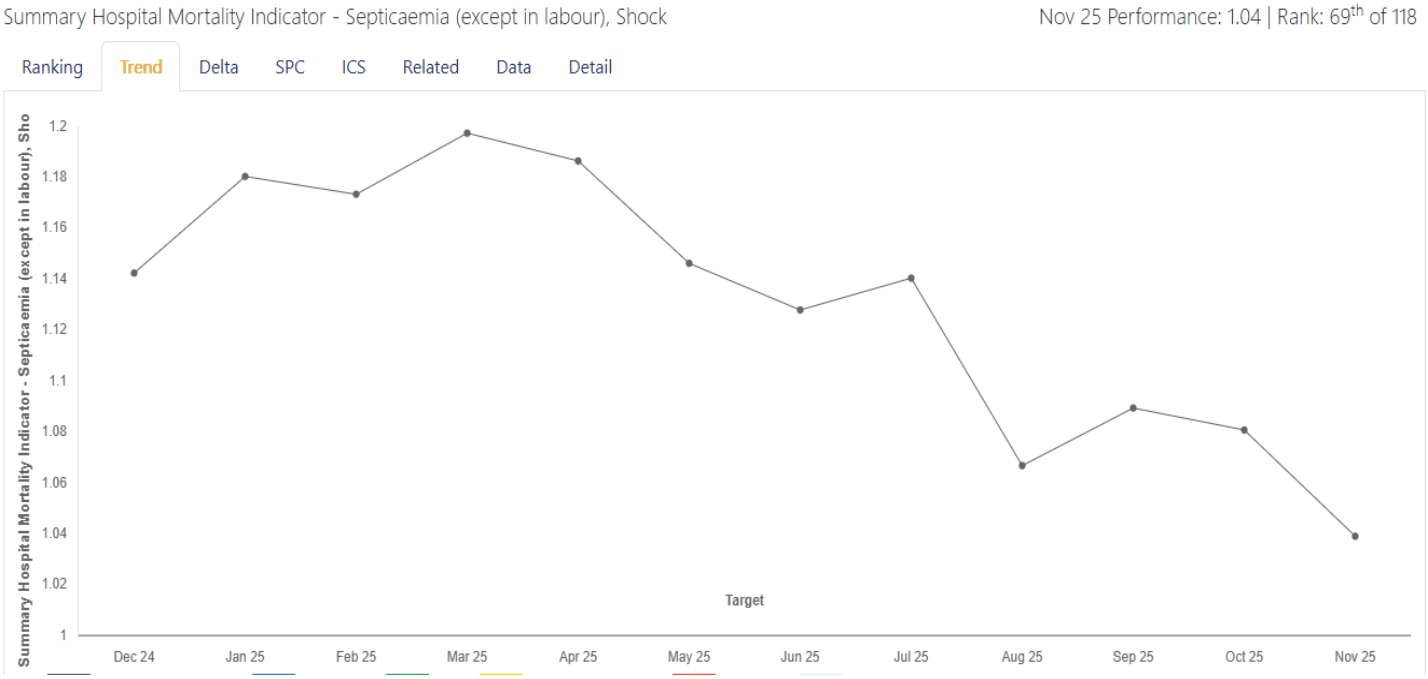
All sepsis deaths are reviewed by the Sepsis Action Group (SAG). SJR reviews feed into governance and the themes discussed at SAG.

[1] Sepsis – The Hive

Themes are usually deterioration recognised but not named as sepsis, blood cultures not sent, antibiotics delayed or not considered for change. These themes provide points of action for targeted interventions. The majority of sepsis deaths reviewed by the Sepsis Lead are in elderly patients or the very frail who are coming to the end of their life where their death is not preventable. Sepsis in these cases is more a mode of death than a cause of death. That having been said the lessons learned from the review of the deaths are valid.

SJRs of recent sepsis cases demonstrate prompt recognition and appropriate escalation in the majority of cases. Where learning themes have been identified these are fed back through clinical governance arrangements and reinforce existing Trust priorities within sepsis improvement workstreams.

The SAG has been working together since 2024 to improve the care of our patients with sepsis, we can see the results of this in the improved SHMI position for septicaemia in the below graph.



Alongside areas for improvement, reviews highlight positive practice, including timely sepsis recognition and early senior decision-making in many cases, providing balanced assurance that improvement activity is building on a sound clinical foundation.

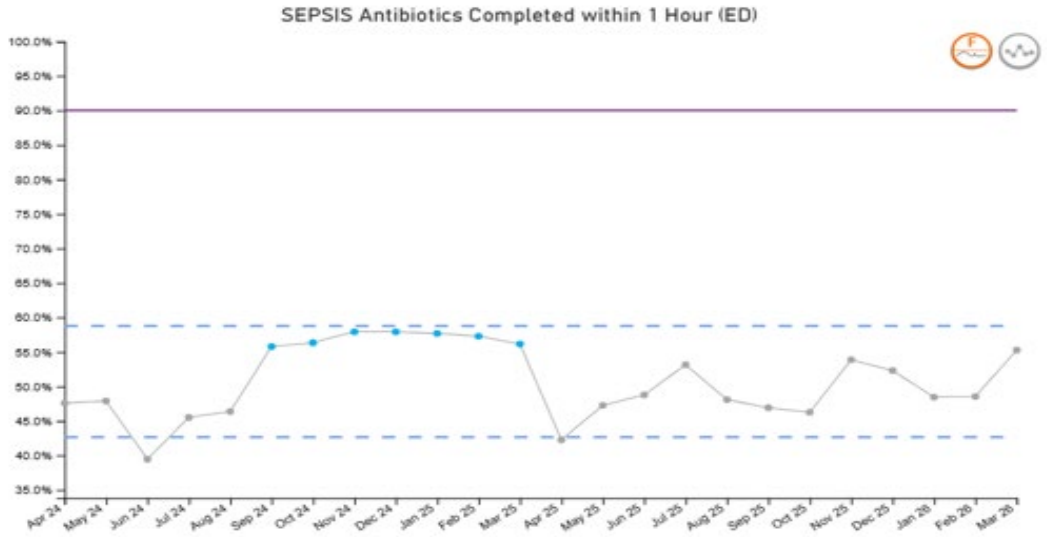
Sepsis SHMI has remained within expected range over the last 12 months reporting period, with no sustained outlier signal.

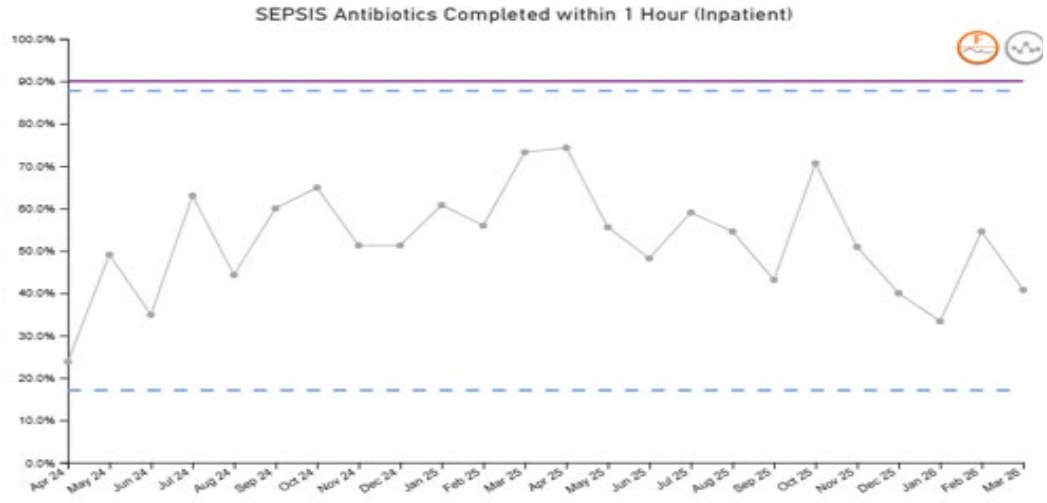
This performance has been delivered within an environment of Urgent and Emergency Care pressure. Outcome and process metrics demonstrate controlled risk with no evidence of unmanaged mortality. Risks relate primarily to time-critical delivery of the Sepsis Six bundle during peak demand and are subject to active Quality Improvement (QI) projects.

Quality Improvement actions underway:

- Increase the use of Individual Plan of Care (IPOC)
- NEWS2-linked screening and escalation standardisation to improve the recognition of deterioration as sepsis
- Increase the percentage of blood cultures in patients
- Front-door antibiotic access and prescribing reliability
- Ward escalation and senior review standards

An area of ongoing concern for the Sepsis Action Group and the Trust in general is the time to first antibiotic from recognition of sepsis. To address this, there are ongoing education projects within Emergency Departments, along with clinical audits and Sepsis Awareness Day held in March 2025.





In addition, there are projects underway to mitigate against the unintentional negatives of increased antibiotic use:

- The acute medicine team have introduced an antimicrobial stewardship (AMS) ward round on the Acute Medicine Unit (AMU) on Tuesdays, and plan to extend this to Fridays too.
- Working with NHS innovations to better manage risks of C. Diff on AMU and in medicine/surgery. This will be through increased AMS measures and education on IPC strategies. This is in collaboration with the IPC team and microbiologists.

The emphasis remains on learning, transparency and improvement, particularly within the context of population complexity and deprivation.

3.4 Board Assurance

- The Board can be assured that SJRs and sepsis reviews are being used not solely as a retrospective review mechanism, but as an integral part of a wider learning system underpinning mortality governance SHMI interpretation and quality improvement.
- Sepsis risk is understood and controlled, with risks relating to system pressure actively mitigated through QI and governance.
- Diagnostic group analysis shows that a small number of high-volume medical groups account for the majority of excess deaths.
- Conditions such as UTI, cardiac failure and renal disease remain under active clinical scrutiny.
- Structured Judgement Reviews (SJRs) are central to mortality governance, providing clinically-led insight into quality of care.
- SJR activity has increased significantly, reflecting a more focused, risk-based approach to case selection.
- The majority of SJRs identify good or excellent care, providing balanced assurance that elevated metrics do not equate to systemic quality failure.
- SJRs conducted in peritonitis and sepsis cases have found the care to be generally good and have not pointed to there being poor care or lapses in care contributing to increased cause of mortality.

3.5 Key risks

- Residual mortality signal within certain diagnostic groups.
- Risk of learning not being embedded at specialty and divisional level if not actively followed through.

3.6 Mitigations

- Targeted specialty-level reviews through divisional Performance Review Meetings.
- Feedback of SJR learning into clinical governance structures.
- Explicit recognition of good practice to reinforce clinical confidence and engagement.
- Sepsis – targeted education, audit activity and Trust-wide awareness initiatives informed by real-time performance data and SJR findings
- Sepsis risks reviewed as part of the wider mortality governance framework rather than in isolation.

4. MORTALITY GOVERNANCE FRAMEWORK

4.1 Mortality Governance

The Trust has a well-established and structured clinical governance framework to provide assurance on mortality, learning from deaths and related patient safety risks. This framework ensures that mortality information is robustly scrutinised, learning is identified and acted upon, and the Board of Directors receives clear and timely assurance that appropriate governance, oversight and improvement mechanisms are in place.

At its core, the framework is designed to ensure that learning from deaths is systematic, clinically led and embedded within routine governance, rather than being driven solely by performance metrics. It brings together quantitative intelligence, such as SHMI and crude mortality data, with qualitative insight from Structured Judgement Reviews (SJRs), Medical Examiner scrutiny and thematic reviews, including sepsis.

- **Board of Directors** retains ultimate responsibility for oversight of quality of care and patient safety, including mortality outcomes.

- **Quality Committee** provides assurance, from receipt of regular, in-depth reporting on mortality performance, Learning from Deaths compliance, emerging risks and the effectiveness of improvement actions. This enables robust challenge, scrutiny and escalation where required.

- **Effective Assurance Group** reports to the Quality Committee, providing Trust-wide oversight of clinical effectiveness and outcomes, triangulating mortality intelligence with information from incidents, complaints, audit and patient safety processes. This ensures that mortality is considered within the broader quality and safety context and that risks are not viewed in isolation.

- **Mortality Governance Group** sits at the centre of the mortality assurance framework and acts as the primary forum for Trust-wide oversight of Learning from Deaths. The group brings together clinical, governance and data expertise to review mortality themes, receive assurance on SJR activity, and oversee compliance with national guidance and statutory requirements. It provides assurance that learning is identified, shared and translated into improvement actions at divisional and specialty level. The Mortality Governance Group reports into the Effective Assurance Group.

- **Mortality Data Assurance Improvement Group** supports the accurate interpretation of mortality metrics and provides dedicated scrutiny of SHMI, crude mortality and related indicators. This group focuses on data quality, methodological understanding and trend analysis, ensuring that mortality information presented to governance forums is reliable, contextually interpreted and appropriately triangulated. This includes supporting the development and use of specialty-level dashboards to identify potential hotspots for early clinical review.

- **Medical Examiner Service** underpins this framework, by providing 100% scrutiny of in-hospital deaths and acting as a critical source of both assurance and learning. The Medical Examiner service identifies cases requiring further review, supports engagement with bereaved families, and ensures that concerns, themes or potential patient safety issues are escalated appropriately through governance routes.

- **Structured Judgement Reviews** (where indicated deaths are reviewed through the SJR process) are undertaken by trained senior clinicians and nurses. SJRs provide a structured assessment of the quality of care delivered, explicitly recognising good and excellent practice as well as identifying opportunities for improvement. Learning from SJRs is fed back to clinical teams and reviewed through divisional and specialty governance arrangements, including Patient Review Meetings and mortality review forums.

- **Sepsis / Sepsis Action Group / Sepsis Governance Group,** the framework also incorporates thematic assurance arrangements for high-risk contributors to mortality, most notably sepsis. Sepsis-related governance and improvement groups provide focused oversight of care pathways, standards and outcomes, and feed learning and assurance directly into the Mortality Governance Group. This ensures that thematic risks are not siloed and that improvement actions are aligned with wider mortality learning.
- Across all levels, there is a clear and deliberate flow:

Assurance flows upward, from clinical teams through specialty and divisional governance groups to the Quality Committee and Board. Improvement actions flow downward, with Board-level expectations translated into specialty, divisional and frontline action.

This Mortality Governance Framework enables the Board to take assurance not only from headline mortality indicators, but from the strength of the systems in place to identify learning, understand risk, address variation and improve care for patients.

4.2 Board Assurance

- The Trust has a well-established, fully integrated mortality governance framework.
- Mortality oversight is clinically led, systematic and embedded within routine governance.
- Learning from deaths is triangulated across:
    - SHMI and crude mortality
    - Structured Judgement Reviews
    - Medical Examiner scrutiny
    - Thematic reviews (including sepsis)
- Clear escalation routes exist from frontline teams through to Quality Committee and Board.

4.3 Key risks

- Risk of fragmentation if mortality, incidents and quality intelligence are not routinely triangulated.

4.4 Mitigations

- Central oversight through the Mortality Governance Group and Effective Assurance Group.
- Dedicated scrutiny of data quality and interpretation through the Mortality Data Assurance Improvement Group.
- Assurance flows upward; improvement actions flow downward in a controlled, visible manner.

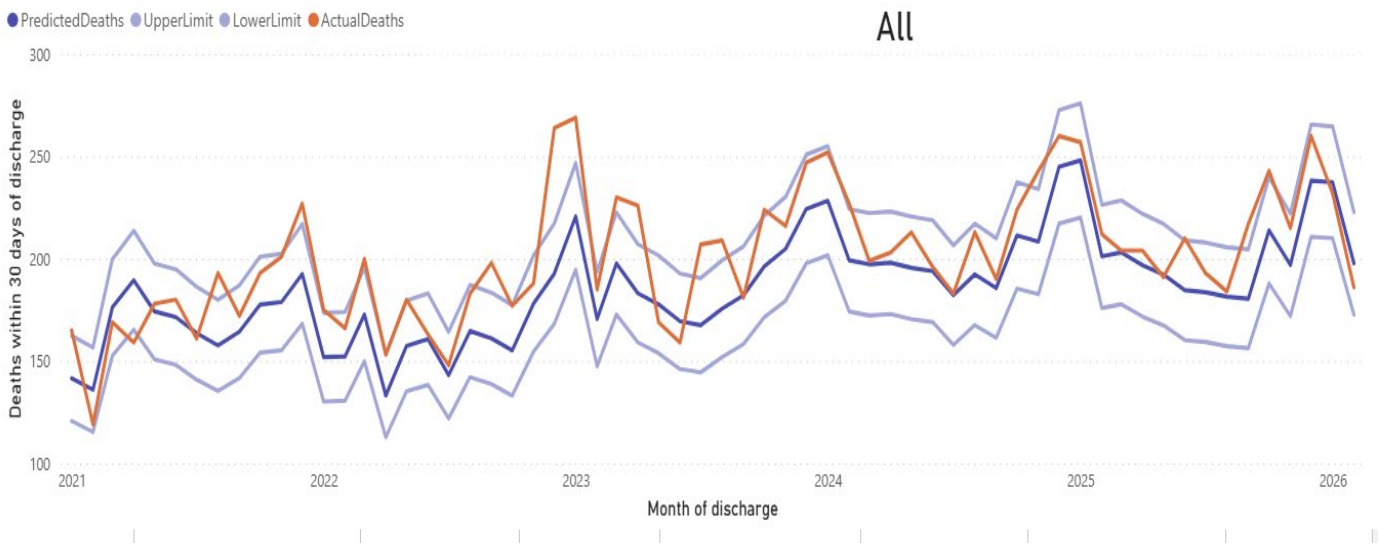
5. CURRENT PERFORMANCE AND DATA ASSURANCE

5.1 Mortality Performance

Below is the most recent mortality performance data, received by the Mortality Governance Group at their April 2026 meeting. Link to online report: SHMI Dashboard - Power BI Report Server

The graph below is the DBTH monthly predicted deaths/SHMI graph where DBTH Information Team use SHMI methodology to predict the number of deaths predicted and compare it to actual deaths.

Predicted Number of Deaths: (Data to end of January 26)



This monthly data is useful to predict where our SHMI will be in a few months' time. As shown in the last 2 months data in the above graph (which represents January and February 2026), the actual number of deaths are lower than the predicted number of deaths (as SHMI is calculated by actual deaths divided by predicted deaths this would indicate that in these last 2 months SHMI performance is under 1.0).

The graph also shows that the last time we had 2 months where actual deaths were below predicted deaths was for a short period in June 2023 and the most prolonged period was back in 2021.

We are aware that on an ongoing basis we miss 1-3% of the actual deaths as these are people who pass away out of area, with no mechanism to capture these deaths. The national SHMI team scrutinise every death certificate in the UK to ensure they are captured; however, this process takes 6 months which explains why the nationally reported SHMI data has a 6-month lag.

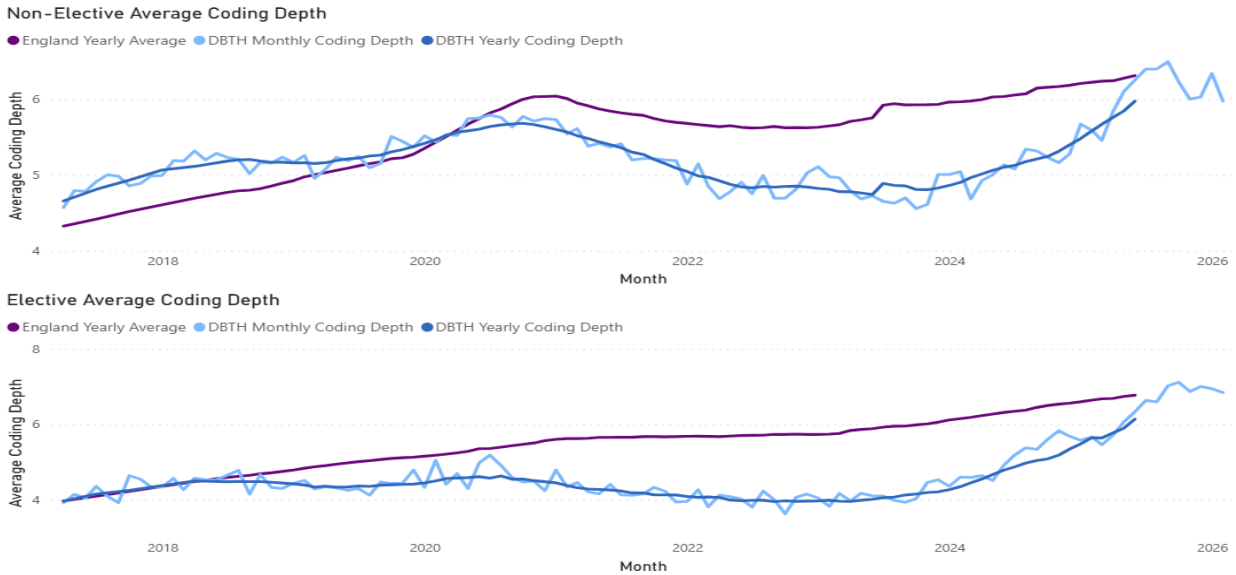
5.2 Data Assurance

Overall mortality for the latest 12-month period is higher than expected, with 2,541 actual deaths compared with 2,411.8 predicted, giving an overall SHMI score of 1.05. Actual deaths exceed the upper confidence limit at Trust level.

Several diagnostic groups are contributing to this position, all banded as higher than expected, including pulmonary heart disease, fluid and electrolyte disorders, cardiac dysrhythmias, pleurisy/pneumothorax, and cancer of bone, thyroid and other malignant neoplasms. These groups show actual deaths above the upper control limit, with SHMI scores typically between 1.45 and 1.77. A small number of low-volume groups (for example diseases of white blood cells and paralysis/late effects of cerebrovascular disease) show very high SHMI scores; however, these are based on very small case numbers and should be interpreted with caution.

Through the mortality data groups we have isolated these conditions where our SHMI is high and have requested the divisions to do some targeted investigation into the cases that contribute to these, looking at quality of care given and any other findings, to be reported through the Performance Review meeting structure. In summary, the Trust's higher-than-expected SHMI position is driven primarily by larger-volume medical groups, with smaller specialties contributing volatility rather than scale.

<u>Depth of Coding Overview (Data to end of February 2026)</u>



For **non-elective activity**, DBTH coding depth has broadly followed national trends over time, with gradual improvement up to around 2020, followed by a decline through 2021–2022. From late 2023 onwards there is a sustained recovery, with a marked increase through 2024 and into 2025. By the most recent period, DBTH non-elective coding depth is approaching, and at times exceeding, the England average, indicating improved clinical detail and coding completeness.

For **elective activity**, coding depth remained relatively stable up to 2020 before declining during 2021–2022, mirroring national patterns. From 2023 onwards there is a strong and consistent upward trend. The improvement accelerates during 2024–2025, with DBTH elective coding depth rising sharply and moving closer to the England average.

Overall, both charts demonstrate a clear and sustained improvement in coding depth since 2023, following the post-pandemic dip. This reflects improving documentation and coding quality across both elective and non-elective pathways, which is likely to support more accurate mortality metrics.

Screenshot of latest 'HED Dashboard' overview:

Custom Indicator Set: Marks Mortality	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
SHMI (monthly) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2026)	113.09 (Dec 2025)	110.90 (Nov 2025)	2.19 ↑	106.72	94.25	Within expected range
SHMI (12 mth rolling) HES Inpatients, HES-ONS Linked Mortality Datasets (Mar 2026)	114.12 (Jan 2025 - Dec 2025)	114.38 (Dec 2024 - Nov 2025)	-0.26 ↓	98.30	100.22	Within expected range

5.3 Board Assurance

- Internal monthly modelling demonstrates that recent actual deaths are below predicted levels, indicating improving trajectory.
- Current higher-than-expected SHMI is driven primarily by medical specialties, not widespread Trust-wide issues.
- Coding depth has improved significantly since 2023 across elective and non-elective activity, improving case-mix accuracy.

5.4 Key risks

- Lag in national SHMI reporting may obscure recent improvements.
- Volatility in low-volume diagnostic groups may distort perception of risk.

5.5 Mitigations

- Use of internal predictive modelling alongside national datasets.
- Cautious interpretation of low-volume outliers.
- Ongoing strengthening of coding quality and documentation standards.

6. CONCLUSION AND SUMMARY

6.1 Summary

In summary, the SHMI is intended as a high-level indicator of quality of care, designed to prompt further investigation where performance moves outside expected statistical control limits.

Currently, the Trust is performing well within control limits and has been consistently for the past 12 months, providing assurance that mortality outcomes are stable and statistically controlled. This reflects the strength of existing clinical governance, mortality review processes and learning from deaths arrangements across the organisation.

Notwithstanding this positive position, we recognise the opportunity to go further as SHMI remains towards the upper end of the control limit and there is a clear ambition to continue driving improvement and reduce SHMI to below 1.0.

While non-clinical factors such as population deprivation and depth of clinical coding influence SHMI, these do not detract from the Trust's responsibility to pursue all appropriate lines of enquiry to ensure consistently high-quality care for all patients.

To support this ambition, and working jointly with the Chief Nurse, the Trust is developing a specialty-by-specialty quality dashboard. This triangulates metrics including specialty-level SHMI, readmission rates and patient safety incidents to identify early signals of concern and target areas requiring further review. This dashboard is currently in a trial stage across the Trust.

In addition to the above, we continue to strengthen care of the deteriorating patient[2] through the Sepsis Action Group, specialty governance arrangements and the rollout of Martha's Rule. These improvement programmes are intended to further enhance early recognition, escalation and timely intervention, supporting safer care and improved outcomes.

6.2 Conclusion and Forward Assurance

6.2.1 Overall Board assurance

- The Trust's mortality position is stable, statistically controlled and subject to robust clinical governance.
- There is no evidence of unmanaged or unexplained mortality risk, and outcomes remain consistent with national predictions.
- Strong systems are in place to support learning from deaths, clinical scrutiny and targeted quality improvement, rather than reliance on headline metrics alone.

6.2.3 Remaining focus

- The Trust recognises that SHMI remains towards the upper end of the control limit and therefore maintains a clear ambition to further reduce mortality, including reduction of SHMI towards and below 1.0.
- Ongoing strengthening of specialty-level intelligence, including trial of multi-metric quality dashboards.
- Ongoing work will continue to strengthen care of the deteriorating patient, including sustained focus on sepsis improvement, specialty governance arrangements and the rollout of Martha's Rule.

[2] https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/

6.2.4 Triangulation and Future Assurance

- A continued priority for future reporting is the systematic triangulation of mortality intelligence, ensuring that all relevant factors influencing mortality are considered together.
- This includes the integrated review of:
    - SHMI and internal predictive modelling
    - Crude mortality trends
    - Structured Judgement Review findings
    - Medical Examiner intelligence
    - Diagnostic group and specialty-level analysis
    - Patient safety incidents, complaints and audit outcomes
- This triangulated approach strengthens assurance by ensuring that statistical signals are consistently interpreted alongside clinical insight, population risk and quality intelligence.
- The development and trial of specialty-level quality dashboards, incorporating multiple outcome and safety metrics, will further support early identification of risk and targeted intervention.

6.2.5 The Board of Directors is asked to:

- Take assurance from the report and that mortality remains within the statistical control limits.
- Triangulation with other systems, such as SJRs, Patient Safety Incident Response Framework (PSIRF) and Medical Examiner recommendations, is used to ensure patient safety and quality of care within the Trust
- Note a commitment to further reduce the headline SHMI indicator towards 1.0 from its current position of 1.14 noting that this may be hampered by the level of deprivation of our population served.
- Note ongoing risks and mitigations detailed in the report.
- Support continued focus on learning-led improvement alongside metric performance.

2605 - D3 HEALTH INEQUALITIES BI-ANNUAL REPORT

Information Item | Zara Jones, Acting Chief Executive | 12:00

Dr Kelly MacKenzie, Consultant in Public Health
10 minutes

REFERENCES

Only PDFs are attached

D3ii - Health Inequalities Bi-annual Report.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Health Inequalities Bi-annual Report**			
Executive Sponsor:	Zara Jones, Acting Chief Executive			
Authors:	Dr Kelly Mackenzie, Consultant in Public Health (DBTH) and Clinical Senior Lecturer in Public Health (University of Sheffield) Richard Woodhouse, Health Inequalities Development Manager			
Appendices:	Appendix 1 – Updated work plan			
Purpose of the report	Assurance	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 1, BAF 2, BAF 3, BAF 5, BAF 6, BAF 7			

Executive Summary – Key messages and Issues
To provide an update on the tackling health inequalities work. The information in the report provides a summary of the key work undertaken by the Health Inequalities Team since our last update in September 2025.

Recommendations
The Board of Directors is asked to note progress to date.

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

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

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

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

1. Background

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

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

To deliver the strategic ambition, the HI Team is working on three main areas of focus for 2026/27:

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

We also provide an updated version of our action plan originally approved by Board in March 2025 (see Appendix 1) which outlines the key actions relating to tackling health inequalities for 2026/27.

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

2. Education and awareness

Over the past 18 months, the HI Team has developed and implemented a tiered Health Inequalities training package which is now embedded at scale across the Trust (see Fig 1). Building capacity within the Trust by training staff about what health inequalities are and how to tackle them ensures that tackling inequalities becomes a focus for everyone and part of business as usual. The model is designed to move beyond simple awareness and support practical service-level change.

Here are our achievements/areas of progress:

- Continued roll-out of the Change Initiator Training, with 230+ staff trained to date. This training is now included as Role Specific Training and has been allocated to relevant colleagues (approx. 600) via ESR. We have received overwhelmingly positive feedback on this training (see Fig 2) with over 98% positive responses across all measures and most importantly, attendees report increased confidence to:
  - Identify inequalities
  - Understand barriers
  - Quality of training delivery
- Launch of Heath inequalities training in SET+ in March 2025, and to date 7,200+ of our people have completed this.
- The Health Inequalities Advocate Training roll-out has stalled due to national changes in training requirements. We are working closely with the Education Team to find a way of embedding this training into the Trust's programme.
- With the support of the Communications Team, we have reviewed and updated our existing comms plan to ensure regular updates on our HI work and opportune links to HIs (where appropriate) are disseminated via our comms channels.

Fig 1: DBTH Tackling Health Inequalities Training Pyramid

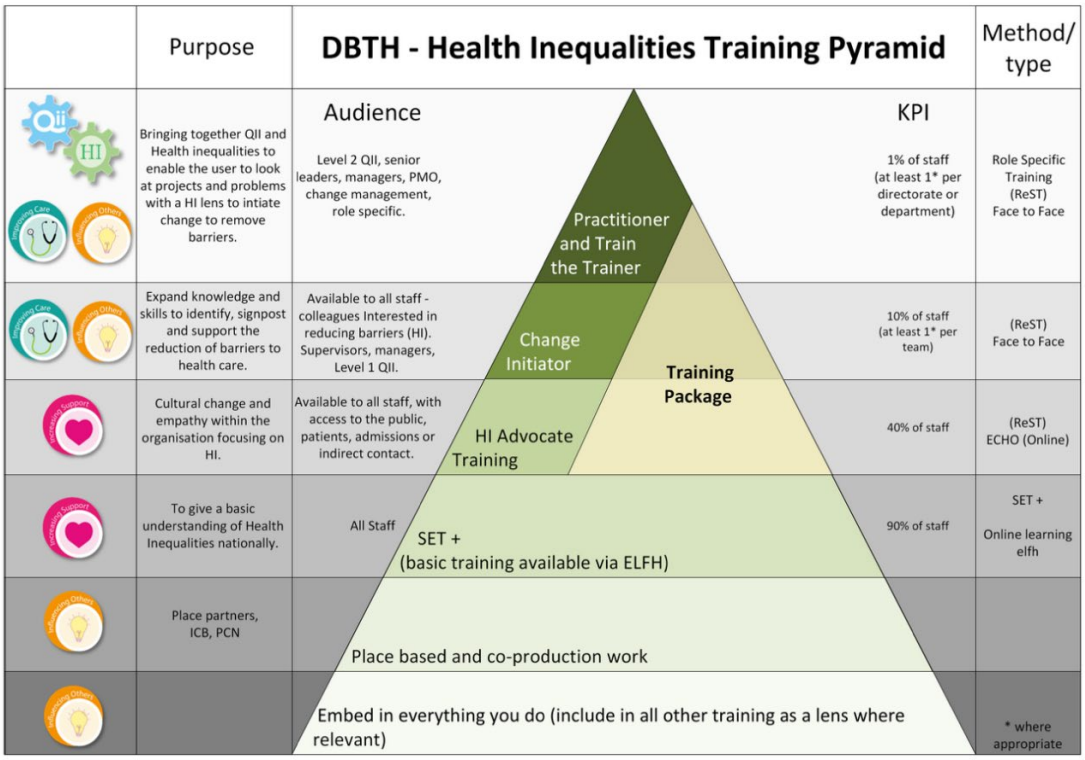
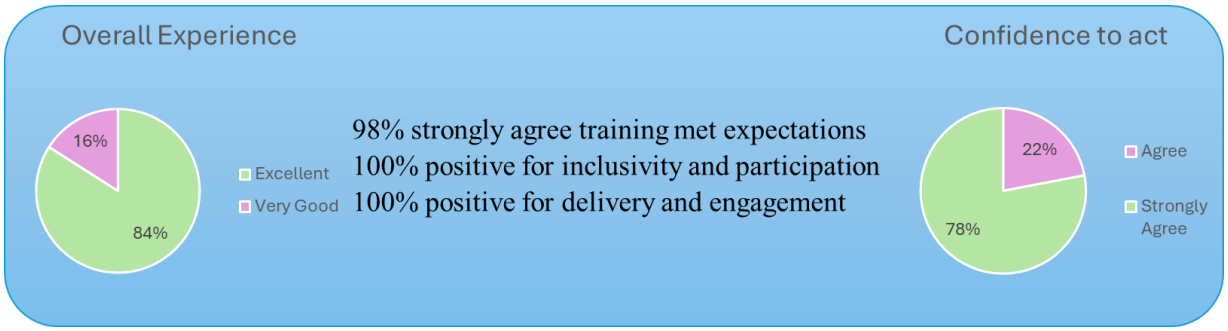


Fig 2: Snapshot of the feedback from Change Initiator training



3. Evidence-based interventions

As approved at the Board of Directors Meeting in September 2025, our current workstreams are focusing on elective care pathways with a health inequalities lens. It must be noted that we are intending to complement and work with existing work on improving elective care pathways, not develop isolated programmes of work.

- **Fair waiting list pilot**
  BEACON (the Barnsley score, formally known as WHaLES) is a health inequalities scoring tool developed by Barnsley NHS Foundation Trust that assigns patients a composite risk score based on factors like deprivation (IMD), ethnicity, comorbidities, ED attendance, and waiting times. The aim is to identify patients most at risk of being disadvantaged by the inverse care law — where those with the greatest need tend to receive the least care — and use that score to reorient clinical decision-making and prioritise treatment more equitably.

- **Targeted Did Not Attend (DNA) / Was Not Brought (WNB) rate reductions**
  We will support and develop existing work to reduce DNA/WNB rates to maximise equity.

We identified key colleagues in the Trust to support these two workstreams and had a high-level initial meeting regarding how to progress this work on 20th April 2026. Given the overlap of these two workstreams, it was decided to progress them together with one working group driving the work. Using a DBTHi approach, we are convening a working group across public health/health inequalities, operations, QI, PMO, data analysts, patient engagement, digital, planning plus external partners from primary care and Doncaster and Bassetlaw Place. We will involve our

Barnsley NHS Foundation Trust colleagues initially to get advice and support on how to implement BEACON in our context (Barnsley have indicated they are happy to support this process at no cost). Progress will be monitored via our new governance structure (see point 4 below for more information).

A third workstream will involve an equity-focused approach to improving access to Women's and Children's services, informed by local data and aligned to national and local priorities. The specific focus of this area of work will be developed with colleagues from Women's and Children's Division and will commence towards the end of 2026/27.

Research and innovation also form an important part of our evidence-based approach. Current projects include:

- The PERIOD Project, an NHS Charities Together funded project (approx. £200k) to be led by Dr Mackenzie and supported by DBTH Charity, which aims to understand the prevalence and impacts of period poverty and menstrual health inequalities with the DBTH workforce and to co-produce practical interventions that improve support and workplace culture utilising both research and quality improvement methodologies. This is an 18-month project which is scheduled to commence in May/June 2026.
- An NIHR-funded intervention development project (approx. £240k) examining barriers to accessing perinatal mental health care for women and pregnant people in South Yorkshire whose needs are not met by existing services. As part of this project, a system-level Fair Care Framework has been co-designed, and further funding is now being sought to implement and evaluate it.
- Involvement in a large NIHR maternity inequalities consortium, working with colleagues at the University of Sheffield, the London School of Hygiene and Tropical Medicine, and the Institute for Fiscal Studies, to tackle the root causes of maternity inequalities, with specific projects anticipated to begin in 2026.

4. Developing a "tackling health inequalities" culture

Significant work has taken place over the last 6 months to strengthen the governance and cultural foundations that will enable health inequalities to become embedded across the organisation. A new governance structure has been established, comprising a Health Inequalities Oversight Group (HIOG), chaired by Zara Jones, which provides a clear escalation route to the Executive Team and formal six-monthly progress reporting to the Board of Directors. The first HIOG meeting is scheduled to take place on 14th May 2026. The previous Health Inequalities Steering Group has been renamed the Health Inequalities Forum (HIF), which continues to provide a broad, inclusive space for stakeholders, partners, and anyone with an interest in tackling health inequalities to share ideas and best practice.

In April 2025, a sub-group of the Board and the HI Team completed the HI Self-Assessment tool, which provided a baseline score for the Trust across four domains: Building Public Health Capacity and Capability (88%, thriving); Data Insight, Evidence and Evaluation (29%, developing); Strategic Leadership and Accountability (67%, maturing); and Systems Partnerships (60%, maturing). The assessment will be repeated in May 2026 to track progress.

Informed by the results of the Self-Assessment Tool, we placed a focus on improving our health inequalities data. With support from our data analysts, we developed an Equity Index, a data tool that provides a score between 0 (complete equity) and 1 (complete inequity) breaking metrics down by deprivation and ethnicity (see Fig 3). The Equity Index supports us to prioritise our work and track progress over time. The Equity Index work is now complete, and we have plans to implement this across the Trust. In parallel, a DNA health inequalities data dashboard has been developed to provide clear insight into DNA/WNB patterns and to support equitable, targeted improvements (see Fig 4). The Equity Index and the DNA health inequalities data dashboard will support the evidence-based interventions described above.

Other notable developments this over the last 6 months include:

- Health inequalities impacts and opportunities are now required on all Trust coversheets and business cases, embedding consideration of inequalities into our decision-making processes.
- All Board members have made personal Health Inequalities pledges, with a communications plan in development to share these across the organisation.
- A trial of Health Inequalities case studies at Public Board meetings was held at the November 2025 meeting and was very positively received.
- DBTH's Citizens' Panel is now up and running, bringing lived experience voices into Trust decision-making.

- We continue to work with the Healthy Hospitals Programme Team to consider how to increase the prevention offer whilst also providing a health inequalities lens.
- A dedicated focus on the veteran's community, with over 13,000 veterans in Doncaster facing distinct barriers to healthcare, employment, and housing. Work included the establishment of an Armed Forces Oversight Group, development of a veterans and armed forces staff network, rollout of the Veterans Covenant Healthcare Alliance National Training and Education Programme and strengthening of employment pathways through the Step into Health programme. The Trust has submitted its application for the Silver Employer Recognition Award, and we are planning a dedicated workshop to develop further short- and longer-term goals to tackle health inequalities for veterans.

Fig 3: Screenshot of our Equity Indices Dashboard

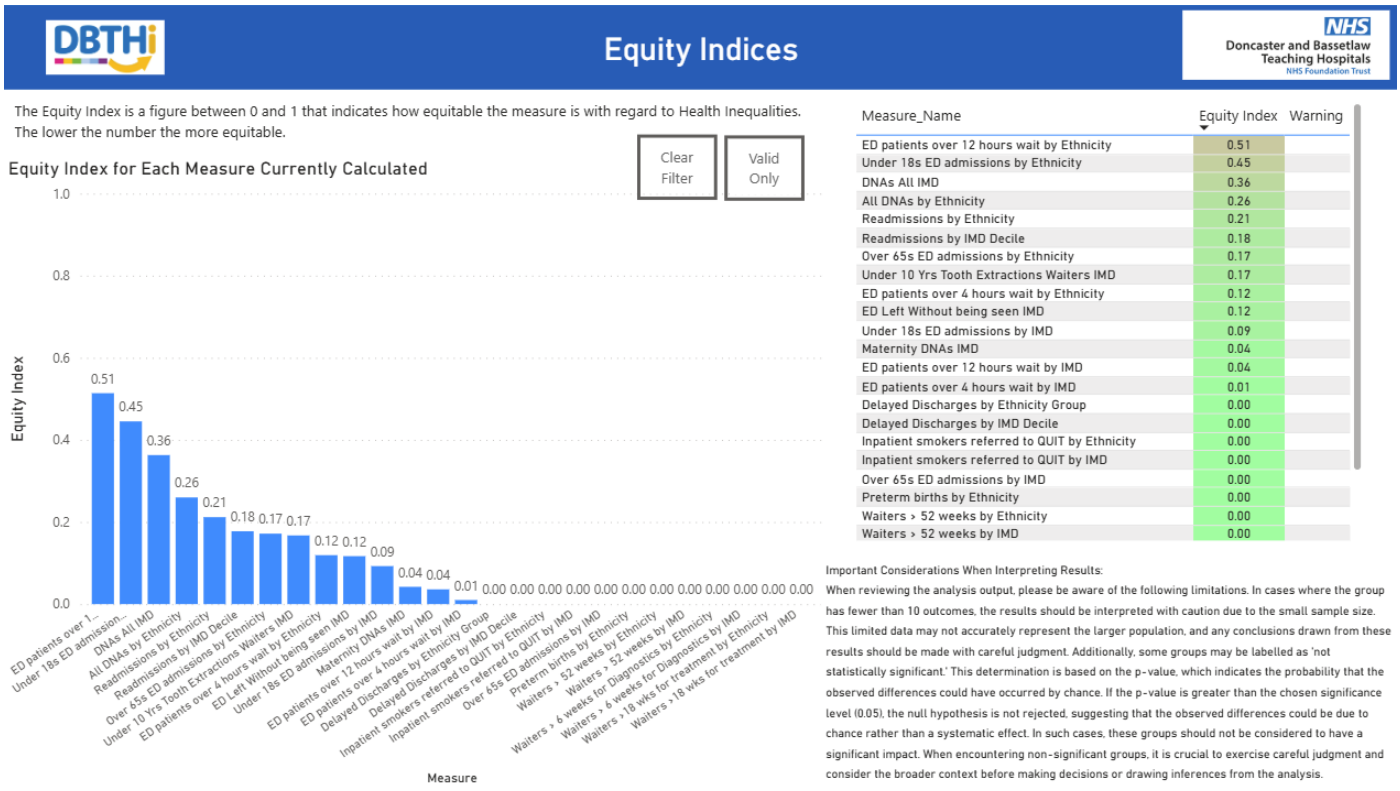
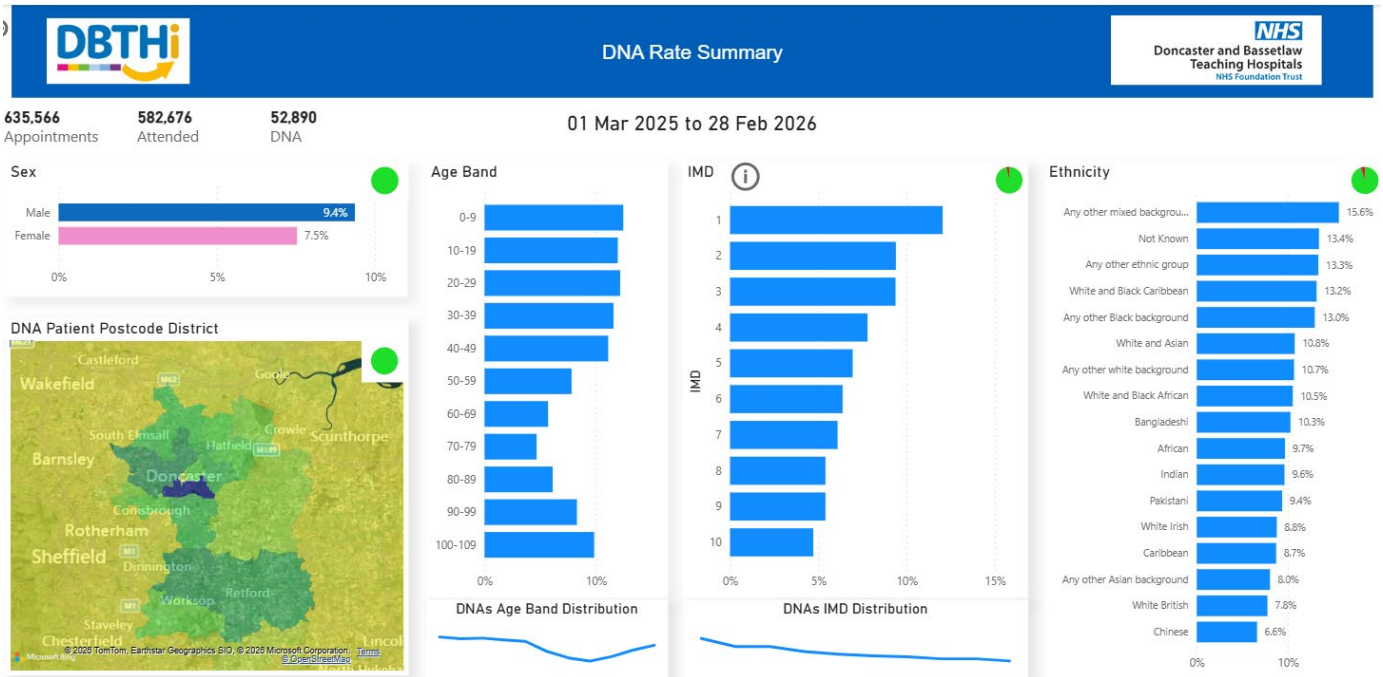


Fig 4: Screenshot of our DNA Health Inequalities Data Dashboard



5. Next steps

Below outlines our key next steps. See the work plan (appendix 1) for further details.

1. Education and awareness – continued roll-out of our Change Initiators training aiming to train a further 150 of our people in the next 6 months (by November 2026). We are recruiting colleagues to support with the delivery of this training and increasing the number of training slots available over the next 12 months to meet the demand (since becoming Role Specific Training).
2. Evidence-based interventions ("top priorities") – involving trust-level quality improvement work, support from the DBTHi team will be sought as well as relevant clinical input:
    a. Fair waiting list pilot and targeted DNA/WNB rate reduction – one working group to be set-up to progress the work. Progress will be monitored via the Health Inequalities Oversight Group meeting.
    b. Delivering targeted health inequalities research – the PERIOD project will begin in May/June 2026 (TBC) now funding has been secured.
3. Embedding tackling health inequalities into everything we do:
    a. Implementation of Equity Index and DNA Health Inequalities Data Dashboards to embed across the Trust.
    b. Repeating the HI Self-Assessment Tool (May 2026) to monitor progress, particularly in the "Data Insight, Evidence and Evaluation" domain – need Board representation to support completion.
    c. Review implementation of inclusion of "health inequalities" on coversheets and inclusion of health inequalities case studies on the agenda of Public Board Meetings.

6. Risks and issues

The following risks are ongoing:

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

Appendix 1: Tackling Health Inequalities Work Plan

Programmes of Work	Action	KPIs / Measures	Lead	Timescale	RAG Rating
Education and awareness raising	Health Inequalities Change Initiator Training package rolled out on ESR as Role-Specific Training	Change Initiator Training on ESR	HI Team with support from Education Team	By end Mar 2026	Done
	Deliver Change Initiator Training to staff required to complete	Deliver out Change Initiator Training to a further 150 of our people	HI Team with support from Education Team	By end Oct 2027	
	Use a "train the trainer" model to build a faculty to support the delivery of the Change Initiator Training	Deliver 2 x "train the trainer" sessions	HI Team	By end Dec 2026	
	Explore roll-out of Health Inequalities Advocate Training as part of Role-Specific Training	Discuss with Education Team / Director of Education and Research	HI Team and Education Team	By end Jun 2026	
	Continue to work closely with comms team to enhance the profile of health inequalities across the Trust	Deliver comms plan and amend / update as required	HI Team and Comms Team	Ongoing	
Fair waiting list pilot	Determine which clinical teams are going to pilot the Fair Waiting List Initiative (BEACON) ensuring a range of teams are included (e.g. medicine, surgery, CSS, and paeds) and set-up a working group to progress the pilot work	Set-up working group to progress work	HI Team with support from DBTHi Team	By end Apr 2026	Done
		Complete pilot work with three specialities	HI Team with support from DBTHi Team	By end Mar 2027	
Equitable DNA / WNB rate reductions	Undertake groundwork to understand baseline DNA / WNB data with a HI lens, current teams involved in managing DNAs / WNBs, and existing work happening across the Trust to reduce DNAs / WNBs. Set-up a working group to progress this work and develop initiatives to reduce DNAs / WNBs whilst also reducing HI.	Develop a DNA data dashboard to understand baseline issues	Information Analysts with support from HI Team	By end Mar 2026	Done
		Set-up a working group to progress work	HI Team with support from DBTHi Team	By end Apr 2026	Done
		Develop, implement, and evaluate initiatives to reduce DNAs / WNBs with a HI lens and demonstrate a reduction in the equity indices and overall DNA rates	HI Team with support from DBTHi Team	By end Mar 2027	

An equity-focussed approach to improving access to Women and Children's services	Begin initial meetings with key people in the Trust (e.g. Janine Grayson, Lois Mellor, Katherine Simpson etc) to scope out existing work happening in the Trust and with partners to understand current work in this space and how we might want to support	Set-up a working group to progress work	HI Team with support from DBTHi Team	By end Sep 2026	
		Determine an area of focus	HI Team with support from DBTHi Team	By end Mar 2027	
		Develop, implement and evaluate initiatives to improve access to Women and Children's services	HI Team with support from DBTHi Team	By end Mar 2028	
Data and evidence	Start using national and local dashboards to report our HI data as part of IQPR and other reports as relevant	IQPR to include HI data	HI Team & Performance Team	By end Sep 2026	
	Finalise Equity Index work and incorporate into existing data dashboards	Equity index data rolled out	Information Analysts with support from HI Team	By end Jun 2026	
Research – The PERIOD Project	Project set-up	Recruit to vacant posts	HI Team & DBTH Charity	By end Sep 2026	
	Apply for ethics approval via University of Sheffield	Secure ethics approval	KM & DBTH Charity	By end Sep 2026	
Leadership and Board action	Re-complete self-assessment tool (small sub-group of the Board) and compare to initial benchmark which was completed in April 2025	Self-assessment tool measures reassessed	HI Team, Deputy CE plus other Board member volunteers	By end May 2026	
	Bring HI issues to life in Trust Board meetings	HI presentations / case on Board agendas	HI Team & Place partner colleagues	Ongoing	
Reactive work	Determine the focus of the Healthy Hospitals Programme Phase 2 (HHP2) work and support the roll-out of this	Set-up a working group to progress this work	HHP Team plus HI and DBTHi Teams	By end Dec 2025	Done
		Have a clear HHP2 plan	HHP Team plus HI and DBTHi Teams	By end Aug 2026	

2605 - D4 DELIVERY OF 2025/26 STRATEGIC SUCCESS MEASURES

Discussion Item | Executive Directors | 12:10

10 minutes

REFERENCES

Only PDFs are attached

D4 - Delivery of 2025-26 Strategic Success Measures.pdf

D4 - Appendix 1 - Strategic Ambitions and Success Measures 2025-26.pdf

Report Template				
Meeting Title:	**Board of Directors**		Meeting Date:	5 May 2026
Report Title/ Ref:	**Delivery of 2025/26 Strategic Success Measures**			
Executive Sponsor:	Zara Jones, Acting Chief Executive			
Authors:	Rebecca Allen, Associate Director of Strategy, Partnerships and Governance James Tabor, Associate Director of Planning, Performance and Improvement			
Appendices:	Appendix 1: Trust Strategic Ambitions and Success Measures Final Report 2025/26			
Purpose of the report	**Assurance**	~~Decision~~	~~Information~~	**Discussion**
Impacts on Strategic Risks (BAF 1-7)	All BAF risks: The paper provides assurance on delivery of the Trust strategy and shows how 2025/26 strategic success measures transition into the Medium Term Plan reset pillars and objectives.			

Executive Summary – Key messages and Issues

Overall position

The Trust has largely delivered its 2025/26 strategic ambitions, with clear evidence of progress across quality, access, people and culture, digital readiness, health inequalities, and financial recovery supported by established governance routes.

There is a clear and credible line of sight into the Medium-Term Plan reset, further detail will be provided in a subsequent Board meeting.

Key strengths

- **Quality and safety:** Measurable improvement across agreed quality priorities, with structured audit programmes, visible executive oversight, and defined plans to sustain and spread improvement.
- **Access and performance:** Delivery of the operational plan with material improvement in urgent and emergency care, elective performance, cancer standards and ambulance handovers.
- **People and culture:** Strong triangulation of staff intelligence (DBTH Way, Well-Led, Speak Up, staff survey), external validation of progress, and clear programmes in place to embed culture and leadership improvement.
- **Health inequalities:** Governance infrastructure is established, the Equity Index is operational, and workforce capability has been built to support targeted action.
- **Digital and estates:** Major enabling milestones achieved, including EPR business case approval and infrastructure investment, positioning the Trust well for delivery in 2026/27.
- **Finance:** Delivery of the financial plan, significant efficiency gains and improved productivity trajectory, providing a stable platform for the reset programme.

Key challenges and residual risks

- **Workforce sustainability:** Outstanding BAPM medical staffing requirements in maternity remain dependent on business case approval and implementation.
- **Health inequalities data maturity:** Further improvement is required to strengthen ethnicity recording and routine disaggregation to fully support equitable performance oversight.
- **Clinical effectiveness:** NICE compliance and GIRFT maturity remain variable and will rely on continued divisional grip and escalation through established assurance forums.
- **Governance transition:** Corporate and divisional governance arrangements are mid-transition and require continued oversight, including alignment with internal audit recommendations.
- **Financial sustainability:** While recovery is evident, an underlying deficit remains, necessitating ongoing productivity and cost control focus.

Assurance assessment

Overall assurance: Significant

The Board can take confidence that the Trust has delivered its 2025/26 Strategic Success Measures, with clear and triangulated evidence of progress across quality, access, people and culture, digital enablement, health inequalities and financial recovery, supported by effective governance and oversight arrangements.

The Board notes that a number of known strategic risks and structural dependencies remain at year-end. These are consistent with the Board's risk appetite, do not detract from delivery of the 2025/26 ambitions, and will continue to be actively overseen through established governance and Board Assurance Framework arrangements during 2026/27.

Board focus for 2026/27

- Confirm grip on identified residual risks and clear ownership through MTP reset governance.
- Maintain pressure on workforce and inequality enablers to avoid erosion of progress.
- Ensure assurance remains evidence-based as delivery transitions into business-as-usual.

Recommendations

The Board of Directors is asked to:

- Take significant assurance from the final 2025/26 position set out in Appendix 1, recognising strong delivery against the Trust's strategic ambitions while noting the residual risks with identified forward plans for resolution, particularly in workforce sustainability, health inequalities data maturity and clinical effectiveness.
- Endorse the transition of oversight into 2026/27 through Medium Term Plan/reset governance arrangements, with a specific expectation further detail on the governance arrangements will be presented in July 2026.

Healthier together – delivering exceptional care for all	
Patients	Provides assurance on delivery of safe, effective and equitable care through progress on national operational priorities, quality priorities, maternity and neonatal services, GIRFT, health inequalities, digital and estate improvements.
People	Provides assurance that people, culture, leadership, education and workforce actions are being carried into the reset programme, particularly through Culture & Leadership and Workforce & Organisational Design.
Partnerships	
Pounds	Provides assurance on 2025/26 delivery of the financial plan and efficiency programme, and shows the transition into the Productivity & Financial Reset pillar for 2026/27 onwards.
Health Inequalities	Provides assurance on delivery of Board commitments to tackle health inequalities and confirms the need for continued focus on data maturity, fair waiting lists and targeted improvement.
Legal/ Regulation:	It is a regulatory requirement for the Board of Directors to set the strategic direction of the organisation and review delivery on a regular basis.
Partner ICB strategies	The paper aligns to ICB and partner strategies, including national access, quality, productivity, digital, workforce and health inequalities priorities.

<table>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Progress has been overseen through relevant Board committees during 2025/26, with further delivery to be monitored through the Medium-Term Plan/reset governance arrangements.</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>N/A</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
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<tr><th>None</th><th>Minimal</th><th>Cautious</th><th>Open</th><th>Seek</th><th>Significant</th></tr>
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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Trust Strategic Ambitions and Success Measures Final Report - 2025/26

April 2026

Strategic Ambitions

Progress Update – Key Highlights

Tackling Health Inequalities

- Health inequalities is now one of four strategic ambitions within Healthier Together.
- 7,214 staff completed Health Inequalities SET+ training and 220+ staff completed Change Initiator Training.
- New governance is in place through Health Inequalities Oversight Group, Health Inequalities Forum and the Citizens' Panel with formal Board oversight.
- The Trust Equity Index is complete, and targeted work is progressing on Did Not Attend / Was Not Brought, fair waiting lists, women and children, inclusion health and veterans.

Leading Centre for Education and Research

- NHS England Senior Leader Engagement Education Quality Review report received. Positive overall, two known specialties requiring additional support.
- Activity against national NHSE statutory & mandatory training project on track.
- Involvement in new South Yorkshire Academic Health Partnership.
- Successful award of external capital investment funding in support of phase 2 of the Clinical Research Hub. Estates work planned to commence Q2.
- Mapping exercise undertaken in relation to national 150-day set up target for clinical research, reported at Executive team and to be reported at next People Committee.

Digitally Enabled and Digitally Mature Organisation

- Digital Enabling Plan 2025-2028 approved
- EPR Full Business Case is fully approved and work underway to implement the Oracle Health system.
- Significant progress against our Digital work programme, including improvements to infrastructure, upgrades of key systems, Co-pilot trial, and Quality Dashboard Improvements.
- Maintaining ‘standards met’ assessment of the Data Security and Protection Toolkit.
- Launched Digital Academy which will lead to digital literacy improvements.

Improved Estate and the Best Care Environment

- Discharge Lounge DRI
- Surgical SDEC DRI
- W&C Roof replacement DRI
- Commenced DCC build DRI
- New Lister Court Car Park DRI
- BDGH Mortuary improvements
- SDEC/Minors ED BDGH
- CT BDGH
- Rehab Robot in New Extension MMH
- X Ray room upgrade MMH

Success Measures

Delivery of year 3 of the People Strategy (Enabling Plan)

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Forward plan 2026/27
• Evidence and feedback from the DBTH Way in Action and Well-Led reviews have been systematically considered and triangulated to inform the People Plan and the wider culture and leadership programme, providing assurance that development activity is aligned to identified improvement themes. • Anti-racism: Bronze accreditation has been achieved through the North-West BAME Assembly, providing external validation of progress against our anti-racism commitments. • The Speaking Up peer review report was received in January; findings and recommendations have been reviewed with the Speak Up Forum, with agreed actions and oversight arrangements in place. The position has been reported to the People Committee and the Board, providing assurance of appropriate governance and escalation. • The Trust continues to contribute to the South Yorkshire HPMA Avoiding Harm framework; supporting resources to strengthen organisational change processes have been launched, providing an evidence-based approach to risk mitigation during change. • Staff survey results were published on 12 March response rate was 54% compared to sector average of 47%. Data have been analysed and triangulation to identify key themes DBTH performed better than sector in 6 out of the 7 People promise themes. 7% of questions showed improvement, 17% declined and 76% - no change.	• Introduction of the new culture and leadership programme, following a soft launch in Q4, with ongoing involvement and engagement. Including “line in the sand” communications. • Embed anti-racism work alongside other diversity and inclusion activities. • Revise EDI improvement plan for 2026/27 • Communications and engagement ongoing during Q1 in relation to themes and outputs of Speaking Up peer review. • IQVIA presentation at May Board (staff survey results) Divisional engagement and action improvement planning is in progress. • Engagement sessions are underway to develop local improvement plans, supported by central oversight to provide assurance of consistent follow-through and accountability • Deep dive into bullying and harassment to commence, following establishment of review group and methodology. • Annual DBTH Leadership Conference to be held on 22 April, with external speaker keynote on behavioural science and internally facilitated workshops. **(cont’d)**

Lead Director Progress Update	Forward plan 2026/27
• A national case study on our flexible working activity has been published, providing external recognition and dissemination of good practice. “we work flexibly” theme in 2025 staff survey shows significant improvement. • Appraisal season 2026 launched with inclusion of new “I will” statement • NHS England Senior Leader Engagement Education Quality Review report received. Positive overall, two known specialties requiring additional support. • Inclusive recruitment practices e-learning implemented. • Significant work undertaken to support the workforce plan submissions as part of the three-year plan. • Healthrota roll-out continues.	• Continued local engagement sessions on staff survey results to develop local improvement plans. IQVIA presentation on the results at May Board. • Ongoing work on the impact of the forthcoming Employment Rights Act, as further details are finalised. • Acute Federation workstream on education and training to continue, including reviewing options for wider governance.

Success Measures

Delivery of year 2 of Research & Innovation Strategy (Enabling Plan)

Zoe Lintin, Chief People Officer

Lead Director Progress Update	Forward plan 2026/27
• Clinical research hub opened in September 2025. • Successful award of external capital investment funding in support of phase 2 of the Clinical Research Hub. • Mapping exercise undertaken in relation to national 150-day set up target for clinical research, reported at Executive team. • Third annual cohort of Chief Nurse Interns underway. Clinical Lecturer post approved in collaboration with University of Sheffield. • Submission of innovation grants to support development of proof of concept for innovation in Head and Neck cancer, maternity and tissue viability.	• Proposal developed to increase the number of Principal Investigators (PIs) and Associate PIs. • DBTH Research Conference to be planned for 2026. • Position on 150-day set up target for clinical research to be reported at People Committee, as part of bi-annual Research & Innovation report. • Delivery of the second cohort of the Innovation Expedition workshop in Q1. • Estates work on phase 2 of the Clinical Research Hub expected to commence Q2. • Development of strategic proposal to further grow our clinical academic pipeline • Trial of secondments for maternal health research. • Development of strategic proposal to focus on commercial research and DBTH-led research. • Ongoing collaboration with key partners in South Yorkshire to support a bid for South Yorkshire Academic Health Partnership

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	Forward plan 2026/27
• Elective activity plan delivered for 2025/26. • Improved position for DBTH in the NHS Oversight Framework league tables. • Improvement in 12 hour performance was ahead of plan at the end of March 2026. March plan 2.9% actual, 2.5%. • Significant improvement in 4 hour performance although slightly behind plan in March, plan 78.2% actual 77.5%. • Average ambulance handover times were ahead of plan at year end. Plan 20:11, actual 16:51. • 52 week waits virtually eliminated in all except two specialties. • Faster Diagnosis standard plan 81.4%, actual 83.3% (Feb) • 31 day cancer waiting time standard plan 96.0% and actual 97.8% (Feb). • % of patients waiting no longer than 18 weeks for a first appt. Plan 71.5%, actual 72.3%. • 62 day cancer waiting time standard, annual plan 75.3% and actual 73.9% (Feb).	• Continue the urgent and emergency care improvement programme, focussed on optimising utilisation of the urgent treatment centre at Doncaster, maximising same day emergency care, reducing longer lengths of stay and aligning the ED model of care to the national blueprint. • Improving elective care, focussed on improving productivity and standardisation of processes. • Improving diagnostic care, focussed on improving productivity and aligning capacity to demand. • Improving cancer waiting times, focused on delivery of best practice pathways and reducing diagnostic delays.

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

Lead Director Progress Update	Forward plan 2026/27
• **Hospital Acquired Pneumonia reduction:** Mortality associated with pneumonia remains below the predicted upper limit and continues to trend downward; pneumonia has not featured within the Trust's top five causes of death over the last 12 months. Mouth care assessment utilisation is 80.09%, supported by targeted implementation activity and workforce capability building (including 214 healthcare assistants completing foundational care training). Product availability audits are in progress, with findings informing standardisation and wider roll-out; compliance and outcomes will continue to be monitored through routine audit and reporting. • **Antimicrobial prescribing improvements:** The IPC and AMS teams have completed quarterly audits of antibiotic prescribing across 41 wards, providing visibility of compliance and variation. Targeted multidisciplinary working in the Acute Medical Unit (AMU) has strengthened stewardship and increased compliance from 57.3% to 89.1%. The approach will be sustained through continued audit, ward-level feedback and education, and a structured plan to replicate the AMU model across services, with progress tracked and escalated via established governance routes. • **Mental Capacity Act (MCA) compliance:** Training completion has increased by 8.94% to 86.45%, with an additional 443 colleagues receiving bespoke MCA-related training to support application in practice. Quarterly audit findings demonstrate improvements in documentation quality, supported by updated Trust policies and proformas. Regular safeguarding liaison meetings provide oversight, assurance and escalation to ensure care is delivered lawfully for patients who lack capacity.	All workstreams for 2025/2026 will continue as business-as-usual and will be monitored through the relevant governance forums, providing ongoing assurance that controls remain effective and improvements are sustained. **2026/2027 Quality Priorities:** The proposed priorities, identified through a Trust-wide survey and senior leadership triangulation, are pain assessment and management, antimicrobial resistance and stewardship, recognition of the dying patient and controlled drugs management. Each priority will have an agreed work plan, identified nursing and medical leads, and defined outcome and process measures. Progress and delivery risks will be reported quarterly to the Quality Committee, with escalation through the Trust governance framework where milestones are not met.

Success Measures

Completion of the three-year (single delivery) plan for maternity and neonatal services

Karen Jessop, Chief Nurse

Lead Director Progress Update	Forward plan 2026/27
• The National single delivery plan finished on 31st March 2026 and DBTHs position has been externally assured by the LMNS. Detailed reports have been provided to the Quality Committee and Trust Board of Directors receiving significant assurance over the course of the year. • Theme 1 - Listening to and working with women and families - Evidence of strengthened engagement and responsiveness to women's feedback is demonstrated through formal governance oversight, learning processes and transparent handling of experience intelligence. • Theme 2 - Growing, retaining and supporting our workforce - Workforce assurance is evidenced through completion and Board oversight of Birthrate Plus®, providing measurable confidence in staffing establishment, skill mix and sustainability. • Theme 3 - Developing and sustaining a culture of safety learning, Safety and learning are evidenced through PSIRF-aligned thematic analysis, formal (including external) oversight of incident learning and action closure, and demonstrable improvement in the maturity of safety reporting • Theme 4 - Standards and structures that underpin safer personalised and equitable care evidenced through sustained executive ownership, strengthened reporting arrangements, and effective management of internal and external assurance."	• The business case for meeting the BAPM medical staffing will progress and the rotas will be reviewed to bring them in line with the guidance. • A paper will be submitted to Quality Committee outlining the final position. • Outstanding work will be monitored by the divisional oversight Committee, and the Board Safety Champion.

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

Lead Director Progress Update	Forward plan 2026/27
• Continued delivery of clinical audit programmes aligned with GIRFT and national standards, using benchmarking and Model Health data to highlight variation, inform specialty priorities and drive consistent clinical practice. Ensured GIRFT principles and insights are integrated into divisional annual planning cycles and Trust-wide quality improvement programmes. NICE guideline response rate is improved at 94.62%, with a compliance rate of 81.3% • Delivered ongoing quality improvements linked to GIRFT and Further Faster priorities, including standardised pathways, reduction of unwarranted variation, improved patient flow and progress against national clinical operational standards for emergency care. • Embedded GIRFT within divisional governance structures, with monthly highlight reporting, deep dives, structured action logs and dashboards nationally benchmarked. • Lead a unified approach to improvement with a Trust-wide GIRFT Teams Channel, enabling transparent tracking of specialty-level actions, RAG ratings, and Further Faster checklist delivery. • Strengthened clinical oversight through clearer escalation processes across divisions, aligning improvement work with Trust governance routes, including EAG, PRMs, Finance & Performance Committee, Quality Committee and Audit & Risk Committee.	• Divisions have been set trajectories to improve their compliance with NICE guidelines these are monitored via Effective Assurance Group. • Deepen alignment of clinical audit with GIRFT intelligence, ensuring full utilisation of Model Health benchmarking to identify persistent variation and translate findings into actionable QI priorities: • Enhance divisional ownership by embedding GIRFT outputs more consistently into divisional annual planning, PRMs, EAG and Quality Committee reporting. • Develop specialty-level GIRFT dashboards (already recommended in Trust GIRFT presentations) to provide real-time oversight, standardised metrics and clear accountability. • Expand cross-specialty learning through regular GIRFT deep dives, shared action learning sets and strengthened links with regional / national programmes. • Apply GIRFT Methodology to advance the Mortality Governance, Learning from Deaths Framework and Medical Negligence Claims • Complete the embedding of the revised Mortality Data Quality Assurance Framework, ensuring all internal audit recommendations remain fully implemented and evidenced. **(cont'd)**

Lead Director Progress Update	Forward plan 2026/27
	• Increase Structured Judgement Review output, aiming toward the National Quality Board expectation of 15–20% of deaths reviewed, supported by targeted reviewer recruitment, protected time and enhanced medical engagement. • Ensure smooth transition from the SJR+ platform to the newly developed DBTH digital SJR system, maintaining continuity of data capture, thematic analysis and divisional reporting. • Strengthen thematic learning loops, linking the SJR findings more directly to divisional governance groups, clinical education and harm reduction priorities (e.g., sepsis, VTE, pain management) to improve learning from deaths processes).

Success Measures

Deliver the boards Health Inequalities commitments for 25/26

Zara Jones, Acting Chief Executive

Lead Director Progress Update	Forward plan 2026/27
• Health inequalities is now one of four strategic ambitions within Healthier Together, supported by the Tackling Health Inequalities Enabling Plan. • 7,214 staff completed SET+ training and 220+ staff completed Change Initiator Training; Advocate Training was piloted through the Aspiring Matrons Programme. • New governance is in place through our Health Inequalities Oversight Group, Health Inequalities Forum and the Citizens' Panel, with formal Board oversight, Board pledges and HI impacts now required on coversheets and business cases. • The trust Equity Index is complete. This tool provides a score for each service area, measured by deprivation and ethnicity. It is our primary mechanism for identifying where inequalities exist and prioritising improvement activity. • Health inequalities focussed Did Not Attend / Was Not Brought dashboard is in development.	• Improve data maturity — particularly ethnicity recording completeness and routine disaggregation of performance data by deprivation, ethnicity, age and sex, with the aim of moving from 29% to a significantly higher score in the Data Insight domain of the Health Inequalities Self-Assessment. • Complete and embed the DNA/WNB health inequalities data dashboard and use it to drive targeted improvement in attendance equity. • Progress the WHaLES fair waiting list tool, drawing on evidence from Barnsley NHS FT. • Repeat the national Health Inequalities Self-Assessment in May 2026, with a target of improvement across all four domains. • Begin specific NIHR maternity inequalities consortium projects.

Success Measures

Embed improved trust governance and risk management at Board and committee level to support robust leadership and decision making

Zara Jones, Acting Chief Executive

Lead Director Progress Update	Forward plan 2026/27
• New clinical leadership forum – the Hospital Leadership Team (HLT) agreed through TLT, with Senior Clinical Leaders supporting decision-making. Agreed at January 2026 Trust Leadership Team Meeting. To include new Terms of Reference and Workplan for the Group. • Review and Approval of Trust Leadership Team Development Group. • Deep dives have been completed to benchmark risks across divisional and corporate areas. • Completed a comprehensive review of the risk register, with an executive led review of all high risks, embedding a process of regular reviews within risk management group for all high risks. • Draft Version 1.0 of Trust corporate governance manual ready for initial review. • 75% of internal audit reviews completed have a rating of significant assurance (27% in 2024/25), 13% had limited assurance rating (33% in 2024/25) and 1 review did not have an assurance rating but has a low risk/high confidence NHSE opinion level (consistent with the previous year). 3 reviews are yet to report. In 2024/25 33% of reviews had a moderate/split assurance rating. • 100% of high-risk internal audit actions closed on time (71% in 2024/25). 96% first follow up rate (86% in 2024/25)	• Hospital Leadership Team meetings commenced in April 2026. • Review and implementation of new governance structures on a rolling programme from April 2026 – September 2026. • Implementation of Trust Leadership Development Programme commencing April 2026. • Review of Board Risk Appetite in April 2026, together with externally facilitated Board development and senior leadership programme on risk and assurance. • Reset programme governance to be finalised.

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	Forward plan 2026/27
• New Radiology Information System and Audiology system implemented • New Patient Self Check in Kiosks installed • Launch of PPMS and the Inpatients FDP module • Extension of the use of the Nervecentre system, rolled out fully at BDGH • Cabinet Office approval received for the EPR Full Business case • Launch of ORBIT programme within the Trust • Purchase of new Wi-Fi equipment, new laptops, monitors, and mobile devices • Establishment of governance between DBTH and Sheffield Teaching Hospitals supporting collaborative working • We have commissioned several significant parts of our programme to include testing, data migration, training and specialist consultancy. • Review of existing operational processes has concluded	• Upgrade of maternity system • Implementation of a new Cancer Management System • Implementation of new digital transcription system with artificial intelligence capabilities, Infection Prevention system and WiFi upgrades across all major sites • Implementation of other Federated Data Platform products, to include Unified Patient List product. • Complete recruitment to fully establish team for EPR delivery • Undertake detailed planning and fully establish programme workstreams • Continue to improve organisational awareness and clinical / operational engagement • Commence work to implement our new EPR system

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	Forward plan 2026/27
• Breakeven position delivered (including deficit support funding). • £31.4M of in-year efficiency savings delivered in line with plan. • Closing cash balance of £53.4M ahead of £15.8M plan. • £65.4M planned capital expenditure programme delivered. • Underlying deficit has improved from c£56M at end July 2025 to c£47M at end of March 2026. • Latest published figures (M9 YTD) show implied productivity has improved by 11.0% (per £) and 6.4% (per WTE) in the last 12 months, making the Trust a top quartile performer nationally. However, implied productivity remains 2.6% (per £) and 1.4% (per WTE) below pre-COVID levels placing the Trust in the second-best quartile of performance nationally. • £22.3M of recurrent full year effect savings delivered.	• Continue to deliver recurrent savings, improve productivity and address underlying deficit over time

2605 - D5 MEDIUM TERM PLAN

Information Item

Zara Jones, Acting Chief Executive & Sam Wilde, Chief Finance Officer

10 minutes

REFERENCES

Only PDFs are attached

D5 - Medium Term Plan.pdf

D5 - Appendix 1 Medium Term Plan.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Medium Term Plan**			
Executive Sponsor:	Zara Jones, Acting Chief Executive Sam Wilde Chief Financial Officer			
Authors:	James Tabor, Associate Director of Planning, Performance and Improvement			
Appendices:	Appendix 1 - Medium Term Plan			
Purpose of the report	**Assurance**	~~Decision required~~	~~**Information**~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	The plan close down outcome and reset programme have a direct impact on BAF 5 and BAF 6, with continued risk around delivery of the agreed access, workforce and financial trajectories, while strengthened reset governance, monthly oversight and scheme-level assurance provide mitigations against slippage and support clearer escalation of risks to quality, patient outcomes and organisational sustainability.			

Executive Summary – Key messages and Issues

DBTH's medium term plan is "Compliant with Conditions" for 2026/27. The acceptance confirms the immediate year one position, but requires refresh of 2027/28 and 2028/29 commitments, detailed underpinning operational improvement plans for UEC, elective care and diagnostics by the end of May 2026, and continued oversight of ambulance handovers.

The final 2026/27 commitments include a breakeven financial plan after receipt of Deficit Support Funding (DSF), 6.8% CIP, RTT 18-week performance of 70.6%, 28-day Faster Diagnosis Standard performance of 80.0%, cancer 62-day performance of 80.3%, cancer 31-day performance of 94.2%, 4-hour A&E performance of 82.0%, 7,350 12-hour breaches and a total workforce of 6,301 WTE by March 2027.

Deficit support funding will be confirmed quarterly throughout 2026/27 subject to evidence of DBTH in-year financial delivery, run rate and CIP. Cost-of-change support for workforce reduction will only be released against Board-approved plans, actual evidenced spend, recurrent establishment reduction and a reasonable payback period.

Reset governance is now in place through the DBTH Reset Board, first held on 15 April 2026, with five pillars: Workforce and Organisational Design; Shape of DBTH; Access and Flow; Productivity and Financial Reset; and Culture and Leadership. The Board will operate as the principal delivery forum for milestone tracking, benefits, risk, workforce change, quality impact and escalation

Recommendations

The Board is asked to NOTE:

- The attached appendix Medium Term Plan document
- The plan close down outcome and the final planning commitments set out in this paper.
- The conditions and further work requested by NHS England, including the end of May operational improvement plans and Q1 refresh of 2027/28 and 2028/29.

- The criteria attached to deficit support funding and cost-of-change support.
- The reset programme structure, pillar schemes, leads and monthly Reset Board arrangements.

Healthier together – delivering exceptional care for all	
Patients	The paper confirms accepted access commitments for 2026/27 and the requirement for detailed improvement plans for UEC, elective care and diagnostics by the end of May 2026.
People	Delivery depends on Board-approved workforce reduction plans, clear consultation materials, reduced premium staffing and robust governance of quality, safe staffing and equality impact.
Partnerships	Delivery will continue to be managed with NHS England regional operations, South Yorkshire ICB and wider partners, including agreement of support requirements for UEC, elective and diagnostic improvement.
Pounds	The plan is accepted on a breakeven basis, with 6.8% CIP in 2026/27 and quarterly confirmation of deficit support dependent on run rate, CIP and wider delivery evidence.
Health Inequalities	Executive-led Equality and Quality Impact Assessment processes are a specific expectation, particularly as workforce and service changes move from design into implementation.
Legal / Regulation:	The close down letter states that further formal intervention, including regulatory action or enforcement undertakings, may be considered if risks are not effectively managed.
Partner ICB strategies	The plan and reset programme align with South Yorkshire recovery, productivity and sustainability priorities and will need to be delivered with system partners where pathway or service changes require collaboration.
Assurance Route	
Previously considered by - including date:	Executive Team / regional planning discussions, November - March 2026.
Any outcomes/next steps / time scales	Complete detailed UEC, elective and diagnostics improvement plans by the end of May 2026; refresh and reconfirm 2027/28 and 2028/29 positions during Q1 2026/27; maintain monthly Reset Board reporting; provide routine assurance to Executive Team, Finance and Performance Committee, Quality Committee and Board as appropriate; support quarterly deficit support funding assessment.
Is this in line with Current risk appetite **YES**	Highlight **only** where this report is outside of the Board Risk Appetite below.

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Medium Term Plan

This paper and attached plan document updates the Board on the medium-term planning process including the close down outcome for 2026/27-2028/29 and the governance now in place to move from planning into delivery. It draws together the final planning commitments, the further work requested by NHS England and the reset programme arrangements that will provide oversight of delivery.

NHS England issued the Trust's plan close down letter on 9 April 2026. The Trust has been assessed as Compliant with Conditions for 2026/27. The practical implication is that the 2026/27 plan position is accepted, but delivery confidence will now depend on evidence of implementation, refreshed later-year plans and robust operational, workforce and financial governance.

The Board should therefore read the close down position as the start of the delivery phase rather than the end of the planning process. The reset programme is the organising structure for that delivery phase.

Final Planning Commitments

Domain	2026/27 commitment	2027/28 commitment	2028/29 commitment
Finance	Breakeven financial plan (after DSF) CIP 6.8%	Breakeven financial plan (without DSF) CIP 6.7%	Breakeven financial plan (without DSF) CIP 2.4%
Elective / Cancer	RTT 70.6% 28-day FDS 80.0% 62-day cancer 80.3% 31-day cancer 94.2%	RTT 81.5% 28-day FDS 80.0% 62-day cancer 82.5% 31-day cancer 96.1%	RTT 92.0% 28-day FDS 80.0% 62-day cancer 85.1% 31-day cancer 96.0%
UEC	4-hour A&E 82.0% 12-hour breaches 7,350	4-hour A&E 83.0% 12-hour breaches 4,567	4-hour A&E 85.0% 12-hour breaches 3,208
Workforce	Total workforce 6,301 WTE Substantive 5,953 WTE Bank 302 WTE Agency 46 WTE	Total workforce 5,865 WTE Substantive 5,591 WTE Bank 244 WTE Agency 30 WTE	Total workforce 5,860 WTE Substantive 5,629 WTE Bank 216 WTE Agency 14 WTE

The plan close down letter sets out the organisational commitments for 2026/27 and the submitted positions for 2027/28 and 2028/29. The later-year positions require refresh and further review during Q1 2026/27, but they remain the current submitted trajectory against which the reset programme and operational plans will be developed.

Diagnostics is also a specific condition of acceptance. Although the annexed organisation plan tables focus on finance, elective, cancer, UEC and workforce metrics, the close down letter requires detailed underpinning operational improvement plans for diagnostics, alongside UEC and elective care, by no later than the end of May 2026.

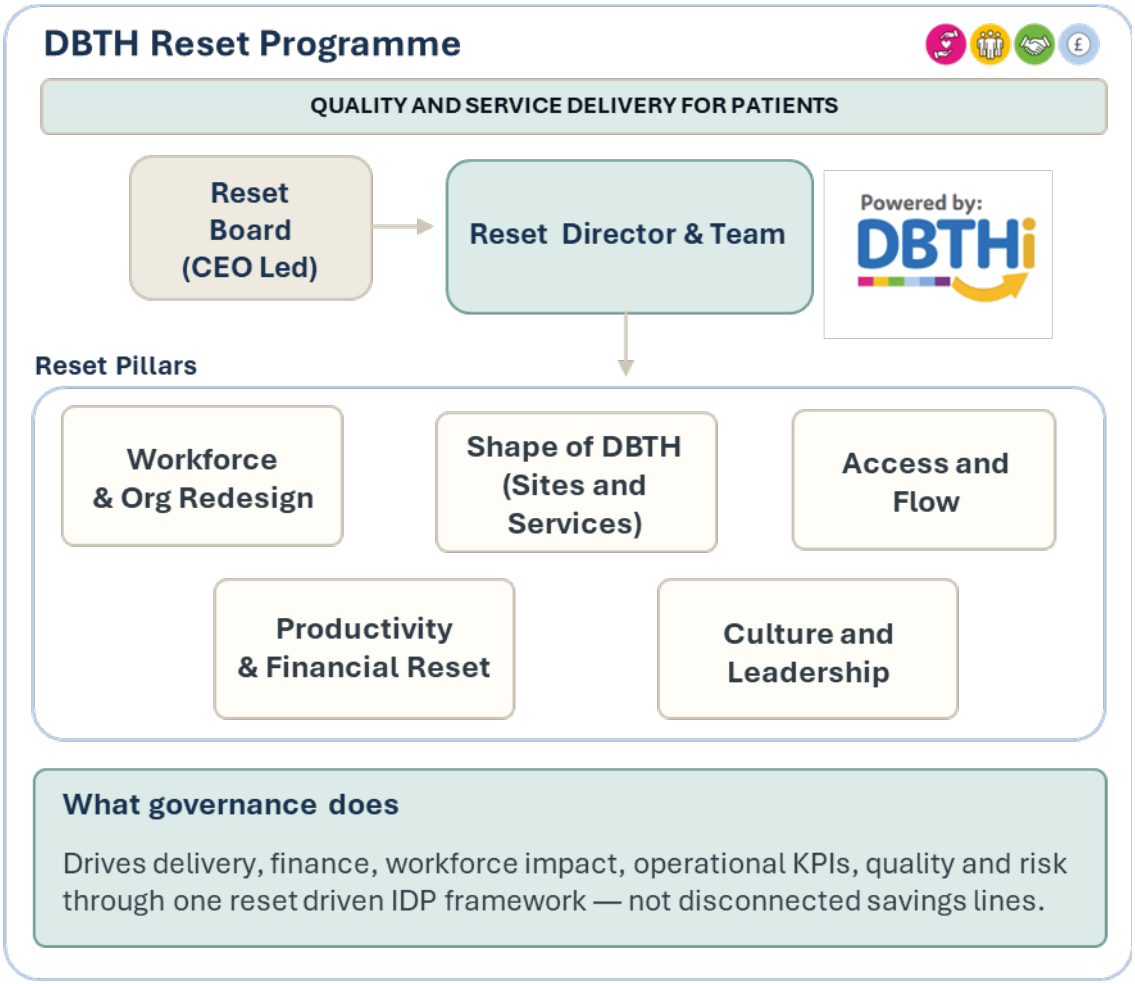
The submitted commitments represent a significant delivery challenge, particularly in years 1 and 2. The most material dependencies are recurrent delivery of the CIP, workforce reductions, conversion of temporary staffing reductions into establishment change, and operational productivity improvement across UEC, elective care and diagnostics.

Further work requested by NHS England

NHS England has accepted the plan with conditions. The further work requested is summarised below

Requirement / condition	Timing	Board assurance response
Refresh 2027/28 and 2028/29 plans	During Q1 2026/27	Reconfirm later-year trajectories and ensure they move to an acceptable position across all metrics. Align the refresh to reset milestones, workforce plans, CIP delivery and operational productivity assumptions.
UEC, elective and diagnostics operational improvement plans	No later than end May 2026	Detailed underpinning plans must be in place for 2026/27 delivery. NHS England regional operations will work with the Chief Operating Officer to agree support requirements.
Ambulance handovers	Immediate and ongoing	Deliver in accordance with plan, do not exceed the previous year for the same period, and seek to achieve the 15-minute aspiration with no delays over 45 minutes. If this is not achieved, immediate mitigations and timescales will need to be agreed.
Deficit Support Funding	Quarterly confirmation	Funding will be confirmed quarterly following detailed assessment of in-year financial plan delivery, including run rate and CIP performance.
Cost-of-change support for workforce reduction	April 2026 plans, then evidenced drawdown	Available only where robust criteria are met, with Board-approved workforce reduction plans, consultation documentation, actual evidenced expenditure, recurrent establishment reduction and reasonable payback.
Quality and Equality Impact Assessment	Throughout implementation	Executive-led EQIA processes must provide robust evidence that delivery does not adversely impact quality of care. This will be embedded in reset governance and escalation.
Regional oversight and intervention risk	Ongoing	Hamish McClure is identified as the regional executive oversight lead for South Yorkshire. Further formal intervention may be considered if risks are not managed effectively.

Reset Programme



The Trust has now put in place strengthened reset governance through the DBTH Reset Board, The reset programme is intended to provide the control environment for delivering the planning commitments, rather than operating as a separate improvement workstream.

The programme is organised through five pillars. Each pillar contains a set of schemes, with named SROs, scheme leads and aligned reset support.

Recommendations and Next Steps

- The Board is asked to note the attached Medium-Term Plan, the plan close down outcome, the final planning commitments, the further work requested by NHS England, and the reset programme governance arrangements now in place to support delivery.
- Note that the plan has been assessed as Compliant with Conditions for 2026/27.
- Note the final 2026/27 commitments and the submitted 2027/28 and 2028/29 positions, which require Q1 refresh.
- Note the end of May requirement for detailed UEC, elective and diagnostics operational improvement plans.
- Note the quarterly conditions attached to deficit support funding and the conditions attached to cost-of-change support.
- Note the reset pillar structure and approach.

- Seek continued assurance through Board, Finance and Performance Committee and Quality Committee on workforce delivery, CIP, operational improvement, quality impact and equality impact.

We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

DBTH Three-Year Plan
2026 to 2029
Doncaster and Bassetlaw Teaching Hospitals

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Our vision is clear:

Healthier Together –
Delivering Exceptional Care for All

Our **three-year plan** sits at the heart of how we deliver our vision. It turns **Healthier Together** into practical action, aligning our **Strategic Priorities** and **Ambitions** with the national **NHS 10 Year Health Plan**, guided by the **DBTH Way** and our **We Care** values, and supported through **Enabling Plans** and improvement frameworks that shape how we work every day.

NHS 10 Year Health Plan

Sets the national direction for improving health and care, focusing on better outcomes, care closer to home, digital innovation and long-term financial sustainability.

Our Trust strategy

Sets out our long-term vision and direction, defining how we will deliver safe, high quality care through our priorities of Patients, People, Partnerships and Pounds.

Our Enabling Plans

Explain the practical work that supports our strategy, helping us build the people, technology and environments needed to deliver better care.

Our three-year plan

Sets out how we will deliver our strategy in practice, translating long-term ambition into clear actions, measurable improvements and sustainable change.

The DBTH Dozen

Organises our improvement work into 12 clear priority areas, providing a shared structure that guides delivery, focuses effort and ensures change is coordinated.

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DBTHi

This plan

Over the **next three years**, we will focus upon **five clear goals**, and associated measurable improvements - practical shifts in how we organise care, support colleagues and secure our future.

Workforce & Organisational Design

Right workforce, organised well, with clear roles and less reliance on temporary staffing. Over the next three years, we will:

- **Reduce reliance on agency and bank**, instead offering substantive roles that provide stability and development
- **Redesign workforce structures** to improve efficiency and clarity.
- Complete **job planning and role reviews** to ensure capacity is aligned to demand.
- Make sure **teams are organised at a size and shape that works well** day to day.
- **Simplify systems and reduce duplication** so colleagues can focus on patient care.
- Use **digital tools to reduce administrative burden** and empower teams.

Shape of DBTH

Clearer roles for our sites and services, making best use of our estate and partnerships. Over the next three years, we will:

- **Define clear roles and identity for each hospital site** so services are organised in the right place.
- Ensure **emergency and planned care** are delivered **in the right environments.**
- **Reconfigure services where needed** to improve quality, resilience and workforce sustainability.
- Develop **stronger partnerships with system partners** to support joined-up care.
- Deliver **more care in community and town-centre settings** where appropriate.
- **Optimise estate** and facilities **to make best use of available space.**

Access & Flow

Helping patients move through services more quickly, reliably and with fewer delays. Over the next three years, we will:

- **Increase planned operations and day-case activity** so patients are treated sooner.
- **Reduce waiting lists** in a structured way.
- **Cut last-minute cancellations** and improve reliability of clinics and theatres.
- Make **better use of clinic appointments** and reduce wasted capacity.
- **Improve discharge and patient flow** so beds and theatres are used effectively.
- **Expand outpatient and diagnostic capacity**, including virtual and community-based care.
- Strengthen **performance management and grip** through regular review and escalation

Productivity & Finance Reset

Using our resources better, controlling spend and improving productivity. Over the next three years, we will:

- Deliver a **significant cost improvement programme** across workforce, procurement and services.
- Make **better use of theatres, clinics** and **estate**.
- Improve **productivity in diagnostics, theatres** and **outpatients**.
- Further **strengthen control of non-pay spend**, **procurement** and **contracts**.
- **Reduce vacancy-related inefficiencies** and improve workforce utilisation.
- **Improve financial reporting**, analytics and grip on delivery.
- Ensure **all improvements are planned, tracked** and **delivered** through one programme.

Culture & Leadership

Stronger leadership, clearer expectations and a more supportive, accountable culture. Over the next three years, we will:

- **Set clear expectations** through a leadership accountability framework.
- Increase **visible leadership and engagement** across services.
- Support teams through change with **strong communication and involvement.**
- Promote a **culture of learning, civility** and **continuous improvement.**
- Ensure leadership **actively supports delivery of all four pillars.**

Getting this right will help us create the conditions for sustainable change and consistent, high-quality care long into the future.

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Timeline 2026 to 2029

1 year

Stabalise & act decisively - 2026/27

We focus on grip, control and early improvement.

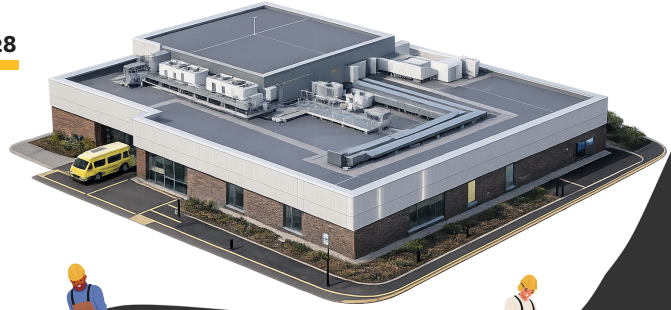
- Improve Emergency Department four hour performance and reduce the longest waits.
- Increase elective and day-case activity.
- Begin reducing the waiting list.
- Strengthen site roles and protect planned care.
- Deliver c.£46m of efficiencies through a coordinated programme.
- Progress workforce changes to safely reduce temporary staffing and improve productivity.

2 year

Deliver change & momentum - 2027/28

We turn early gains into consistent delivery.

- Further improve emergency, elective and cancer standards.
- Deliver a second year of significant savings (c.£44m), with increasing recurrent benefit.
- Expand care closer to home and embed digital pathways.
- Embed clearer roles across Doncaster, Bassetlaw and Montagu.
- Progress service reconfiguration and partnership-led changes.



3 year

Secure a sustainable future - 2028/29

We achieve long-term balance and resilience.

- Emergency Department performance at 86%.
- 52-week waits eliminated and RTT in line with national standards.
- Waiting list reduced while treating more patients.
- Cancer standards restored.
- Financial balance achieved with mostly recurrent savings.
- Services operating in a stable, sustainable model.

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Our sites

Doncaster Royal Infirmary

We serve communities across two regions, covering busy urban areas and rural towns and villages. That gives us scale, reach and opportunity - here are our plans for each of our unique sites:

Strenghten emergency and time-critical services

Emergency care will become faster and more reliable, with fewer long waits, improved four-hour performance and ambulance handover delays reduced to zero.

Support specialist teams at the right scale

Bringing specialist teams together at the right scale will protect skills, improve consistency and ensure patients receive expert care in the right place.

Clear purpose

As our principal hot site, this hospital will play a leading role in delivering the following clinical services:

- Urgent and Emergency Care
- Complex planned and elective
- Women's and Children's services
- Adult inpatient
- Diagnostics

Improve patient flow across acute services

Patients will move more smoothly through services, with fewer delays, shorter stays where appropriate, and quicker access to the care they need.

Strong training and development opportunities

We will support colleagues to grow their skills and careers, strengthening expertise across all of our sites and building a confident workforce for the future.

Over the next three years, we will make better use of that footprint by organising our sites and clinics with greater clarity and purpose. Each location has distinct strengths - and it's crucial we make the most of them.

Bassetlaw Hospital

Grow reliable planned and day-case care

We will increase planned and day-case activity in a stable setting, helping more patients be treated on time with fewer cancellations.

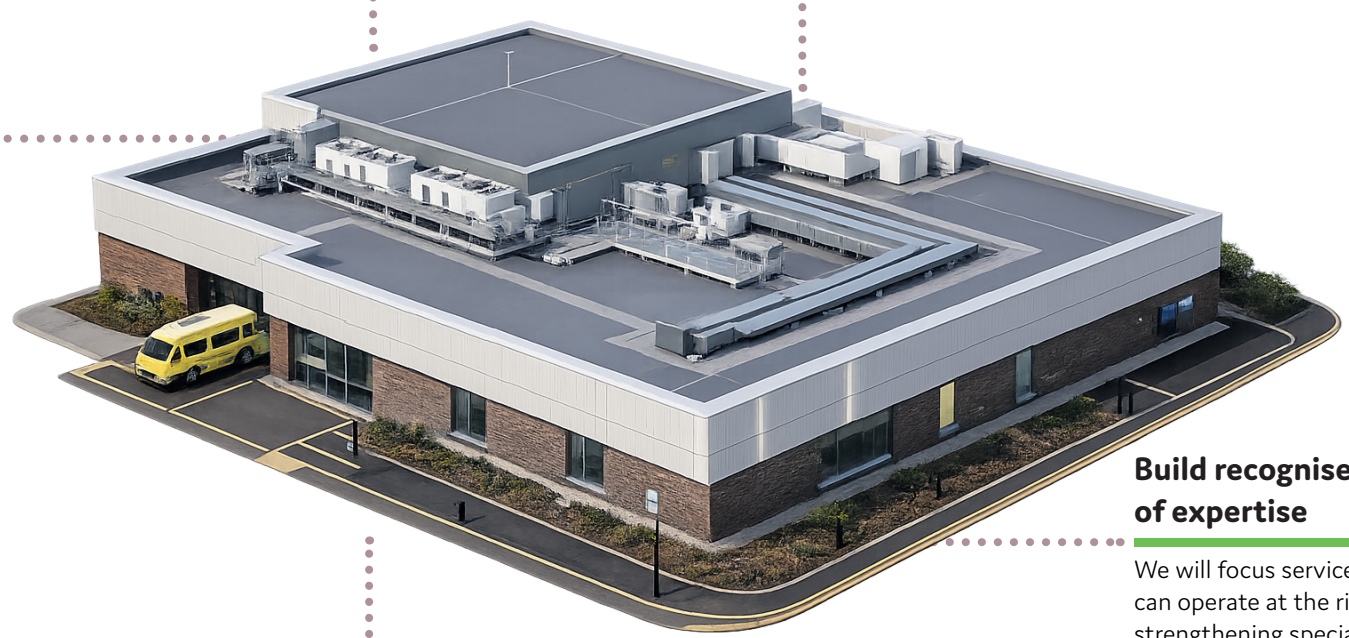
Provide predictable services in a stable setting

Care will run more consistently, with fewer last-minute changes and a clearer, more dependable experience for patients and colleagues.

Clear purpose

As a hybrid hot and cold site, Bassetlaw Hospital will play a vital role in delivering both urgent and planned care for the communities it serves.

- Urgent and Emergency Care
- Planned and elective
- Women's and Children's services
- Adult inpatient
- Diagnostics
- Outpatients



Build recognised areas of expertise

We will focus services where they can operate at the right scale, strengthening specialist skills and delivering consistently high standards of care.

Work closely with local primary and community

We will strengthen links with GPs and community services to provide more joined-up care and make it easier for patients to access support closer to home.

This is about building on what we already have - our geography, our people and our facilities - and using them in a way that delivers safe, exceptional, person-centred care.

Montagu Hospital

Protect and expand specialist planned services

We will safeguard dedicated elective services and grow specialist planned care, ensuring patients are treated in focused environments with fewer disruptions.

Improve productivity in elective care

We will make better use of theatres, clinics and staff time so more patients can be treated safely and efficiently.

Provide focused recovery and rehabilitation environments

We will offer calm, dedicated spaces that support safe recovery and high-quality rehabilitation after treatment or surgery.

Clear purpose

As our dedicated elective and rehabilitation centre, Montagu Hospital will lead in delivering focused planned care and recovery services:

- Outpatients
- Planned and elective
- Adult inpatient
- Therapies
- Diagnostics

Strengthen overall capacity across the Trust

Montagu will provide dedicated elective and rehabilitation capacity, creating additional headroom and reducing pressure on our acute sites.

Our ambition is to combine local access with specialist strength, ensuring every site plays a confident and valued part in the future of DBTH.

Community clinics

Improve convenience and access for patients

We will provide care in community and town-centre locations, making it easier for patients to attend appointments closer to home.

Reduce travel and parking pressures

Providing more care closer to home will cut down unnecessary journeys and ease parking pressures at our main hospital sites.

Clear purpose

As part of our community and prospective High Street network, these sites will play an important role in delivering care closer to home:

- Outpatients
- Therapies
- Diagnostics
- Pre-operative assessment

Allow hospital sites to focus on specialist and acute care

By delivering more routine services in community settings, our hospitals can concentrate on complex, urgent and specialist care.

Support all our communities, wherever they are

We will bring services closer to towns and villages across our footprint, making it easier for people to access care without travelling long distances.

Improving performance

Strengthening our hospital sites is not just about structure. It is about creating the conditions for better care, and we can turn our attention to improving our performance, as well as outcomes.

Current demand

At the moment, our services are working hard under sustained pressure, and our current position is:

- Around seven in 10 patients are seen within four hours in our emergency departments.
- Just over six in 10 patients start planned treatment within 18 weeks.
- More than 54,000 people are currently waiting for care.
- Around seven in 10 cancer patients start treatment within the 62-day standard.
- Colleagues are working hard every day. The next three years are about turning that effort into sustained and reliable improvement.

Colleagues are working hard every day. The next three years are about turning that effort into sustained and reliable improvement.

Predicted demand

We are not planning for a quieter NHS. We are planning for more people needing care. Over the next three years:

- Emergency Department attendances will rise from 215,074 to 224,115.
- Emergency admissions will increase from 60,057 to 66,334.
- Elective day-case activity will increase from 50,026 to 52,607.
- First outpatient appointments will increase from 145,537 to 168,783.

That means more patients arriving urgently, more people needing beds and more planned activity taking place across clinics and theatres. All of the performance improvements described here will happen alongside that growth.

Areas of improvement

Urgent and emergency care

Over the next three years, we will deliver:

1. **Four-hour performance** will improve from **76% to 86% by 2028/29**.
2. **12-hour waits** will reduce from **4%** to around **1%**.
3. **Ambulance handover delays over 45 minutes**, currently **3.5%**, are planned to **reduce to zero**.

In simple terms, with further support, emergency care should feel more stable, with fewer extreme delays.

Planned care and waiting lists

Over the next three years, we will deliver:

1. Our **waiting list will reduce** from just over **54,000 to around 51,000** — while we treat more patients each year.
2. **Elective day-case activity** will increase from approx **50,000 to 53,000**.
3. **Inpatient elective activity** will grow from approx **8,900 to 9,600**
4. **Referral to treatment (RTT)** performance will **improve in line with national standards of 92%.**

Outpatients

Over the next three years, we will deliver:

1. **First appointments** will increase from approx **145,500 to 168,700**.
2. **Follow-up appointments** will reduce as more patients move onto patient-initiated pathways, increasing from **18,000 to 22,200**.

This means more new patients seen sooner, fewer unnecessary routine follow-ups and greater control for patients over when they need to be reviewed.

Cancer care

Over the next three years, we will deliver:

1. **Cancer 62-day performance** will improve from **68% to 85%**.
2. **Maintain Cancer Faster Diagnosis Standard** performance of atleast **80%.**
3. **Cancer 31-day performance** will be sustained at **96%**.

This means more patients diagnosed and starting treatment sooner, with fewer delays at critical stages of care.

Financial stability

We are here to deliver safe, exceptional, person-centred care and to achieve that consistently, we must also be financially sustainable. One does not trump the other - they depend on each other.

The next three years

At present, we are operating in deficit which reflects a long-standing gap between what it costs to run our services and the income we receive. To address this, over the next three years, we will deliver:

- Our in-year deficit reducing over the period, with financial balance achieved by 2028/29.
- Our underlying deficit reducing over the period through sustained delivery of efficiency and productivity improvements.
- Approximately £90 million of recurrent savings delivered over period of plan.

This means bringing what we spend and what we receive back into balance in a steady and controlled way.

Workforce and efficiency

Since 2019/20, our workforce increased significantly to support pandemic response and recovery. With these pressures now long behind us, we must ensure staffing levels are aligned to activity and affordable in the long-term. Over the next three years, we will deliver:

- A move to a more sustainable workforce model over time.
- Continued enhanced Vacancy Control, with posts reviewed carefully when colleagues leave.
- Recruitment prioritised for clinically essential and safety-critical roles.
- Reduced reliance on temporary and agency staffing.

With appropriate oversight and action, this will ensure teams are right-sized to demand while maintaining safe, effective services.

What this means for us

This three-year plan represents a significant and exciting period of change for DBTH. It reshapes how we organise care, strengthens the role of our sites, improves access, supports our workforce and restores financial stability. It affects every part of the organisation.

Delivering change at this scale requires clarity, discipline and visible leadership. Delivery will be structured and accountable.

Each major programme of work has:

- Clear executive sponsorship.
- Defined milestones and delivery plans.
- Agreed measures of success.
- Regular reporting through Trust governance.

Progress will be monitored formally, with risks identified early and performance tracked consistently.

Ensuring financial stability protects care - it allows us to invest in care environments, digital systems, supports substantive roles and fufilling careers, and gives us confidence to plan for the future.

Our delivery

This plan represents a significant and exciting opportunity for DBTH. Delivery requires clarity, discipline and visible leadership - with clear executive sponsorship, defined milestones, agreed measures of success and regular reporting via agreed governance.

A structured approach

Improvement will be organised through DBTHi and the DBTH Dozen.

This ensures work is:

- Joined up across clinical, operational and corporate teams.
- Aligned to our Strategic Priorities and Strategic Ambitions.
- Supported with data, programme management and governance.
- Measured in terms of quality, workforce and financial impact.

Further information on the DBTH Dozen is available here:
https://extranet.dbth.nhs.uk/the-dbth-dozen/

Clinically-led and professionally informed

Change will be shaped and led by clinical and professional expertise, ensuring improvements are safe, practical and focused on patient care.

This means we will:

- Involve clinical teams in redesigning pathways and services.
- Test proposals against safety and quality standards.
- Use professional insight to guide decision-making.
- Maintain openness and transparency as plans develop.

The DBTH Way underpins delivery. Working together, taking responsibility and maintaining high standards will be central to success.

Productivity and performance

Improvement will focus on practical changes that strengthen delivery.

This includes:

- Better use of theatres, clinics and diagnostics.
- Improved patient flow across sites.
- Reduced cancellations and delays.
- More effective outpatient pathways.
- Workforce aligned to activity.

Productivity is about removing duplication, reducing waste and organising services so they function reliably and safely.

Financial discipline

Restoring financial balance is essential to long-term stability. Over the three-year period, we will deliver steady improvement through structured programmes.

This includes:

- Reducing reliance on temporary staffing.
- Strengthening procurement and contract management.
- Making better use of our estate.
- Addressing variation and duplication.

All schemes are subject to quality impact assessment and oversight to ensure patient safety remains central.

Powered by: DBTHi

DBTH dozen

Bringing together our key improvement priorities into one clear framework, helping us turn strategy into practical change across the organisation.

Right care, right place

Services are delivered in the most appropriate physical or digital setting, based on patient need and local population demand.

Effective patient journey

To ensure patients experience a smooth, joined-up journey from first contact through to treatment and discharge.

Delivering quality care

To ensure care is safe, reliable, and consistently high quality.

Emergency care excellence

To provide excellent urgent and emergency care through clinically prioritised access and digital-first models.

Elective care excellence

To deliver high-quality elective care through digital-first, patient-led models.

Doing things fairly

To place health equity at the centre of all decision-making and service design.

We are Team DBTH

To ensure colleagues feel valued, supported, and prepared for current and future challenges.

Leading in Research & Education

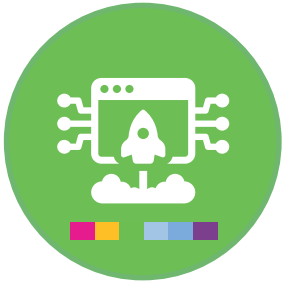
To develop DBTH as a leading centre for research and education.

The best care environments

To improve care spaces and facilities for patients and colleagues.

Digital transformation

To deliver digitally enabled services with a single view of patient information.



Corporate enablement

To strengthen governance, risk management, and organisational effectiveness.

Making the money work

To ensure funding is focused on delivering the best possible patient care.

Powered by: DBTHi

Get involved

This plan will only succeed if we deliver it together. While structure sits at Board and executive level, day-to-day improvement happens in teams, wards, departments and clinics.

Everyone has a role to play

Small changes in how we work make a real difference. Starting clinics and lists on time, escalating delays early, reducing avoidable cancellations and planning discharges will all improve flow and patient experience.

Using agreed processes, avoiding duplication and being mindful of supplies helps reduce waste. Stable teams, thoughtful rota planning and reducing reliance on temporary staffing support quality and morale.

When new digital tools are introduced, using them consistently and confidently helps reduce paperwork, improve communication and strengthen decision-making.

This is not one-way.

- If something is not working, speak up.
- If you see a better way of doing something, share it.
- Bright Ideas and local improvement forums exist so colleagues can shape change, not just receive it.

Living the DBTH Way means working together, focusing on solutions and keeping patients at the centre of every decision.

This is about collective responsibility - and collective opportunity.

Powered by: DBTHi

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

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LUNCH 12:30 - 13:00

2605 - E STATUTORY & REGULATORY

13:00

2605 - E1 MATERNITY & NEONATAL SAFETY REPORT

Discussion Item | Karen Jessop, Chief Nurse | 13:00

Lois Mellor, Director of Midwifery

10 minutes

REFERENCES

Only PDFs are attached

- E1 - Maternity & Neonatal Safety Report.pdf
- E1 - Appendix 1 Trust Quality Metrics.pdf
- E1 - Appendix 2 Maternity Outcomes Signal System (MOSS) Update.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Maternity & Neonatal Safety Report (interim)**			
Executive Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Lois Mellor, Director of Midwifery Danielle Bhanvra, Deputy Director of Midwifery			
Appendices:	Appendix 1 - Trust Quality Metrics Appendix 2 – Maternity Outcomes Signal System (MOSS) Charts			
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

This paper provides the Trust Board with a concise assurance update on maternity and neonatal safety for March 2026, drawing together the Perinatal Mortality Review Tool (PMRT) position and the maternity quality metrics/dashboards. It is intended to enable Board-level scrutiny and confirm that appropriate governance and escalation arrangements are operating effectively.

Board assurance summary (March 2026)

- Perinatal mortality performance for March remains within the expected range and did not trigger a Maternity Outcomes Signal System (MOSS) alert.
- Reportable outcomes for March were: 1 stillbirth and 0 late fetal losses (>22 weeks) reportable to MBRRACE; and 0 neonatal deaths reportable to MBRRACE.
- Learning from PMRT reviews (March 2026): no issues were identified on review.
- Quality metrics oversight is in place via the maternity dashboard (Appendix 1) and divisional governance, with defined escalation routes through the Quality Committee to the Trust Board.

Key areas requiring ongoing focus

The maternity metrics position is largely stable, however the paper highlights areas of significant deterioration that require continued oversight, including postpartum haemorrhage (PPH) and the neonatal death rate per 1,000. Actions are in progress, including progression of a business case for the use of carbetocin to support PPH management. These metrics will continue to be monitored through divisional governance with escalation of any emerging themes, risks, or sustained deterioration via the Quality Committee.

This report should read in conjunction with the Quality Committee Chair's Assurance Log from the meeting held on 23 April 2026, where maternity and neonatal services were discussed in detail.

Recommendations

The Board is asked to receive this update, note the assurances provided in relation to maternity and neonatal safety performance and governance, and formally record in the Trust Board minutes (for Maternity Incentive Scheme evidence) that the Trust Quality Metrics and the MOSS update have been reviewed/noted as appropriate.

Healthier together – delivering exceptional care for all

Patients	*We deliver safe, exceptional, person-centred care*
People	*We are supportive, positive, and welcoming.*

<table>
<tr><td>Partnerships</td><td>We work together to enhance our services with clear goals for our communities.</td></tr>
<tr><td>Pounds</td><td>We are efficient and spend public money wisely</td></tr>
<tr><td>Health Inequalities</td><td></td></tr>
<tr><td>Legal/ Regulation:</td><td></td></tr>
<tr><td>Partner ICB strategies</td><td></td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>The Paediatric and Perinatal 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 MIS standards going forward</td></tr>
<tr><td>Is this in line with Current risk appetite

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

Maternity and Neonatal Safety (Interim) Report

1. Report Overview

This interim report provides assurance to the Trust Board by confirming the items previously reviewed and approved by the Quality Committee on behalf of the Trust Board in April 2026, as documented in the Quality Committee Chair's highlight report on the agenda.

It also presents the Trust Board with the Perinatal Mortality Review Tool (PMRT) update for March, which the Board is required to receive. The update is provided to support Board-level assurance that perinatal outcomes are being monitored, reviewed and acted upon in line with national requirements and the Trust's governance arrangements, together with:

- The Trust's Quality Metrics

2. Perinatal Mortality Rate

A summary of March data is provided below for Board scrutiny. The mortality rate remains within the expected range and did not trigger a Maternity Outcomes Signal System (MOSS) alert. This position has been reviewed through established divisional governance processes and will continue to be monitored and escalated in accordance with the Trust's oversight framework.

2.1 Stillbirths and late fetal loss > 22 weeks

In March 2026 we recorded 1 stillbirth and 0 late fetal losses reportable to MBRRACE.

2.2 Neonatal Deaths

In March 2026 we have had 0 neonatal deaths reportable to MBRRACE.

2.3 Learning from the PMRT reviews March 2026

Issues

There were no issues identified on review.

3. Perinatal Metrics

The Trust maternity dashboard has been included in Appendix 1.

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

Metrics with significant deterioration:

- PPH - a business case has been submitted for use of carbetocin is progressing
- Neonatal death rate/1000

Metrics with a significant improvement:

- HIE rate /1000
- Stillbirth rate / 1000
- 3rd and 4th degree tear rate / 1000

Maternity Outcomes Signal System (MOSS): latest March 2026

- Level one signals Last 1 months - 0
- Level two last 1 months - 0

This data is reviewed through divisional governance meetings, with oversight and challenge to ensure any emerging themes, risks or deteriorations are identified promptly. Where required, actions are agreed, tracked to completion and escalated via the Quality Committee, providing ongoing assurance to the Trust Board.

4. Recommendation

The Board of Directors is asked to receive this report and note the assurances provided in relation to maternity and neonatal safety performance and governance. The Board is also asked to formally record in the Trust Board minutes - as evidence for the Maternity Incentive Scheme - that the following have been reviewed and approved/noted as appropriate:

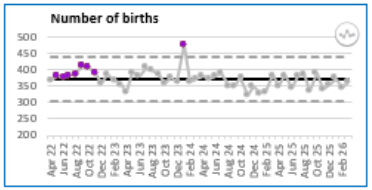
- Trust Quality metrics
- MOSS update noted

Maternity overview

Trust Total

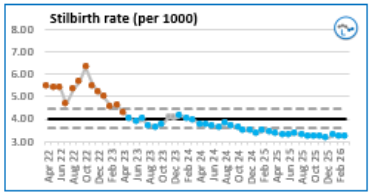
Latest month 01/03/26
Number of births 360

No significant change



Latest month 01/03/26
Still birth rate/10 3.2

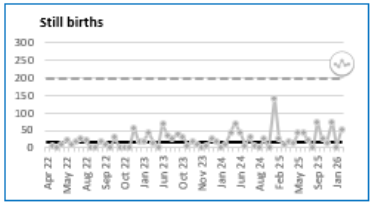
Significant Improvement



Date of last stillbirth 15/03/26

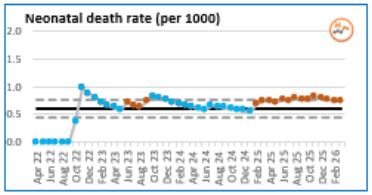
Average days between 15.0

No significant change



Latest month 01/03/26
Neonatal Death rate/1000 0.7

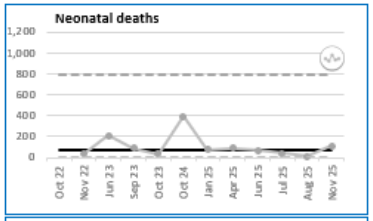
Significant deterioration



Date of last neonatal death 22/11/25

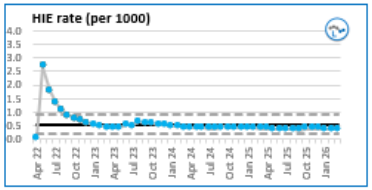
Average days between 77.7

No significant change



Latest month 01/03/26
HIE rate/1000 0.3

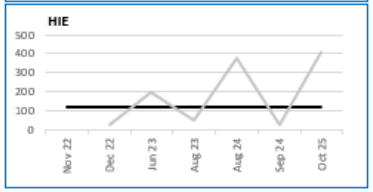
Significant Improvement



Date of last HIE 22/10/25

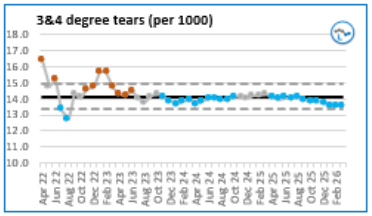
Average days between HIE 122.1

No significant change



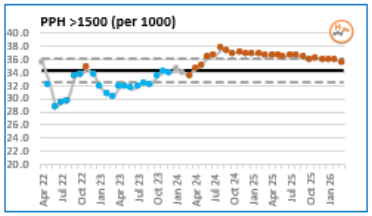
Latest month 01/03/26
3&4 degree tears (per 1000) 13.6

Significant Improvement



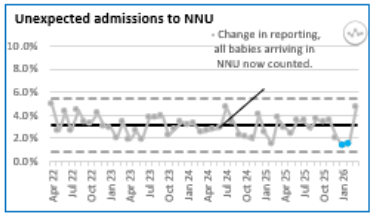
Latest month 01/03/26
PPH >1500 (per 1000) 35.4

Significant deterioration



Latest month 01/03/26
Unexpected admissions to 0.0

No significant change



Maternity Outcomes Signal System (MOSS) - Charts

Latest Event: **06 Apr 26**
Refreshed: **13 Apr 26**

MOSS is a safety management system and not a performance management tool. MOSS signals flag potential safety issues, prompting a locally led critical safety check (see Standard Operating Procedures) to determine if there are real safety issues. Safety issues are governed under the Perinatal Quality Oversight Model.

Sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death. Potentially adjusting this data will be reviewed in 2026. Until then, perinatal leadership teams in these sites should remain curious and still proceed with the MOSS critical safety check as part of good practice.

Trust	Chart type	Site
Doncaster and Bassetlaw Te..	CUSUM chart(s)	All

All sites | Glossary of terms

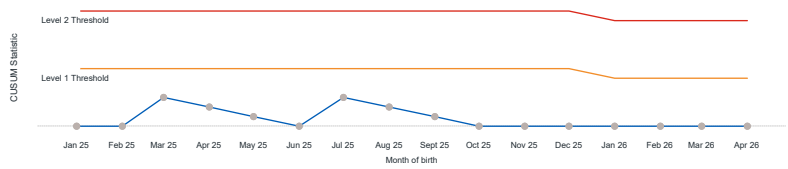
Maternity Outcomes Signal - Cumulative sum (CUSUM) - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

Chart guidance can be found using the "i" icon.

Site: Bassetlaw Hospital



Site: Doncaster Royal Infirmary

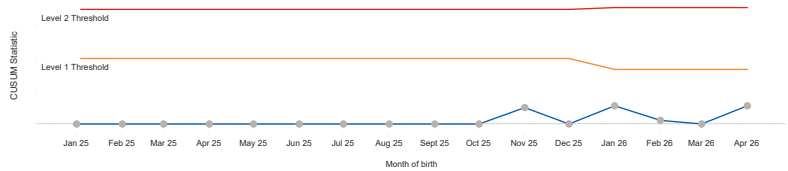


Table of Events - Trust: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Date of term birth	Events (term only)	Site name
06 Apr 26	1 Term Neonatal Death(s)	Doncaster Royal Infirmary
20 Jan 26	1 Term Stillbirth(s)	Doncaster Royal Infirmary
06 Nov 25	1 Term Stillbirth(s)	Doncaster Royal Infirmary
15 Jul 25	1 Term Stillbirth(s)	Bassetlaw Hospital
24 Mar 25	1 Term Neonatal Death(s)	Bassetlaw Hospital

2605 - E2 PROVIDER LICENCE COMPLIANCE & SELF-CERTIFICATION

Decision Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

5 minutes

REFERENCES

Only PDFs are attached

E2 - Provider Licence Compliance & Self-assessment.pdf

E2 - Appendix 1 - Self certification - Provider Licence CoS7.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Provider Licence Compliance & Self-assessment (Continuity of Services)**			
Executive Sponsor:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance			
Authors:	Angela O'Mara, Deputy Company Secretary			
Appendices:	Appendix 1 – Self-certification			
Purpose of the report	~~Assurance~~	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	**BAF strategic risk 5** *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.*			

Executive Summary – Key messages and Issues

This report outlines evidence for the Board of Directors in respect of the Continuity of Services condition (CoS7) of the NHS Provider Licence. This has been reviewed by the Audit and Risk Committee and recommended to the Board for approval.

Condition CoS7 requires providers of Commissioner Requested Services (CRS) to certify they have a reasonable expectation that required resources will be available to deliver the designated service in the next 12 months. This requirement remains in place following the 2023 Provider Licence review.

In making this declaration, the Board will have regard to the Board Assurance Framework (BAF), the Risk Register, as well as the Trust's performance reporting and assurance arrangements, established via the committee structure of the Board.

The going concern assumption was reported to and supported by the Finance and Performance Committee on 19 March 2026, as documented in the minutes and supporting papers. The year-end accounts and statements will be provided to the Audit & Risk Committee on 23 June 2026 and will provide the evidence that the Trust will operate on a going concern basis.

Recommendations

The Board of Directors is asked to:

- Review the document and recommend this is signed by the Acting Chief Executive and Interim Chair of the Board for publication on the Trust's website.

Healthier together – delivering exceptional care for all	
Patients	*This document confirms the Going Concern status of the Trust and its continued delivery of patient care.*
People	*This document confirms the continued delivery of services by its people.*
Partnerships	*This document confirms the Trust's commitment to operate, working with its partners.*
Pounds	*This document confirms the Going Concern status of the Trust.*
Health Inequalities	*This document has no positive or negative impact on health inequalities.*
Legal/ Regulation:	*There is a regulatory requirement to confirm the Going Concern status of the organisation within two months of the financial year end.*

<table>
<tr><td>Partner ICB strategies</td><td>This document has no positive or negative impact on ICB Strategies</td></tr>
<tr><td colspan="2">Assurance Route</td></tr>
<tr><td>Previously considered by - including date:</td><td>The Going Concern status was considered at the Finance & Performance Committee on 19 March 2026 and Audit and Risk Committee on 17 April 2026</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>To be approved by the Board of Directors on 5 May 2026</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>
</table>

Worksheet "CoS7"

Financial Year to which self-certification relates | 2026/27 | Please complete the explanatory information in cell E36

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (designated CRS only)

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | Confirmed | Please fill details in cell E22

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | | Please Respond

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. | | Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust's Going Concern status is based upon the financial support provided by NHS England, ensuring the Trust has suitable liquidity to pay suppliers and staff. The Trust's medium term plan for 26/27 - 28/29 has now been confirmed as complaint with conditions by NHS England and includes deficit support funding in 26/27 which should enable the Trust to breakeven in the year.

In addition, the Trust has the support of the South Yorkshire Integrated Care Board, as indicated by the fact that services will continue to be commissioned to the Trust in 2026/27, with contract offers now being received.

An outline cash flow plan as part of the medium term plan suggests adequate liquidity.

The Trust's Finance & Performance Committee will oversee delivery of the Trust's financial plan, a robust governance structure maintains the internal controls, with risks to delivery of the plan and the strategic aim monitored and risk mitigation articulated through the Board Assurance Framework.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Zara Jones	**Name**	Mark Bailey
Capacity	Acting Chief Executive	**Capacity**	Interim Chair of the Board
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations.

2605 - E3 UNANNOUNCED CARE QUALITY COMMISSION INSPECTION OF CHILDREN & YOUNG PEOPLE

Information Item | Karen Jessop, Chief Nurse | 13:15

verbal

5 minutes

2605 - F POUNDS

13:20

2605 - F1 2025/26 GOING CONCERN ASSUMPTION & DELEGATION OF AUTHORITY TO APPROVE THE ANNUAL REPORT & ACCOUTS

Decision Item | Sam Wilde, Chief Finance Officer | 13:20

10 minutes

REFERENCES

Only PDFs are attached

F1 - 2025-26 Going Concern Assumption & Delegation of Authority to Approve AR&A.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**2025/26 Going Concern Assumption and Delegation of Authority to Approve the Annual Report and Accounts**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Yasmin Ahmed, Deputy Director of Finance			
Appendices:	N/A			
Purpose of the report	**Assurance**	**Decision required**	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)	BAF 5 – Financial Sustainability - If DBTH does not deliver its annual financial plans and address its underlying deficit over time, then the Trust may face reputational damage, regulatory action and loss of financial autonomy, impacting adversely on our ability to deliver sustainable services for the population we serve.			

Executive Summary – Key messages and Issues

The going concern assumption is the most fundamental of all the assumptions made in preparing annual accounts for the Trust.

The Going Concern principle is broadly that the organisation will continue to operate 12 months after the signature of the statutory accounts (NB DBTH accounts for 2025/26 are expected to be signed in June 2027).

For the Trust, the main criteria of the Trust's Going Concern status is around the financial support provided by NHS England, ensuring the Trust has suitable liquidity to pay suppliers and staff. Given the national cash support received during 2024/25, the Trust has precedent to suggest that such support will be forthcoming in 2026/27. Also, the Trust has the support of the ICB as indicated by the fact that services will continue to be commissioned to DBTH in 26/27 with contract offers now being received.

Planning for 26/27 is completed, an outline cash flow plan suggests adequate liquidity to June 2027. This is based on all the planned efficiencies being achieved, and those efficiencies are cash releasing. If the efficiencies are not achieved and/or they are not cash releasing, then the Trust will have to look for PDC cash support from DHSC.

Recommendations

The Finance and Performance Committee in March reviewed a detailed paper on this issue and **AGREED TO RECOMMEND TO THE BOARD** that the Trust prepare its 2025/26 accounts on a going concern basis. Since then the Trusts medium term plan has been accepted as complaint with conditions, further strengthening the basis for adopting the going concern assumption.

The Trust Board is asked to **APPROVE** using the going concern basis to prepare the annual accounts for 2025/26.

The Trust Board is also asked to **DELEGATE AUTHORITY** to the Audit and Risk Committee to approve the audited report and accounts on behalf of the Board and authorise relevant Trust officers to sign them on behalf of the Trust as in previous years given the deadline for submission.

<table>
<tr><th colspan="2">Healthier together – delivering exceptional care for all</th></tr>
<tr><td>Patients</td><td>We deliver safe, exceptional, person-centred care.</td></tr>
<tr><td>People</td><td>We are supportive, positive, and welcoming.</td></tr>
<tr><td>Partnerships</td><td>We work together to enhance our services with clear goals for our communities.</td></tr>
<tr><td>Pounds</td><td>We are efficient and spend public money wisely</td></tr>
<tr><td>Health Inequalities</td><td>N/A</td></tr>
<tr><td>Legal/ Regulation:</td><td>In line with Group Accounting Manual 2025-26</td></tr>
<tr><td>Partner ICB strategies</td><td>N/A</td></tr>
<tr><th colspan="2">Assurance Route</th></tr>
<tr><td>Previously considered by - including date:</td><td>Finance and Performance Committee 19th March 2026</td></tr>
<tr><td>Any outcomes/next steps / time scales</td><td>Complete Annual Report and Accounts and audit thereof</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></td><td></td><td></td><td></td></tr>
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</td></tr>
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Year-end Accounts – 24/25 Going Concern

Going Concern

The 'Group Accounting Manual 2025-26' published by the Department of Health contains the following guidance:

4.18 The FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.19 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.21 Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.22 Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances), it must raise the issue with its sponsor division or relevant national body as soon as possible.

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

Assessment

The accounts will be prepared on a going concern basis on the basis of:

- Where there is support from local commissioners and NHS England for the continuing operations of the trust, the national guidance strongly indicates that the Trust should assess itself as a going concern. The Trust is not aware that the operation of the Trust will materially change or cease over the next 12 months.

- Cash position and national cash support:
    - The going concern status has been historically supported by a healthy cash position. The cash balance is £54.4m at March 2026, with capital creditors of £40.8m.
    - The Trust's financial plan for 26/27 was a breakeven plan to NHS England supported by a lower level of deficit support funding than in 2025/26. Delivery of the plan is dependent on a significant level of expected financial efficiencies.
    - If the plan is achieved, then it is unlikely that the Trust will need cash support. However, should there be slippage, then the Trust may need cash support. Given that this support has been forthcoming in the past and the Trust has a well-rehearsed process to obtain this cash.

Initial discussions with external audit have suggested that the approach that they will take to review this assessment is one based on the continuity of NHS provision in the local area. This is in line with their viewpoint of the sector as a whole and allows for a more nuanced approach to the issue, as opposed to simply focusing on cash flow and I&E sensitivities.

As the year end audit progresses, it is felt that this assessment and note will be reviewed and refined and as such, it is likely that a final, agreed wording will be presented back in June 2026. External audit are happy with this approach and allows for best practice across the sector to influence the final disclosure note.

2605 - G ASSURANCE

13:30

2605 - G1 DONCASTER & BASSETLAW HEALTHCARE SERVICES UPDATE

Discussion Item | Sam Wilde, Chief Finance Officer | 13:30

5 minutes

REFERENCES

Only PDFs are attached

G1 - Doncaster and Bassetlaw Healthcare Services Update.pdf

Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Doncaster and Bassetlaw Healthcare Services Ltd Update**			
Executive Sponsor:	Sam Wilde, Chief Finance Officer & Director (DBHS) Mark Bailey, Interim Chair of the Board & Chair (DBHS)			
Authors:	Mark Olliver, Managing Director Doncaster & Bassetlaw Healthcare Services Ltd			
Appendices:				
Purpose of the report	**Assurance**	~~Decision required~~	~~Information~~	~~Discussion~~
Impacts on Strategic Risks (BAF 1-7)				

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 (DBHS).

Financially, the business continues to perform strongly, with profit levels in 25/26 exceeding budget.

All 4 pharmacy Key Performance Indicators have exceeded target in both the month of March 2026 and across the year as a whole. The internal Pharmacy Professional Audit (86.8%) and Customer Satisfaction Questionnaire (88.6%) have also delivered strong results.

Board are reminded of the 5 strategic aims of DBHS and 4 key priorities for 2026-27 are set out in support of those.

Recommendations

The Board is 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>N/A</td></tr>
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<tr><td></td><td></td><td>Regulatory
Quality</td><td>Finance</td><td>People</td><td></td></tr>
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</table>

1. Executive Summary

This briefing document aims to provide the Trust Board with an update on the performance of Doncaster and Bassetlaw Healthcare Services Ltd, at year end 2025/26.

The paper presents current financial business performance and highlights business delivery against all KPIs specified. 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.

2. Financial Performance

Table 1: Full Year trading performance for Doncaster and Bassetlaw Healthcare Services Ltd

March 2026 (£k)	**Actual**	**Budget**	**Variance**
Turnover	**11,889**	**12,122**	**(233)**
Cost of Sales	(10,798)	(11,144)	346
Gross Profit	**1,091**	**978**	**113**
Admin Expenses	(840)	(886)	(46)
Profit before tax	**251**	**92**	**159**
Tax	(67)	(23)	(44)
Profit after tax	**184**	**69**	**115**

The business has delivered a pre-tax profit of £251k and has exceeded budget by £159k. The Gross Profit Margin is 9.2%, which is in line with historical performance.

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

	£k
Inventory	754
Accounts Receivable	1,096
Other Receivables	1,666
Cash	539
Total Assets	**4,055**
Accounts Payable	1,075
Other Payables	1,835
Total Liabilities	**2,910**
Total Net Assets	**1,145**
Share Capital	550
Retained Earnings	595
Total Shareholder Equity	**1,145**

The balance sheet above outlines good financial stability, with retained earnings set at £595k. The business remains fluid and agile to future short-term investment.

Key Performance Indicators KPIs

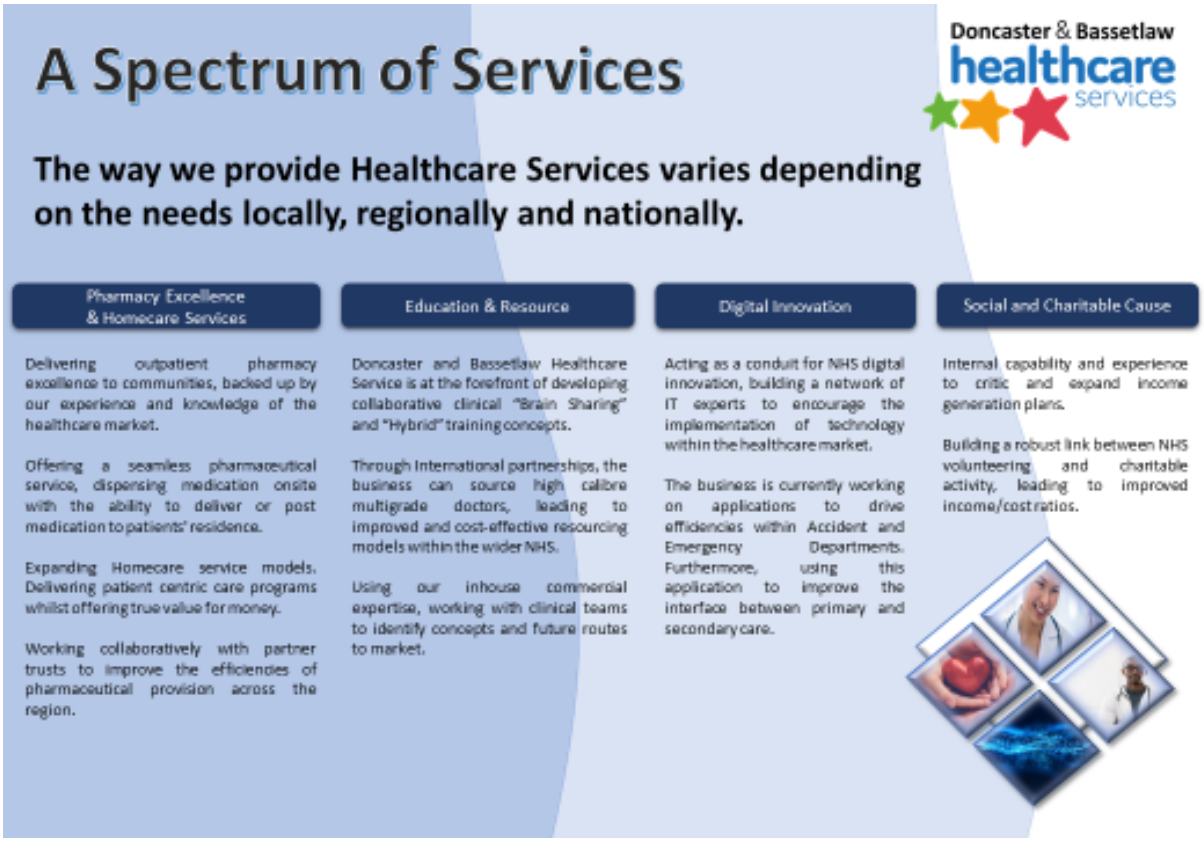
Table 3: Business Pharmacy KPI Performance Indicators

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%
March 2026	96.9%	78.2%	1.09%	0.002%
Year 2025/26	96.4%	77.4%	1.28%	0.004%

The table above highlights KPI scorecard performance for the month of March and the 2025/26 year. All measures have been delivered within the targets set. Furthermore, the internal Pharmacy Professional Audit (86.8%) and Customer Satisfaction Questionnaire (88.6%) have also delivered favourable results.

3. 5 Year Strategic Plan Summary

The board are asked to note the following strategic aims of the business.



4. Key Priorities 2026-27

The Subsidiary Board have highlighted four key priorities for the new financial year, and these are outlined below. To support the operational delivery of all projects, the business is currently recruiting for a new Business Operations Development Manager.

Pharmacy Excellence

To future-proof current pharmaceutical provision, it is appropriate and vital that the business considers expansion into the digital arena. Online pharmacy services have been in existence for over 20 years and the continued expansion and growth of e-commerce, aligned against a dynamic and ever-changing consumer need, supports this view.

The business proposes to set up a Dr Online portal, working in collaboration with a local GP practice. This platform would allow patients and/or customers to obtain private prescriptions for a number of medical complaints.

All online pharmacy services (within the UK) are fully regulated by the same authorities as physical pharmacies. This regulated activity is governed by the General Pharmaceutical Council (GPhC) and the Medicines and Healthcare products Regulatory Agency (MHRA). Furthermore, advertising for such services is regulated by the Advertising Standards Authority (ASA).

The General Pharmaceutical Council (GPhC) provides specific guidance on the provision, at distance, of safe and effective pharmacy services. This guidance must be applied alongside regulatory standards associated with 'registered' premises and 'standards for registered professionals' i.e. pharmacists and technicians.

The board have discussed the concept in detail and reviewed potential financial forecasts. To pressure-test the concept, the business has commissioned Apira /IQVIA to conduct a detailed Options Appraisal. The work will consider a detailed analysis of the market, competitor activity, sensitivities (to the model) and favourable options for sourcing the required IT platform and payment gateway. Should the Options

Appraisal prove positive commercially, the business will commence development and deployment as a priority.

Homecare Services

Working closely with the Trust inpatient pharmacy team and haematology and rheumatology specialities, two existing homecare services have been incorporated into the business portfolio. This alternative model, reducing reliance on expensive external homecare providers, has reduced costs and maintained patient care. Initial Trust cost savings have been estimated at circa £50k, with further savings predicted to be circa £40k per annum.

To support the Trust in delivering increased productivity and financial efficiencies, the business is keen to explore further homecare options and requires Trust guidance on identifying the size of the prize. At present the business is set up to support simple homecare service provision. However, future service provision could adopt higher complexity and the business would increase capability accordingly, to deliver a step change in cost savings and/or commercial return. Furthermore, more complex services may require CQC registration.

To support in the expansion and development of the homecare offer, the business has budgeted for an additional FTE role within its organisational structure. It is expected that strong focus will achieve two benefits i.e. increased business profitability and increased Trust savings. This activity supports the Trust's strategic goal associated with 'Productivity and financial reset'.

Capability and Resourcing

For many years, the business has worked in partnership with QIMET International, providing alternative resourcing solutions across healthcare.

Despite recently announced changes to the Medical Training Initiative (MTI) process, the programme will continue to expand across multiple specialities, including but not limited to Gastroenterology and Anaesthesia.

'Expressions of Interest' have been noted with a number of external Trusts, and future programmes will focus on sourcing doctors across a number of clinical grades. The programme aims to provide Trusts with a steady pipeline of international candidates, supporting departments in reducing agency spend and improving continuity of care. The programme has been rolled out to other partner Trusts, with notable success.

Successful expansion and delivery could support the Trust in delivering the goal of 'improved workforce and organisational design'. The business will continue to work with the Trust, to identify future opportunities that align to the resourcing requirements of the Trust. When initially incorporated into Doncaster Royal Infirmary in 2019/20, agency shift spend was reduced by circa 32% across the financial year.

Service Innovation

Current out-of-hours outsourced radiology services present the Trust with a significant financial burden. Past data has evidenced that emergency activity alone can cost the Trust circa £130k per month. Alternative arrangements could provide suitable financial savings and improved patient care.

Working in collaboration with consultants at the Trust, the business is currently exploring the delivery of high quality 'out of hours' radiology services. A service arrangement between the Trust, subsidiary and a newly formed LLP could provide a number of measurable benefits such as Improved quality and seamless patient care, improved financial grip and control and future commercial scalability.

Once the proposed Standard Operating Procedures have been completed, the business will review with our partnered legal representatives. The introduction of such a programme would support the Trust in delivering the strategic goals of 'Production and Financial Reset' and 'Shape of DBTH'.

Conclusion

Doncaster and Bassetlaw Healthcare Services has delivered strong financial performance and corporate liquidity remains high. 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.

The strategic plans highlighted above align well with the strategic priorities for Doncaster and Bassetlaw Teaching Hospitals Foundation Trust. Continued strong collaboration between the parties could lead to further service improvements and even better financial control.

Mark Olliver

Managing Director

27th April 2026

2605- G2 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE COMMITTEE

Discussion Item | Stephen Radford, Non-executive Director | 13:35

5 Minutes

REFERENCES

Only PDFs are attached

G2 - Chair's Assurance Log - Finance & Performance Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Finance and Performance Committee - Chair's Highlight Report to Trust Board

Subject:	**Finance and Performance Committee**	**Board Date: 5 May 2026**
Prepared By:	Stephen Radford, Non-executive Director & Committee Chair	
Approved By:	Finance & Performance Committee Members	
Presented By:	Stephen Radford, Non-executive Director & Committee Chair	
Purpose	The paper summarises the **key highlights** from the Finance and Performance Committee meeting held on 28 April 2026	

Matters of Concern/Escalation Items (with Partial or No Assurance)	**Major Actions Commissioned / Work Underway**
The F&P Committee received Partial Assurance in the following areas: **Operational Performance – March 2026** Partial Assurance **Emergency Care**: • ED 4 hours performance has improved significantly in the month in the to 77.5% against a planned target of 78%. This reflects UEC Sprint Re-set improvement actions taken in March 2026. However, notable variation in performance between the two acute sites remains which indicates inconsistency in flow /operations. The challenge will be to make this positive change sustainable • ED waits over 12 hours decreased to 2.5% against a plan of 2.9%. Again, a significant improvement over the position in January 2026. • Ambulance hand-over performance has continued to improve, with average handover performance ahead of plan. This reflects improved patient flow/system responsiveness • Demand for A&E was 2.8% above plan in the month and has increased particularly in Bassetlaw **Elective Care**: • Trust performance continues to improve with 61.1% of patients waiting less than 18 weeks against a target of 65.8%. • The Trust remains in Tier 2 for elective performance • The most significant risks to >18 week & 52-week performance targets is Trauma and Orthopaedics (T&O) speciality. Substantive improvements are required or both overall targets are likely to be missed by the Trust **Cancer**: • For 62-day Referral to Treatment is behind plan of 75.3% by 1.5%, other cancer standards were deemed to provide significant assurance • The Trust continues to experience internal delays in radiology and external delays relating to histopathology. **Local Security Management** Partial Assurance The F&P Committee noted that there were certain elements of the NHSE Violence Prevention & Reduction (VPR) standard meant that the the Trust's compliance level had	**Revised GIRFT Approach & Governance Model** • The F&P Committee received a proposal to revise the Trust governance model for GIRFT that separates clinically led peer reviews and from specialty reports from the Further Faster, surgical hubs, theatre productivity, coding and outpatient improvement programmes. These changes will resolve the current ambiguity in ownership and embed GIRFT into existing Trust governance rather than creating additional boards. • It is planned to implement the initial Model Health System and local metrics dashboard for routine review Q1 2026/27 • The Committee approved the planned changes to GIRFT governance and reporting for implementation

been assessed as 'Amber' category. It was explained that factors were largely outside the control of the Trust. The F&P Committee decided assurance level should be split accordingly

Planning Update 26/27 Partial Assurance

- The F&P Committee received a report setting out the accepted 2026/27 closed down planning position and the conditions attached to its delivery
- New Reset governance has been implemented to oversee operational improvement, workforce change, CIP delivery and financial run rate
- Budgets for 26/27 have now been rolled-out across the Trust including divisional saving targets
- Represents good progress for the Trust to-date

Significant or Full Assurances to Provide	Decisions Made

The F&P Committee received Significant Assurance in the following areas:

Financial Performance – Month 12 Significant Assurance

- The Trust Group reported an outturn deficit of £17m before deficit support funding in line with plan
- Productivity schemes yielded both recurrent and non-recurrent savings for the year ended of £31.4m with recurrent standing at £22.3m. Both above the original plan. 66 FTEs had been saved in the year.
- Cash position outturn position was significantly favourable to plan owing to receipt of £38.4m PDC funding.
- Capital spend was in line with plan at year end with a major surge in spending in the last month of the financial year.
- Draft accounts for 26/27 have been submitted to NHSE and our external auditors

Local Security Management Significant Assurance

The F&P Committee received the Local Security Bi-Annual Report for the second half of 2025/26. For this report the Committee took split assurance. Significant assurance was taken from the internal controls and processes in place to manage security and violence prevention and reduction at DBTH. These demonstrated comprehensive oversight and action.

IT Business Continuity Incidents Update Significant Assurance

Following a number of IT issues, the F&P Committee received an initial report in February 2026. A further report was requested re-planned actions and progress which had been achieved. This report showed significant progress in the action plans and the lessons that had been learnt from these incidents.

Board Assurance Framework – BAF 3, 7 & 4 Trust Risk Register Significant Assurance

These BAF risks were reviewed with updates having been made to key controls, progress, closing out 25/26 actions, risk appetite and mitigating actions. The wording for BAF Risk 7 had been revised. These and other changes to the BAF risks were considered, and the BAF risks under consideration were found to provide significant assurance. The latest BAF was recommended to the Board for approval.

Contract Award Via G-Cloud 14 procurement

- The F&P Committee reviewed the procurement request and the renewal of the three-year contract from 1 April 2026 to 31 March 2029
- The supplier supports SMS reminders, two-way messaging, digital letters, patient-initiated follow-ups (PIFU), and waiting list validation
- The renewal is being progressed via a direct award under the G-Cloud 14 procurement framework - a fully compliant UK public sector procurement framework managed by the Crown Commercial Service (CCS)
- It was agreed that contract length should be updated to 1+1 year and the value of the contract renewal updated accordingly before submission to the Board
- The Committee after due consideration recommended the Contract to the Trust Board for approval in line with the SFI values.

Finance & Performance Committee – Terms of Reference

The updated Terms of Reference were discussed and approved by the Committee. These were commended to the Board for approval, acknowledging that there would need to be a further in-year review to accommodate the reset programme and MTP.

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.

2605 - G3 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

Discussion Item | Jo Gander, Non-executive Director | 13:40

5 Minutes

REFERENCES

Only PDFs are attached

G3 - 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: 5 May 2026**
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 23 April 2026	

Matters of Concern (Partial or No Assurance)	**Work / Major actions commissions**
• National Clinical Audit Alerts relevant to DBTH – demonstrating that divisions are delivering the clinical audit programme and comply with National Institute for Health and Care Excellence (NICE) guidance as appropriate. However, the Trust has received notification that it is an outlier for National Early Arthritis Audit (NEIAA) and National Emergency Laparotomy Audit (NELA) - **Partial Assurance**	The following items were received for information and noted; • Medical Devices Annual Report The following items were discussed; • CNST Year 8 Expectations • Quality Committee Effectiveness Survey
Significant or Full Assurances to Provide	**Decisions Made**
• Maternity & Neonatal Safety & Quality report received giving significant assurance against the single delivery plan, maternity self-assessment tool & Clinical Negligence Scheme for Trusts (CNST). **Significant Assurance** • Maternity Patient Experience Survey – maternity services have completed the annual National Maternity Survey and that findings demonstrate measurable and sustained improvement across a range of patient experience measures, supported by triangulated evidence (including staff feedback, Maternity and Neonatal Voices Partnerships (MNVPs) engagement, Datix incidents and complaints). **Significant Assurance** • Safeguarding assurance and capability framework gap analysis - this provided significant assurance that the Trust has effective safeguarding arrangements in place, supported by clear accountability, robust governance and multiple sources of triangulated assurance in relation to the safeguarding of patients in our care. **Significant Assurance** • Patient Safety report inc. Martha's Rule implementation received on delivery of 25/26 Quality Priorities and sets out the 26/27 Quality priorities for approval along with a summary of performance against agreed measures, key improvement actions taken to date and the governance arrangements that will provide ongoing oversight and escalation where required. **Significant Assurance**	The Committee took assurance from the detail provided within the Maternity & Neonatal Safety & Quality report and recorded in the Committee minutes to provide evidence for the Maternity Incentive Scheme the following. • Reviewed and approved on behalf of the Trust Board progress updates on Maternity Self-Assessment & CNST. • Reviewed and approved on behalf of the Trust Board the Neonatal nursing & Medical Workforce progress updates. • Reviewed and approved on behalf of the Trust Board the Trust Quality metrics. • Noted on behalf of the Trust Board the number of Maternity and newborn Safety Investigation (MNSI)/Early Notification Scheme (ENS) cases, that families have received information on the role of MNSI and ENS and that compliance with the statutory duty of candour has taken place. • Noted that the 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. • Noted that progress against the maternity and neonatal cultural improvement plan (SCORE survey) is being monitored at the Board Safety Champion meetings, and the maternity and neonatal safety quality committee and any identified support is being considered and implemented. • Noted MOSS update

• PLACE Assessments Annual Reported to the committee that a jointly owned Nursing and Estates & Facilities Action Plan will be approved through Patient Experience and Involvement Group (PEIG), monitored bi-monthly and subject to quarterly reporting and escalation, ensuring robust oversight and timely escalation where necessary. **Significant Assurance** • Quality of Care trends via review of IQPR metrics **Significant Assurance** • Board Assurance Framework Risk 1, including Trust Risk Register discussion triangulated to the assurances provided by the reports on the agenda, which linked to the required actions in progress. The Committee recommend the BAF for approval to the Board of Directors in March 2026. **Significant Assurance**	• Quality Committee Terms of Reference and workplan was reviewed and approved.

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.

2605 - G4 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

Discussion Item | Lucy Nickson, Non-executive Director | 13:45

5 minutes

REFERENCES

Only PDFs are attached

G4 - Chair's Assurance Log - People Committee.pdf

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

People Committee - Chair's Highlight Report to Trust Board

Subject:	**People Committee**	**Board Date: 5 May 2026**
Prepared By:	Lucy Nickson, Non-executive Director & People Committee Chair	
Approved By:	People Committee Members	
Presented By:	Lucy Nickson, Non-executive Director & People Committee Chair	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 21 April 2026	

Matters of Concern (Partial 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**
Engagement and Leadership - Annual Staff Survey Results – Significant Assurance 2025/26 saw a survey response rate of 54%, against a sector average of 47%. This was an anticipated decline from 62% in 2024/25. A decline is in line with the sector averages, although the Trust's is marked due to previous significant success since 2023. The Trust has performed better than the sector in six of the seven People Promise themes and is in line with national average on the seventh ('We are a team'). Of the two additional themes measured nationally, the Staff Engagement score is lower than average but the Morale score higher. 7% of questions have shown significant improvements since 2024, 17% have shown significant decline and 76% have shown no significant movements. The question areas showing improvement do demonstrate the impact of targeted work, such as flexible working. Learning and development, feeling safe and healthy at work as well as many of the immediate manager questions also show improvements. The areas which have declined include raising concerns and confidence in speaking up, engagement, involvement in decision-making and some of the team-working questions. The decline in confidence in speaking up, whilst not welcomed, triangulates with some feedback contained within the DBTH Way in Action review. A full briefing will be shared at the Board meeting in May, with opportunity for further questions and deeper analysis. Next steps and follow up actions are planned and clear. The committee noted that some of the key elements of concern are well triangulated with other work which will come back to PC for further	

exploration in June and also to Board in May 2026.

Education Report - Significant Assurance

Statutory Essential Training (SET) compliance was 86.69% as of the end of February 2026, a further reduction from previous months and below 90% target despite continued engagement, good data and clarity that SET is part of the accountability framework for all clinical and corporate divisions. There was good discussion about the impact of reduced compliance and the tension between SET and Role Specific Training (ReST) which is linked to capacity to release challenges and impact on rotas of time expected to complete all SET modules. The 360 Assurance audit on SET is scheduled to conclude in April 2026 and should provide further insight into challenges and suggestions for improvement.

An overview of DBTH's widening participation activity highlighted the breadth, of work and how demonstrated how we continue to meet our NHSE Education standards commitments.

The NHSE National Education Training Survey 2025 results data were presented within the paper. Unfortunately, only 128 individuals completed the survey with the majority being from resident doctors. The data is as expected, including where there are areas for improvement. All scores have increased except wellbeing, which is a trust outlier. The results will be used within the existing speciality action plans led by the College Tutors and supported by the Associate Director of Education

Health and Wellbeing Annual Report – Significant Assurance

The Trust continues to deliver a comprehensive, evidence-based programme focused on keeping colleagues physically and mentally well, supporting retention, and enabling high-quality patient care. Targeted wellbeing interventions have been prioritised using 2024 NHS Staff Survey intelligence. Feedback from teams continues to be positive and indicates the workforce value the Health & Wellbeing (HWB) offer. The committee discussed in detail how impact measures on the value of the HWB could be further developed.

Key wellbeing priorities continued to progress, which clearly have a wider impact on employee health such as retention of the Trust's Menopause Accreditation, delivery of menopause awareness sessions, and strong utilisation of smear clinics for our female workers. Wellbeing Wednesday webinars and the Trust-wide Health & Wellbeing event further strengthened workforce engagement and access to support.

The Occupational Health Service retained Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation, continued to meet key performance standards, and increased

collaborative working across People and operational services.

The 2025/26 Flu Vaccination Campaign achieved a 36.9% uptake, exceeding NHSE's required year-on-year improvement, however, falling short of the Trust target of 48%. Strengthened arrangements are planned for the 2026/27 campaign.

Workforce Supply and Demand Advanced Practitioner Workforce – Significant Assurance

A review of the Advanced Practitioner role has been taking place with the intention of aligning roles to the four National Pillars (launched May 2025), identifying workforce establishment over future years and to address retention issues linked to pay banding. In recent years the Trust has been unable to retain some experienced Advanced Practitioner colleagues as they have taken up roles at a higher band in other organisations.

Work is currently underway to commence the process of aligning individual practitioners' practice with the four national pillars of practice. The workforce review plan and costings were approved by DBTH Executive team in March 2026. The assimilation review and progression to the updated DBTH Advanced Practitioner job description and banding, commences April 2026.

Safe Staffing and Skill Mix: Significant Assurance

Where inpatient wards have operated below planned staffing levels, daily senior oversight, structured escalation, and active mitigation are consistently applied and no significant patient safety events reported. Staffing-related incidents remained no or low harm. Red flag reporting mechanisms are embedded across nursing and functioning, providing real-time visibility of risk and enabling prompt response.

The Trust has demonstrated effective control and governance in managing additional capacity when needed – underpinned by clear decision-making, redeployment, and proportionate use of temporary workforce solutions.

Agency usage remains limited, compliant with NHS Cap rates and confined to theatre services only. Workforce actions including phased registered nurse skill mix changes, targeted recruitment and strengthened temporary workforce controls, are progressing as planned and provide confidence in the sustainability of the staffing position into 2026/27.

Research Strategy Bi-Annual Report – Significant Assurance

The research and innovation (R&I) contractual obligations, and the delivery plans underpinning the R&I strategic plan are on track. Actions are being taken in relation to new 150-day clinical trial set up target and discussions are underway with support services to

identify barriers to clinical trial delivery. A strategic proposal focusing on commercial research is being developed and opportunities for external funding to support commercial research continue to be explored but worth noting, commercial research grew by 10% in 2025/26. The Clinical Research Hub opened in September 2025 offers dedicated clinical space for patients on Rheumatology, Gastro and Dermatology research studies. Vascular and Paediatric research clinics are also being explored. Funding from the National Institute of Health and Care Research has been awarded to create two bedded day bays in the research hub – due to complete early 2027. Penalties for non-compliance of the 150-day target are as yet unknown.

Bi-annual Nursing Workforce Review - Significant Assurance

The Committee was presented with a report confirming that the Trust's nursing staffing establishments are safe, sustainable and compliant with national guidance and best practice. The completed review incorporates the outcomes of the November 2025 workforce reviews across Adult inpatient wards, Children's and Young People's services and Emergency Departments.

The Safer Nursing Care Tool (SNCT) rigorous triangulation of data, professional judgement and quality intelligence provided the methodology.

Theatre and critical care environments have been reviewed using nationally recognised speciality-specific standards.

Focus on non-ward-based nursing teams is planned to be undertaken across 2026/2027. The committee was updated on specific recommendations regarding skill mix adjustments - in line with reporting to Trust Board in Jan 2026. Further phased skill mix recommendations will be provided following establishment reviews to be completed during 2026 and 2027, with the aim of transitioning closer to National best practice. There is a schedule of further reporting to come to People Committee in June and December 2026.

Birth Rate Plus - Significant Assurance

The committee took assurance that the midwifery service at DBTH is compliant with birthrate plus® enabling the service to provide excellent care in line with national recommendations.

Resident Doctors 10-point Plan – Significant Assurance

The Trust continues to make progress in delivering NHS England's 10-Point Plan to improve the working lives of resident doctors. Clear improvements are visible across several core areas. Progress is also evident across training-related processes. Facilities and rest-space reviews have shown no significant concerns, with ongoing monitoring and feedback being

channelled through the Resident Doctor Peer Lead. National guidance continues to evolve, and the Trust remains responsive to this. Overall, the Trust remains on track in the majority of domains, with several actions now complete and others progressing. It was agreed that the Trusts broader well-being offer should be reflected in the plan's response actions as this is something that genuinely offers further wellbeing enhancement when utilised. **Job Planning – Significant Assurance** Performance at 31 March 2026 (2025/26 year end) was 82%,- below the national 95% target but in line with ongoing Trust completion rates of 80–82%. There is targeted work underway in three specialties affected by system errors, rota redesign and on-call standardisation, Underachievement of the target at year end relates in part to some job plan changes requiring new templates, which is time consuming and required discussions to ensure accuracy. Policy, governance and reporting arrangements are well established, with weekly senior job planning meetings and regular oversight via the Job Planning Consistency Group and Effectiveness Assurance Group. Work continues on diary exercises for out of hours unpredictable activity and validation of planned sessions against actual delivered. Data quality continues to improve through ESR validation and reconciliation of activity with support from senior project managers and the workforce team. Focus continues to complete job plan sign off for general surgery, trauma and orthopaedics and paediatrics - along with quality improvements to support compliance with national standards and further maturity of the Trust's job planning framework. **Board Assurance Framework (BAF)- Significant Assurance** Committee reviewed the risk report and the current BAF. There were no new gaps in controls recognised but the work on culture that is being presented to board was noted as an area where further controls will be articulated in the BAF. The committee held a good discussion around all of the evidence presented in risk report and was satisfied the committee business was appropriately relevant to and aligned with the articulated risks and controls.	

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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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.
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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.

2605 - G5 CHAIR'S ASSURANCE LOG - AUDIT & RISK COMMITTEE

Discussion Item | Kath Smart, Non-executive Director | 13:50

5 minutes

REFERENCES

Only PDFs are attached

G5 - 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: 5 May 2026**
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 17 April 2026	

Matters of Concern (with moderate, partial, limited or no assurance)	**Work Underway / Major Actions Commissioned**
a) Audit Reports - None issued that were graded as moderate, partial or limited b) Management Reports -None issued that were graded as moderate, partial or limited c) Key risks to escalate - None	a) Single Tender Waivers – A minor number of STW's were challenged regarding the documentation of reasons why they were not tendered. Agreed to follow up with the CFO. b) Draft Annual Governance Statement – The draft AGS was discussed with some areas identified for further consideration; work is underway to finalise with areas highlighted for further amendments. c) External Audit – ISA 260 Recommendations follow-up – The narrative was accepted and will be followed up by EY as part of their year-end work d) Committee Effectiveness – Following the assurance discussions at the Board Strategic session on 14 April a number of areas were recommended to be taken forward including: - • Integrated Governance section on agendas • Committee effectiveness evaluations on a more regular basis • More focus when appropriate on triangulation • Continued training & support for report authors to analyse and estimate assurance levels and gaps
Significant Assurances to Provide	**Decisions Made**
a) **Counter Fraud progress Q4 25/26 – Significant assurance** was given to the arrangements in place to prevent, detect, investigate fraud. Note was taken of the conclusion of the LPE work in relation to declarations of interest and the current cases being managed by the LCFS.	**Internal Audit Plan 26/27** - The internal audit plan was approved by the Committee following review of previous audit work done, the BAF/ risk register, input from Executives and Non-Executives. It was agreed items which didn't make it onto the IA plan would be reviewed alongside Committee workplans to identify if further assurances would be needed

b)	**Counterfraud workplan & risk assessment 26/27 –** The fraud risk assessment has been updated and utilised to inform planned work for 26/27. This covers: strategic governance, inform and involve, prevent and deter and hold to account. ARC was satisfied this meets the needs of DBTH.	**External Audit Plan and Fee** – The external audit plans & risks for conclusion of the 25/26 work was presented and accepted by ARC
c)	**Internal Audit Update -** The audit plan is 94% delivered and is aiming to be on target to provide the year end opinion for the June ARC. Audit Recommendations closure rate for high & medium risks remains high at 96% (timeliness for high & medium risks). The year-end HOIA was not able to be finalised as 2 audits are yet to conclude and the outcomes of the Culture and Well Led work needs to be reviewed, which is due for presentation at May's Trust Board.	**Policy Approvals made: -** Standards of Business Conduct Policy Fraud, Bribery & Corruption Policy
d)	**Management reports - Risk Management & BAF – Significant Assurance -** ARC reviewed the risk report, the risk report and the current BAF. It was noted the Board has recently reviewed the high risk BAF 4 in relation to the Care Environment and changes agreed to be made were not yet reflected; work to include the areas from the recent Well Led; Culture and Medium Term plan; and Board discussions on SHMI and Sepsis may need consideration for BAF1. Compliance with BAF being presented at Board/ Committee was noted and positive.	
e)	**Management Report –** Losses/ Special Payment and Single Tender Waivers - These were found to be mainly in line with processes (see work commissioned a)	
f)	**Management Report** - Register of Interests, Hospitality & Sponsorship – A good year-end position giving significant assurance of decision makers who have completed declarations of interests in line with Policy.	
g)	**Management Report**: EPRR Workplan – Plans noted to continue to increase compliance with the national standards, supported by clear priorities and plans. Significant assurance was assigned to the process, with impact/outcome to be evaluated later in the year	
h)	**Management Report** – Committee Self Assessment; Chairs Annual Report; Terms of Reference, Workplan and Review of Board Committees Annual Reports and Effectiveness – Discussion was held that these reports were accurate and represented that the Committees had met their TOR during 25/26. The Board session on "assurance" highlighted additional areas to take into account and the Committee were keen to adopt these. (See work commissioned d).	

2605 - H INTEGRATED ASSURANCE

13:55

2605 - H1 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK REGISTER

Decision Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

Executive Directors
10 minutes

REFERENCES

Only PDFs are attached

H1 - Board Assurance Framework Compliance & Trust Risk Register.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Report Template				
Meeting Title:	**Board of Directors**		**Meeting Date:**	5 May 2026
Report Title/ Ref:	**Board Assurance Framework Compliance and Trust Risk Register**			
Executive Sponsor:	Zara Jones, Acting 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)	All BAF risks are effectively managed and monitored via the appointed committees and the Board of Directors.			

Executive Summary – Key messages and Issues

This report presents the Board Assurance Framework (BAF) up to and including reviews to 28 April 2026. The Board Assurance Framework and Trust Risk Register are presented to the Board of Directors for further discussion and decision to approve.

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, 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 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. Reporting is also in line with the Trusts own Risk Management policy which is further monitored through the Audit and risk Committee.

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 / director and monitored through the responsible committees. All risks and action plans are discussed in line with the risk policy. The trust risk appetite scores are also provided on the template to support risk aware decision making.

In April 2026 – the Board of Directors reviewed its risk appetite scores and statements, while no changes to the risk appetite scores were made, there have been changes to the statements against each of these. These will be incorporated within the risk summary once finalised, and will be approved at the July BoD meeting but are mentioned here for context.

The 'clean version' of the Board Assurance Framework is enclosed in appendix 2 for Board review, discussion, and to approve the recommendations made at the relevant committees. This has had all changes updated that were shared within the committees. The BAF is a working document and will continue to change over time as risk profiles change and in response to Internal Audit recommendations and best practice.

BAF risk 6 –partnership and collaboration will be reviewed in the confidential board in May – and its updates will be shared for approval ant the July 2026 Board meeting.

Recommendations
The Board of Directors is asked to: • Receive the report and note that the BAF and Trust Risk Register are live documents, which will be reviewed and updated regularly throughout the year. • Approve the current BAF risk content and take significant assurance that this enables the Board to fulfil its duty to monitor its highest strategic risks.

Healthier together – delivering exceptional care for all	
Patients	Regular review and assessment of the risks support the delivery of safe and effective services.
People	Regular review and assessment of strategic risks, support our people to deliver safe and effective care.
Partnerships	Regular review and assessment of strategic risks, supports the identification of partnership and collaboration risks and opportunities as part of a triangulated approach to risk management.
Pounds	Regular review and assessment of strategic risks, support delivery of the strategic priority to be sustainable and spend money wisely. Regular review may identify areas of financial or resource risk and opportunities as part of a triangulated approach to risk management.
Health Inequalities	All risks and mitigations are assessed for potential impact, positive or negative, on health inequalities
Legal/ Regulation	It is a regulatory requirement as part of the NHS Code of Governance for the Board of Directors to have mechanisms in place to manage and address risk throughout the organisation.
Partner ICB strategies	These documents have no positive or negative impact on ICB Strategies
Assurance Route	
Previously considered by - including date:	Quality Committee People Committee Finance and Performance Committee Board of Directors Development Session Confidential Board / Board Development session
Any outcomes/next steps / time scales	Board of Directors
In line with Current risk appetite **Yes**	**Risk Appetite levels: -** highlight only if this report is outside of Board Assessment

None	Minimal	Cautious	Open	Seek	Significant
		Regulatory Quality	Finance	People	

Board Assurance Framework and Trust Risk Register Review

BAF Summary of Changes:

- Assurance levels on actions and controls have been agreed by respective lead committees – see highlight reports from each committee. These state the emerging risks as presented in the Trust Risk Register relevant to each committees' BAF risks, plus the assurance around the mitigating actions described therein.
- There has been significant review and updates for BAF 3 and 7 with changes to the articulated risks. All BAF risks have been updated with the risk appetite and scores, with some (where they have been to a later committee) with suggested overall target risk scores that reflect the risk appetite.
- The Board of Directors 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 April 2025
Author: Tracy Evans-Phillips, Trust Risk Manager.

Introduction

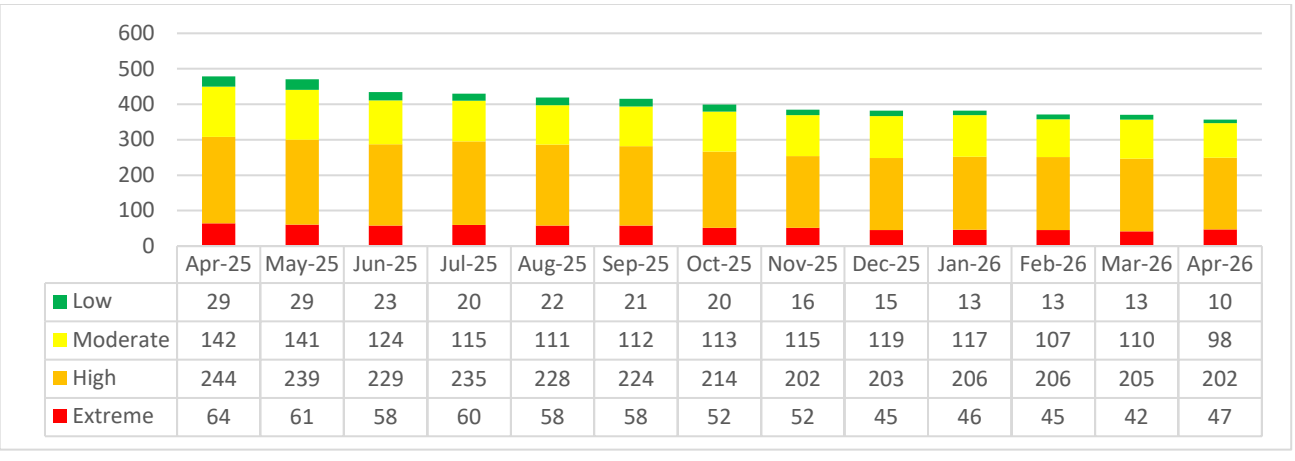
This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the continued efforts of the Risk Management Group to assess and moderate risks, including escalations and any 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 live updates occur within the risk management system.

Risk Activity March 2026 to April 2026

From March 2026 to April 2026, the risk register declined from 370 to 357 entries due to resolved issues, updated controls, and completed action plans. The number of open risks fell compared to the previous period, showing the effects of ongoing mitigation, register maintenance, and risk archiving or downgrading of risks that had met their target threshold.

Over the last financial year there has been a 25.5% reduction in the number of recorded risks with the number of Extreme risks falling by 26.6%. Work has been ongoing throughout the year to review and update risks, consolidate where relevant and maintain a focus on active risk management across the Trust.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Low	29	29	23	20	22	21	20	16	15	13	13	13	10
Moderate	142	141	124	115	111	112	113	115	119	117	107	110	98
High	244	239	229	235	228	224	214	202	203	206	206	205	202
Extreme	64	61	58	60	58	58	52	52	45	46	45	42	47

Overview of Risk Numbers and Changes

- Risks archived: 43
- New risks added: 30
- Risks escalated (risk rating increased): 2
- Risks downgraded (risk rating decreased): 13
- Risks with no change in rating: 312

From March to April 2026, the Trust updated the risk register: more risks were downgraded than escalated, new risks were added as needed, and resolved risks were removed. These actions demonstrate active risk management and oversight and the expected cycle of risk identification, mitigation and closure. Many of the new risks identified are as a result of the refreshing of the annual reported risks for the new financial year.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	**4**	
Moderate	**20**	
High	**16**	10 Risk have been archived and reintroduced for the new financial year, the remaining risks have been fully mitigated and closed.
Extreme	**3**	One Finance and one Access risk were archived and reintroduced for the new financial year. A duplicate Estates risk was archived.
Total	**43**	

Risk Management Group (RMG) Update

The Risk Management Group continue to provide robust oversight of the Trust's risk profile, with a strong focus on risk quality, risk scoring consistency, action delivery and assurance. Across March and April 2026, RMG strengthened its role in challenging risks, validating controls and ensuring risks are appropriately escalated or de-escalated where evidence supports this.

Performance highlights

- The Risk Management Group has strengthened its focus on assurance, not just action completion, ensuring risk scores reflect current exposure and control effectiveness.
- A themed Deep Dive approach has been embedded:
    - March: Urgent and Emergency Care (UEC) – provided challenge and assurance on system-wide UEC risks, supporting evidence-based downgrading where controls were effective and continued escalation where constraints remained.
    - April: Estates and Facilities – introduced a more robust Deep Dive process, testing the maturity of controls, dependencies and objective assurance (audits, compliance, oversight) for long-standing, capital-constrained risks.
- This enhanced approach has improved confidence that high and long-standing risks are appropriately scored, clearly articulated, and supported by ongoing assurance when score reduction is not yet achievable.
- As a result, RMG has enabled safe downgrading, closure or archiving of risks where evidence supports this, while providing clearer assurance to the Board for risks that must remain escalated.

Risks escalated to Hospital Leadership Team (HLT)

Two risks have been identified for escalation to HLT. Risk 3502 in relation to deficit in intensivist cover at Bassetlaw and Risk 3599 in relation to the continued breakdown of the lift in the Rehabilitation Unit at Montagu. The Acting Chief Medical Officer will present these in Mays HLT meeting.

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 and 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	30/09/2026	✓	15	6	No	21 Months	RMG Deep Dive ✓	0	✓
BAF 1	3209	Chief Operating Officer	Inaccuracies in patient tracking across multiple pathways leads to potential harm to patients	15/05/2026	✓	8	6	No	9 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	30/06/2026	✓	12	9	No	1 Month	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.	01/06/2026	✓	10	6	No	33 Months	RMG Deep Dive ✓	0	✓
BAF 1	3454	Chief Medical Officer	Insufficient governance and service gaps risk failure to meet guidance, leading to harm, regulatory action, and reputational damage	29/05/2026	✓	16	8	No	24 Months	RMG Deep Dive ✓	4	✓
BAF 1	3678	Chief Operating Officer	Shortfall in PRPS Stock and Training Undermines CBRN Readiness, Risking Staff Safety and Regulatory Non-Compliance	01/05/2026	✓	5	1	No	2 Months	No	0	✓
BAF 1	3883	Chief Operating Officer	Incomplete Emergency Response Plans Risk EPRR Non-Compliance and Delayed Incident Response (Domain 3)	30/09/2026	✓	12	3	No	0 Month	No	0	✓
BAF 1	3884	Chief Operating Officer	Insufficient On-Call Training Risks Delayed Incident Command and Non-Compliance with EPRR Standards (Domain 4)	30/09/2026	✓	12	3	No	0 Month	No	0	✓
BAF 1	3885	Chief Operating Officer	Lack of EPRR Training and Exercising Risks Delayed Incident Response and Non-Compliance with Statutory Duties (Domain 5)	30/09/2026	✓	12	3	No	0 Month	No	0	✓
BAF 1	3887	Chief Operating Officer	Insufficient HAZMAT/CBRN Capability Risks Unsafe Incident Response and Non-Compliance with EPRR Standards (Domain 10)	30/09/2026	✓	12	3	No	0 Month	1 Month	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	31/08/2026	✓	9	6	No	7 Months	No	1	✘
BAF 2	19	Chief People Officer	Inability to engage with and involve colleagues, learners and representatives to improve experiences at work	30/10/2026	✓	9	6	No	2 Months	RMG Deep Dive ✓	0	✓
BAF 3	3890	Deputy Chief Operating Officer	Timely access to diagnostic services - Demand, Capacity & Flow	31/07/2026	NEW	12	12	RMG	0 Month	No Jun 26	1	✓
BAF 3	3891	Deputy Chief Operating Officer	Timely access to elective care - Demand, Capacity & Flow	31/07/2026	NEW	12	12	RMG	0 Month	No Jun 26	0	✓
BAF 3	3892	Head of Cancer Nursing	Timely access to cancer services - Demand, Capacity & Flow	31/07/2026	NEW	12	12	RMG	0 Month	No Jun 26	1	✓
BAF 3	3893	Deputy Chief Operating Officer	Timely access to emergency care - Demand, Capacity & Flow	31/07/2026	NEW	16	12	RMG	0 Month	No Jun 26	1	✓
BAF 4	12	Director of Infrastructure	Failure to maintain estates to standards may cause compliance breaches, service disruption, and reputational harm.	29/05/2026	✓	25	10	No	12 Months	RMG Deep Dive ✓	9	✓
BAF 4	1083	Operational Director of Estates and Facilities	Non-compliant, aging electrical systems may fail, increasing risk of incidents and reducing operational resilience.	01/05/2026	✓	15	10	No	92 Months	RMG Deep Dive ✓	1 RMG Deep Dive ✓	✓

BAF 4	1412	Deputy Director of Estates and Facilities	Failure to maintain estates to fire safety standards may lead to enforcement, service disruption, and reputational harm.	26/06/2026	✓	15	10	No	60 Months	RMG Deep Dive ✓	7 RMG Deep Dive ✓	✓
BAF 4	1807	Operational Director of Estates and Facilities	Aged lifts may fail beyond repair, reducing patient transfer capacity and impacting safety and care.	01/06/2026	✓	16	8	No	12 Months	RMG Deep Dive ✓	2	✓
BAF 4	3348	Chief Medical Officer	As a result of equipment being near EOL there is a risk of malfunction & will be unable to meet service objectives	01/10/2026	✓	12	8	No	17 Months	Yes Jun 26	1	✓
BAF 5	3895	Chief Finance Officer	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3896	Chief Finance Officer	Failure to redesign services leads to failure to improve implied productivity at the required rate	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3897	Chief Finance Officer	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3898	Chief Finance Officer	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3899	Chief Finance Officer	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3900	Chief Finance Officer	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non-pay costs within plan	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3901	Chief Finance Officer	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3902	Chief Finance Officer	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3903	Chief Finance Officer	Failure to achieve cash-releasing savings in line with plan leads to failure to generate sufficient cash flow	15/05/2026	NEW	16	6	RMG	0 Month	No	0	✓
BAF 5	3880	Chief Finance Officer	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust	01/07/2026	✓	9	9	No	1 Month	RMG Deep Dive ✓	0	✓
BAF 5	3826	Chief Finance Officer	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm	15/05/2026	✓	9	9	No	2 Month	RMG Deep Dive ✓	0	✓
BAF 6	3507	Director of Education and Research	Failure to meet MHRA research inspection standards	29/06/2026	✓	12	4	No	20 Months	RMG Deep Dive ✓	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	30/04/2026	✓	10	10	No	9 Months	RMG Deep Dive ✓	0	✓
BAF 7	1663	Chief Information Officer	Failure of the HSCN, Internet, or VOIP telephony external network connections	26/06/2026	✓	8	4	No	16 Months	No	0	✓
BAF 7	2727	Digital Infrastructure Manager	BDGH, MMH, and Pathology Server Rooms - Environmental Factors may cause Server Damage/H&S Concerns	30/06/2026	✓	9	3	No	23 Months	RMG Deep Dive ✓	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	30/04/2026	✓	9	6	No	48 Months	RMG Deep Dive ✓	0	✓
BAF 7	3184	Chief Information Officer	Non-maintenance of LAN may lead to degradation of equipment affect clinical systems/service delivery	30/06/2026	✓	8	4	No	16 Months	RMG Deep Dive ✓	0	✓
BAF 7	3384	Chief Information Officer	Unsupported or unreliable software/hardware may increase the risk of outage/unavailability of key Clinical/Corporate Systems.	17/09/2026	✓	12	4	No	1 Month	No	0	✓
BAF 7	2638	UEC – Divisional Nurse Manager	Prescribing medicines in ED for patients waiting for admission to hospital - failure to give or duplication of administration	12/05/2026	✓	15	3	No	27 Months	RMG Deep Dive ✓	0	✓

Appendix 2: Board Assurance Framework

BAF Risk Summary

Introduction:

The Board Assurance Framework (BAF) enables the Board to identify and understand the principal risks to achieving its strategic objectives. Our 'Healthier Together – Delivering Exceptional Care for All' Strategy is structured around four key priorities and these are mapped against each of the risks on the BAF.

Aligning Controls and assurances

The BAF Template format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and assurances are required and what actions we need to include.

Three lines of assurance model

The Trust uses the three lines of assurance model. The assurance provided on the BAF is split by each of the three lines so that we can be clear which part of the organisation is providing assurance and undertaking mitigating action. This also helps us to identify and rectify any gaps

Cause Risk and Consequences

The cause, risk and effect format allows us to see controls, assurances and actions by the cause and effect of each risk, so that we can be sighted on how we are reducing the likelihood and the consequence. Risk descriptors are written using the cause, risk, and effect model to help shape the way we present risk on the BAF.

Clarity over scoring stages and methodology

Scoring terminology is defined as;

- **Inherent Score**. This is the score of a risk based on there being no controls in place. This would apply if the BAF were to identify that current controls are not working effectively.
- **Current score.** This is the score considering the controls currently in place, assuming that they are working. This can also be termed as residual risk by some organisations, due to this, we are avoiding the use of this term.
- **Target score**. This is the score once any new mitigating controls have been put in place; this will need to be within our target appetite or will need to be tolerated and justified as such in the covering risk report.

The Trust uses the 5 x 5 multiplication scoring method of likelihood x consequences/impact

BAF 1

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		Target reduction date March 2028	Risk Type	Strategic	Links to Significant Risks on Risk Register
Executive Lead	Chief Nurse / Chief Medical Officer	Likelihood	4		4	Risk Appetite	Quality: Cautious (2) Regulatory: Cautious (2)	3209; 3454; 3290; 1517, 3769, 3883; 3884; 3885; 3887, 3246; 3678
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Last reviewed (by on behalf of Lead Directors)	April 2026	Risk Rating	**16**		**12**			
Last Changed (By Lead Committee)	December 2024	Inherent Score	5 x 4					

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 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**
Chief Nurse Oversight Framework – which includes ongoing monitoring of quality metrics, peer reviews, expert reviews, and the ward accreditation process.		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 (1) Maternity, Neonatal Quality and safety Group (1) IQPR (2) CQC Action plan completion assurance paper (2) Safeguarding Annual Report at board (2) Annual Director of Infection Prevention and Control Report at board (September 2025) (2) Section 11 Safeguarding return provided to Safeguarding Partnership board (3)	
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.		Biannual establishment review reporting for Nursing to People Committee (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 (2) Biannual Midwifery Workforce report to Trust Board of Directors (2)	
Clinical Audit Programme and monitoring.		Report to Quality Committee (2) Monday.com dashboards reports into Audit and effectiveness forum (1)	
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)	
Clinical policies, processes and clinical guidelines	**GC9** High numbers of Clinical policies are out of date	Infection Prevention Control Steering Group (1)	

		Risk Management Group (1) Risk Management Group assesses and moderates significant risks and presence of valid action plans monthly (2) CQC unannounced visit to DRI ED (3)	
Patient safety incident response plan		Never event and PSII tracker at internal meetings (1) Patient experience Annual reports to Trust Board (2) Never Event Exception report to QC (2) Divisional and Trust LFPSE panels (1) Trust Executive Patient Safety Oversight Group (2) Patient Safety report to QC (2) Internal Audit of Patient Safety Incident Response Framework 25/26 plan (3) (Significant Assurance)	**GA4:** Internal Audit report completed, will go to Audit and Risk Committee for review of any actions that would then be monitored at Quality Committee
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 (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 (3) Maternity and Neonatal report to QC	

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: Completion of any actions from the Internal Audit report of PSIRF (significant assurance)	August 2026	CN	Ongoing work to complete to the low risk recommendations, to be completed by the due date
GC4) SJR plan in place to address current gaps	April 2026	EMD	Partial Assurance gained at the February 2026 Quality Committee. During the last quarter the number of trained SJR individuals has increased from X to Y against a trajectory of attaining Z by *Date. The latest data suggests that . . . .
GC5) Recruitment to Learning From Deaths Manager	September 2026	EMD	The team has been reviewed and structured to increase the dedicated time and resource available for this function. Initial recruitment was not successful; however these roles have been readvertised which will delay implementation and the roles impact.
GC9) Implement and embed processes to ensure Trust wide clinical policies are reviewed in a timely fashion	July 2026	CoSec	Recruitment has commenced for a Risk and Policy coordinator role. Currently out to advert. Continued reduction in the number of out-of-date policies and oversight at the executive team. Extended date to align with recruitment and hiring process.

BAF 2

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**		**Target (March 28)**	**Risk Type**	Strategic People	Links to Significant Risks on Risk Register
Executive Lead	Chief People Officer	**Likelihood**	4		4	Risk Appetite	People: Seek	**16;19**
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by on behalf of Lead Director)	April 2026	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)	December 2025	**Inherent Score (L x I)**	5 x 4					

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**
Listening engaging and supporting colleagues Equality, Diversity and Inclusion Improvement Plan Education Quality Framework and Safe Learning Environment Charter People Engagement Strategic Approach Speaking Up Process and partnering activities 2025-26 Internal Audit report Equality Diversity and Inclusion (**Significant Assurance)**	**GC5:** National initiative 10-point plan for improving working lives of Resident Doctors'	EDI Forum (1) Operational Delivery Groups and Networks (1) Reports to People Committee (2) WRES and WDES data reporting to Board (3) Diversity and Inclusion 2025-26 Audit Plan (3) External Annual Quality Visits (3) Learner Feedback and Surveys (3) Annual National Staff Survey (3) Peer Review of DBTH Speaking up Process (3)	
Embedding the DBTH way for an open and inclusive culture The People Plan Delivery Plans HR Policies and support resources Health and Wellbeing activities and resources Leadership Development Offer and Organisational Development activities Exit Interview process and management	**GC1:** Additional actions identified to support return to work and reduce sickness absence. **GC4:** Further work required to articulate the DBTH leadership framework for different levels of leadership role.	Chief People Officer Senior Leadership meeting (1) Operational Delivery Groups (1) Reports to People Committee (2) IQPR to Board (2) Annual National Staff Survey (3) Learner Feedback and Surveys (3) Externally Commissioned Review of the DBTH Way in Action (3) Anti-racism Accreditation (3) Bronze award Internal Audit SET training 2025 – 26 Audit plan (3) (Commenced Q4 2025/26)	**GA2:** the Trust wide Culture and Leadership programme to include the recommendations and actions following external cultural review of DBTH Way in Action.

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions	**Timescale**	**Lead**	**Progress update**
GC1: The Workforce workstream reviewing identified actions for improvements in return to work and sickness absence, deep dive reporting to Executive team	March 26	Chief People Officer	The policy went to the Policy Formulation Group in November 2025, Feedback from this engagement is being incorporated into the next draft which will go back to this forum in January 2026. Continuing evidence of a sustained improvement in the DBTH sickness absence, in contrast to the trend of other neighbouring trusts.

			Further feed back received from colleague engagement and scheduled to further review and sign-off at the Policy Formulation Group in May 2026.
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	Work continues on the design and engagement of the programme modules, leadership conference now booked for 22nd April 2026
GC5: Implementation of the 10-point plan for the national initiative of 'improving working lives of resident doctors	July 2026	Acting Executive Medical Director	Update included on the April 2026 People Committee agenda.
GA2: Development of Trust Wide Culture and Leadership Programme	March 2027	Chief People Officer	Further work and engagement with colleagues across the Trust continue at pace during the months of March and April 2026. A more detailed update to be presented for discussion at the May 2026 Public Board of Directors. The 2025 Staff Survey results will be presented at the May 2026 Public Board of Directors to support the triangulation of this information.

BAF 3

Strategic Risk 3 (Cause – Event-impact)	***If demand for clinical services exceeds the capacity available 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 28)**	**Risk Type**	Strategic / Regulatory Quality	Links to Significant Risks on Trust Risk Register
Executive Lead	Chief Operating Officer	**Likelihood**	4		4	Risk Appetite	Quality: Cautious Regulatory: Cautious	3890; 3891; 3892; 3893
Initial Date of Risk Assessment	July 2023	**Impact**	4		3	Risk Treatment Strategy	Treat	
Risks Last reviewed (by / on behalf of Lead Director)	April 2026	**Risk Rating**	**16**		**12**	Risk Target	10	
Score Last Changed (By Lead Committee)	November 2024	**Inherent Score (L x I)**	5 x 4					

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**
Waiting time standards Access Policy Cancer Access policy Capacity and flow policy Trust validation Programme Patient Tracking List management Consistent across all Trust services Cancer Patient Tracking List management Clinical Prioritisation	**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 1 meeting (fortnightly) (3) Model Health reporting system (3) SYB Cancer performance meeting (3) Operational Delivery Group (monthly) now in progress (2) Internal Audit of Data Quality, Cancer metrics 25/26 Plan (3) (limited Assurance) External review of PTL arrangements by GIRFT Elective (3)	**GA2)** Inconsistently applied Divisional Governance arrangements **GA5)** Internal Audit: Outpatients appointments 25/26 plan (limited Assurance) **GA6)** Internal Audit of Data Quality, Cancer metrics 25/26 Plan (3) (limited Assurance)
Demand management Doncaster Place UEC improvement programme Patient initiated Follow-up (PIFU) policy Advice and Guidance policy Diagnostic improvement programme Virtual ward	**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)	
Efficiency GIRFT Programme Outpatient improvement programme Theatres improvement programme Urgent Emergency Care improvement programme		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) Deep Diver reports to F&P (2)	

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**
GC4) Clinical prioritisation action plan	March 2027	COO	Head of Elective Care has been appointed and will lead on this once they commence in post. Will be picked up with the new Head of Elective Care role to commence this work plan. Timescale dates moved accordingly.
GC5) Elective Care improvement programme	March 2027	COO	DBTH have met with GIRFT Elective and now have agreed governance arrangements established.- will go through the EPR governance route.
GC9) Urgent Treatment Centre First model to be implemented at all sites	October 2026	COO	Phase 1 had been implemented at DRI, now paused following the CQC feedback and is under review pending this. This remains suspended
GC10) Frailty and surgical SDEC implementation plan	July 2026	COO	Included in the UEC Improvement programme for 26/27 and will be taken forward as part of that and evidenced through the IDP reporting
GA2) Divisional Governance arrangements mapping exercise	April 2026	COO / Associate Director of Strategy, Partnerships and Governance.	Initial draft or Corporate Governance Manual shared with executive colleagues for further updates and improvements
GA5) Implementation of Internal Audit recommendations for Outpatients Appointments	March 2026	COO	Timescales remain on track for implementation of all recommendations Action on track for completion ahead of deadline Actions completed
GA6) Internal Audit of Data Quality, Cancer metrics (Limited assurance)	March 2026	COO	Action on track for completion, no outstanding actions as reported at the ARC in April 2026. Actions Completed

BAF 4

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, Pounds**	***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**	Quality / Financial / Regulatory	Links to Significant strategic Risks on Trust Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	4		4	Risk Appetite	Regulatory: Cautious (2) Quality: Cautious (2) Finance: Open (3) People: Seek (4)	**12; 1412; 1807; 3348; 1083; 1224, 1216, 1077, 1095, 1214, 1225, 2941, 1204**
Initial Date of Risk Assessment	July 2023	**Impact**	5		4	Risk Treatment Strategy	Manage	
Risk Last reviewed (by / on behalf of Lead Director)	April 2026	**Risk Rating**	**20**		**16**	Target score	10	
Score Last Changed (By Lead Committee)	July 2023	**Inherent Score (L x I)**	5 x 5					

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**
DRI Development Master Plan 2024 and long-term capital investment plan.		Review of incidents on Datix via Quality and Safety Group (1) East Ward Block Strategic Outline Case for £442m submitted to DoH and NHSE 25th November 2025 following approval at F&P and BoD (3) Department of Critical Care (DCC) relocation project due to complete Jan 2027, this project is an enabling project to the full East Ward Block refurbishment project (2) Bids submitted to NHSE on 13th January for funding via Return to Constitutional Standards (RtCS) which includes at large £25m project to Co-located UEC/UTC/SDEC at DRI (3) Bids have also been submitted against the Estates Safety Fund (ESF) in January for schemes to the value of £24m over 4 years, £6m each year, in addition to a two £25m main theatre bids to first expand by two theatres and then to refurbish the 8 existing theatres (3) Board Development Session BAF 4 & DRI Development Master Plan and accompanying bids to accelerate Backlog and Critical Infrastructure Risk eradication at DRI on 3rd February (3)	
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	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)	

	aims to improve preventative maintenance measures in line with industry guidance as a control against estates infrastructure risks.		
Doncaster Royal Infirmary Site Evacuation Plans	**GC2**: Work is currently in progress to establish effective site evacuation plans for DRI, supported by a System 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:** Complete the internal and system wide evacuation response plan
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)	
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) ROSPA accreditation (3) Gold Accreditation	
Robust Health and Safety Management System		Datix incident data (1) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Data (1) Monitoring from Trust Health and Safety Committee (2) Biannual Health and Safety Report to F&P committee (2) Annual Internal Health and Safety Audit (1) Royal Society for the Prevention of Accident (RoSPA) Gold accreditation (3) Premises Assurance Model (PAM) Safety Domain Assessment (1) Annual report to Board of Directors on PAM (2) Annual submission of PAM data to NHS England (3) Annual report to Board of Directors on Estates Return Information Collection (ERIC) (2) Annual ERIC Submission to NHS England (3)	

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

Actions	Timescale	Lead	Progress update
GC1a: Confirm the funding availability for estates maintenance based on the findings of the estates review and associated business case by the end of quarter 1 of FY2025/26	June 2025	CFO	Cost pressure not funded for 25/26 due to the financial position of the Trust. As a result, we will not yet be able to move to have preventative maintenance in line with industry guidance and estates infrastructure risks will remain higher than otherwise would have been the case.
GC2: Complete site evacuation plans for DRI	May 2026	COO	The Trust now has an active validated inpatient evacuation response framework, which has been tested through two multi-agency exercises held in September 2025. The lessons learned from these exercises are currently being reviewed and incorporated into both the Trust's framework and ICB and regional planning arrangements. Ongoing work on the inpatient evacuation plan will continue throughout 2026 to further strengthen these arrangements.
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. Funding approved by Trust Executive Team Q3. Work has now commenced to gather data to inform development plans. Outcomes from medium term planning currently underway will also inform the site development plans.

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. In addition to annual planning requirements detailed above, the Trust is also submitting a 5-year capital plan to the ICB in January 2026 to inform the new multi-year capital investment regime utilising Estates Safety Fund and Return to Constitutional Standards Funding.
GA2: Complete the internal and system wide evacuation response plan	March 2026	COO	The learning from the 2 exercises undertaken in 2025 will inform the next stage of planning.

BAF 5

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 28)**	**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; 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)	February 2026	**Risk Rating**	**16**		**12**			
Score Last Changed (By Lead Committee)		**Inherent Score (L x I)**	4 x 5					

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**
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)	
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)	
BAU Financial Operating policies, procedures HFMA checklist processes 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 Estates Contract Management 25/26 plan(3)	
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)	

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.	March 2026	CFO	Draft plan submitted to NHSE in December. Final plan due to be submitted in February with Board approval.
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	Finance team structure approved by Executive Team in December. Consultation dates with staff TBC

BAF 6

Strategic Risk 6	Due to insufficient resource and focus on key partners, we will not maximise the opportunities of collaboration, impacting our ability to transform and enhance services						**Strategic Objective: Partnerships**	**We work together to enhance our services with clear goals for our communities**
Lead Committee	Board of Directors – development session	Risk Rating	Current Exposure	Tolerable	Target March 26	Risk Type	Strategic	Links to Significant Risks on Risk Register
Executive Lead	Deputy Chief Executive Officer	Likelihood	2		2	Risk Appetite	Seek	3507
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Manage	
Risk Last reviewed (by on behalf of Lead Director)	March 2026	Risk Rating	**8**		**6**			
Score Last Changed (By Lead Committee)	March 2025	Inherent Score (L x I)	3 x 4					

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) **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**
Key Partner Focus and Resource CEO Is partner member of South Yorkshire Integrated Care Board. Chair and CEO attendance at key South Yorkshire and Nottinghamshire strategic forums. Full DBTH engagement in any emerging Collaborative Opportunities in the South Yorkshire and Bassetlaw areas Partnership governance arrangements for Acute Federation Wholly Owned Subsidiary Board	**GC7:** Uncertainty on the implementation dates for the 10-year plan legislation and the subsequent impact on DBTH governance and partnership arrangements **GC6:** Opportunities to maximise the use of the WOS for both quality and financial gains not fully explored	Board of Directors (2) Board to Board meetings (3) Partner Governor arrangements (2) Embedded partnership reporting at Trust Board and committees. Reports to the Board of Directors (2) Limited company Accounts submitted (3)	**GA1** Reporting arrangements through the individual organisations are not fully embedded.
Collaborative transformation of services South Yorkshire Acute Federation professional groups, leading on key services and pathways. Pathology Partnership Agreement and governance arrangements MEOC agreement and governance arrangements Changes due to the Nottinghamshire Government restructure may impact service delivery for Bassetlaw	**GC1:**Collaborative Opportunities and impact on DBTH being assessed for priorities to take forward **GC2:** Traction on some of the key identified workstreams has yet to be demonstrated **GC5:** Risk of overspending on the contractual arrangement and the efficiencies of scale described in the business case not being realised for all partners	Reporting through to each Board on activities from the CEO report (1) The DGH Collaboration Opportunities Report (3) DBTH involvement with Acute Federation Clinical Sustainability Review report. (2) Professional Partnerships Company Secretary Network reviews governance arrangements including ToR review.(2) Acute Federation Commissioned Audit of Partnership arrangements due in 2025 (3) Pathology Partnership Board (2) Internal Audit of Partnership governance arrangements - Pathology 25/26 Audit plan (3)	

Research Innovation Strategy delivery plans		Reports to People Committee (2) Updates to DBTH Board (2)	
Tacking Health Inequalities Ambition Trust and Place level HI Activities. Health Inequalities considered on each Board and Committee paper explicitly		Health Inequalities reported through to Board of Directors on progress(2)	

Actions to Address Gaps in Controls and Assurance (specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)			
Actions	**Timescale**	**Lead**	**Progress update**
GC1: Assessment of the Opportunities / risks for DBTH as part of this report's conclusions.	September 2026	CEO	DGH opportunities report received and shared at Board of Directors of all DGHs. Working through the options to increase collaboration for delivery of strategic aims. Interim Chairs in place at SYB DGH's including DBTH from 1st January 2026, confirming options remain to review shared leadership opportunities in 2026/2027
GC2: Engagement in Acute Federation workstreams to drive change and improvements.	March 26	DCEO	Clinical Sustainability Review workstreams established. Outcomes to be delivered by defined timescales in programme mandates. Waiting published report on Acute Federation workplans and future structure
GC5: Contract management arrangements of the partnership agreements	March 2026	DCEO	Identifying key areas of financial spend and reviewing in the partnership board.
GC6: Opportunities to maximise the use of the WOS with service transformations for both quality and financial gains to be quantified.	July 2026	CFO/DECO	For discussion in the new financial year and as part of wider partnership working discussions
GC7: Ensure mechanisms are in place so that funding decisions in respect to CoG are articulated on a benefit / risk basis	March 2026	DCEO/CFO	Work to further CoG engagement, including appointments and membership for post legislative changes
GA1: Mapping of the partnership governance arrangements. 360 Assurance reviewing partnership arrangements across the ICB, will feed into these recommendations	June 2026	DCEO	DBTH will review any recommendations from the wider audit review Mapping of meetings and reporting has been completed Awaiting outcome of the report for assessment of impact and any recommendations on DBTH Waiting on Internal Audit report

BAF 7

Strategic Risk 7 (Cause – Event-impact)	***If we fail to develop robust and resilient digital, data and technology systems and services that includes cyber resilience, we increase the risk of key system failure, disruption to services and negatively impacting patient care***						**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**	Strategic	Links to Significant Risks on Risk Register
Executive Lead	Chief Finance Officer	**Likelihood**	3		3	Risk Appetite	People: Seek (4) Quality: Cautious (2)	1410; 3384; 2727; 3184; 1663;2736 2638
Initial Date of Risk Assessment	January 2025	**Impact**	5		4	Risk Treatment Strategy	Treat	
Last reviewed (by / on behalf of Lead Director)	March 2026	**Risk Rating**	**15**		**12**	Risk target Score	12	
Last Changed (By Lead Committee)		**Inherent Score (L x I)**	5 x 5					

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)
Digital Enabling Plan (including Analytics) Digital Business Plan (versions to be updated)		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)	
Electronic Patient Record (EPR) Programme Board, overseeing EPR FBC and programme delivery. Intra-Trust Agreement in Place		DSPT Audit reports, external cyber security assessments such as penetration testing, ad testing of information sharing agreements. (3)	**GA1:** Potential gap in board assurance and strategic oversight of the digital programme delivery
Digital policies and procedures and Standard Operating Policies and Procedures for all digital activities Compliance to the DPST Toolkit 25/26		Data Security and Protection Toolkit assessment	
Data quality improvement plan.	**GC6:** Unsupported and out of data core systems or systems running unsupported versions of Microsoft Server	Digital Maturity Assessment (3)	
Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware) Cyber Assurance Framework actions implemented (IA Significant Assurance)		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)	
Digital EPRR and business continuity arrangements	**GC8)** Recommendations following on from the IT service management review report	Reported to Audit and Risk Committee (2) IT service Management review (3)	
Information Asset Management Framework		Reviewed by IG Group and SIRO (1)	

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**
GC6: Unsupported and out of date core systems or systems running unsupported versions of Microsoft Server (2016 and below)	March 2026	CIO	**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:**-The business case was approved in September. Work is underway to upgrade to Office 365. Progress continues at pace and the team are on tranche 8 of 10. This project is expected to be complete in early December 25.
GA1: Potential gap in board assurance and strategic oversight of the digital programme delivery	April 2026	CIO/EMD	To review board level engagement with the programme This has been discussed within the executive team and the Acting Executive Medical Director is currently mapping the operational governance arrangements in order to provide options for board oversight and assurance.
GC8: IT Service management Report Recommendations	October 2026	CIO	Implementation of the recommendations from the report. Currently drafting action plan and owners.

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.

2605 - H2 TRIANGULATION OF INFORMATION TO IDENTIFY AGENDA ITEM THEMES

Discussion Item | Mark Bailey, Interim Chair | 14:05

10 minutes

2605 - H3 BOARD EFFECTIVENESS AND DEMONSTRATING THE DBTH WAY

Discussion Item | Mark Bailey, Interim Chair | 14:15

- Was sufficient time allocated to enable focused discussion for items?
- Did papers contain the appropriate level of detail?
- Was open and productive debate achieved?
- What could we do less of ? more of going forward?
- Were discussions courteous and in line with the DBTH Way?

5 minutes

2605 - I CLOSING ITEMS

14:20

2605 - I1 MINUTES OF THE MEETING HELD ON 24 MARCH 2026

Decision Item | Mark Bailey, Interim Chair | 14:20

5 minutes

REFERENCES

Only PDFs are attached

I1 - Board of Directors Draft Minutes - 24 March 2026.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the Board of Directors held in public on
Tuesday 24 March 2026 at 9:30am
in the Boardroom at Bassetlaw Hospital

Present:	Mark Bailey - Interim Chair (Chair) Helen Best - Non-executive Director Jo Gander - Non-executive Director Karen Jessop - Chief Nurse Zara Jones - Acting Chief Executive Zoe Lintin - Chief People Officer Lucy Nickson - Non-executive Director Stephen Radford - Non-executive Director Kath Smart - Non-executive Director Denise Smith - Chief Operating Officer Sam Wilde - Chief Finance Officer
In attendance:	Rebecca Allen - Associate Director of Strategy, Partnerships & Governance Paula Hill - Freedom to Speak Up Guardian (agenda item D3) Joseph John - Medical Director for Operational Stability and Optimisation Mohammad Khan - Guardian of Safe Working (agenda item D4) Angela O'Mara - Deputy Company Secretary (minutes) Lois Mellor - Director of Midwifery (agenda item D1) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Gail - Member of the Public Alec Phillps - Member of the Public Tracey - Member of the Public
Apologies:	Dr Nick Mallaband - Acting Executive Medical Director Richard Parker OBE - Chief Executive

ACTION

P26/03/A1 **Welcome, apologies for absence and declarations of interest**

The Chair welcomed everyone to the Board of Directors meeting, the above apologies for absence were noted, and no conflicts of interest were declared.

P26/03/A2 **Actions from Previous Meetings (Enclosure A2)**

Action 2 – Action Plan - DBTH in Action - to be received at the Board meeting of 5 May 2026.

Action 3 – Sharps Injuries - a deep dive report would be received by the Quality Committee in August 2026

P26/03/B1 **Chair's Report including Partnership Update (Enclosure B1)**

The Board received and noted the Chair's report, which reflected on the Trust's strategic ambitions and the development of its medium-term plan, which translates ambitions into practical, structured and stretching plans to deliver measurable improvements.

Whilst it was recognised that there was a national reset required across the NHS, the Chair encouraged colleagues not to lose sight of the positive work underway to deliver services across the communities served.

The Board:

- ***Noted the Chair's Report***

P26/03/B2 **Chief Executive's Report (Enclosure B2)**

The Acting Chief Executive brought the Board's attention to the following highlights of the report.

As the end of the financial year approached, the Trust was in a strong position, and the Acting Chief Executive recognised and shared her appreciation of colleagues' contributions.

The positive impact of improvements to lung cancer services and diabetic eye screening was noted, improving co-ordination, earlier intervention, patient experience and engagement.

The Trust had recently welcomed the Lord Lieutenant of Nottinghamshire to Bassetlaw Hospital. The adult and paediatric emergency care and assessment facilities had been showcased, and colleagues had been able to share the positive impact on patient flow and experience.

Productivity improvements at the Trust had been recognised at a national level and in Quarter 3 the Trust's ranking in the NHS Oversight Framework (NOF) league table had increased from 60th to 45th out of 134 trusts. The Trust remained in segment three, due to the financial override associated with its deficit financial plan.

The Trust had been invited to take part in the NHS Spring Reset programme, it would be fully engaged in this work to accelerate delivery in key operational areas.

The Acting Chief Executive thanked executive colleagues for their support in the absence of the Chief Executive and wished Richard a speedy recovery.

Non-executive Director, Stephen Radford, recognised international pressures on the supply chain and enquired of any impact in respect of the availability of bone cement. The Chief Operating Officer confirmed there had been an impact on activity, however, the Trust had worked closely with NHSE, and an alternative product had been sourced, and the matter was now resolved.

Non-executive Director, Kath Smart, welcomed the improvements seen in productivity and highlighted the positive impact on patients and colleagues, alongside the financial benefit.

Non-executive Director, Helen Best, reflected on the Trust's improved position in the Quarter 3 NOF league tables and enquired of the drivers of change. The Chief Operating Officer confirmed marginal improvements had been realised over a range of performance measures.

The Chair thanked the Acting Chief Executive for her leadership.

The Board:

- ***Noted the Chief Executive's Report***

P26/03/B3 **Medium Term Planning Framework Final Submission (Enclosure B3)**

The Acting Chief Executive welcomed the introduction of multi-year planning. A draft medium-term plan had been iteratively developed to deliver a strong position, with clarity on the progress required to deliver its ambitions. Discussions continued with NHSE to finalise the plan.

There would be a need for the Board to satisfy itself of the plan's credibility, whilst recognising the need for delivery at pace and in a sustainable manner. A significant step change would be necessary to deliver service and workforce transformation. Partnership working and the receipt of deficit support funding would be key, as would. the delivery of workforce reductions.

Dedicated support would be required to oversee delivery of the plan, which would be subject to regional scrutiny and require a strong oversight and governance framework.

The Chief Finance Officer confirmed that a 2026/27 deficit financial plan of £15.7m (excluding deficit support funding) had been submitted, it was noted that some elements of the support package required national approval.

The final activity submission confirmed a compliant Referral to Treatment position of 92% by the end of three-year planning period.

In response to a question from Non-executive Director, Stephen Radford, regarding alignment of provider and commissioner intentions, the Chief Finance Officer confirmed one exception would be worked through in Quarter 1 2026/27 with South Yorkshire Integrated Care Board in respect of growth and the level of rebasing that may be required to the block contract.

Non-executive Director, Kath Smart, enquired how the impact of service change would be considered, recognising the Trust would not wish to compromise patient safety and the quality of care. The Chief Nurse confirmed a Quality Performance Impact Assessment (QPIA) would be undertaken where a change in service was proposed, should the assessment indicate the proposed change was high risk the matter would be considered by the Board of Directors.

Non-executive Director, Kath Smart, enquired of the role of the Board's assurance committees in overseeing delivery of the medium-term plan. The Acting Chief Executive confirmed committee workplans would be reviewed to establish alignment with the key programmes of work, to ensure the correct flow of information and discussion. Whilst it was recognised that reporting was reflective in nature, the Acting Chief Executive encouraged the need for a forward view, with improvement trajectories and the use of Statistical Process Control charts.

In response to a question from Non-executive Director, Lucy Nickson, regarding trust wide communication plans and the opportunity to understand colleagues' views. The Acting Chief Executive confirmed executive visibility and engagement opportunities had been strengthened. Mechanisms to support colleague input and avoid working in isolation were in place and following today's meeting the Chair and Acting Chief Executive would share the key outputs from the Board. The Chief Finance Officer encouraged clarity on the multi-year approach of the plan.

Non-executive Director, Jo Gander, noted the challenges presented by the Doncaster Royal Infirmary estate and enquired if there would be a future opportunity to be part of the New Hospital Programme (NHP). The Acting Chief Executive confirmed that this was not being pursued as a solution, referencing the extensive delays experienced by those organisations included in the programme. The Trust's business case for the development of the East Ward Block was progressing and would serve to mitigate risks and drive change.

The Chair recognised the need to ensure focused and clear communication, recognising the importance of sharing positive change in a tangible way.

The Board:

- ***Noted the final planning submission and the attached conditions related to financial support and monthly oversight. Delivery of workforce reductions were key to delivery***

P26/03/C1 **Integrated Quality & Performance Report including Finance Report (Enclosure B1)**

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for December 2025 and remaining access, quality, and workforce standards for January 2026. Where a local or national standard was not met an assurance report provided supporting commentary of the challenges, actions and emerging concerns.

The Chief Operating Officer confirmed that improvements had been seen in four hour waits during February and the Trust was currently on track to deliver the 78% standard by 31 March 2026, in line with national expectations.

The standard for patients waiting less than 18 weeks from referral to treatment had not been met, the assurance report confirmed the actions in place which included Q4 Sprint funding to increase outpatient capacity, marginal gains were expected.

In relation to cancer, the Trust had delivered the Faster Diagnosis Standard and 31-day decision to treatment standard. The 62- day wait from referral to treatment standard had not been met and focused work continued on cancer pathways.

The Medical Director for Operational Stability and Optimisation confirmed that the twelve-month rolling Summary Hospital-level Mortality Indicator (SHMI) stood at 113.6. against the threshold of 100, the latest reported monthly data in September 2025 stood at 117.4. The assurance report identified the reduction of avoidable mortality as a core priority, with significant improvement work in train, including clinical coding, sepsis management and through the completion and learning identified from Structured Judgement Reviews (SJRs). There were plans to integrate mortality management in the Medical Directors' Office, with recruitment of a Mortality Co-ordinator and senior data analyst planned.

The Chief Nurse confirmed that no significant variation was reported in respect of patient safety key performance indicators, with the exception of E. coli and MRSA, where thresholds were based upon historical performance. The assurance report documented the actions to address risks, issues and emerging concerns. The Director of Infection, Prevention and Control had direct oversight of this, and the strengthening of antimicrobial stewardship was a key quality priority for the Trust.

The Chief Finance Officer highlighted improvements to financial risks related to recruitment and bank mandate checks. A new model to assess the Trust's underlying deficit had been developed, the current estimated underlying deficit was £42.2m, which had improved in month due to CIP performance.

The latest published data (month six) showed implied productivity was 6.9% behind pre covid levels, this was an improvement from 13.8% in month five and placed the Trust in the second-best quartile nationally. Delivery of recurrent efficiencies was ahead of plan.

At month 10, a year-to-date deficit of £0.6m was reported, £1.4m behind plan due to Q4 deficit support funding not being secured by South Yorkshire Integrated Care Board. No cash support was expected to be required until September 2026.

The Chief People Officer confirmed that sickness absence stood at 5.5% as at January 2026, against a target of 5%, the Trust continued to perform relatively well when compared to other organisations in this area. Statutory and Essential Training compliance was 88.2% against a local target of 90%.

The Acting Chief Executive confirmed that SHMI had been the subject of discussion by the Executive Team and whilst the complexities were recognised, and the situation was not unique to the Trust there was a need to re-evaluate the position, including divisional discussions at the Performance Review Meetings. A plan of action and improvement trajectory would be required to move towards the threshold of 100. An established governance route for the reporting of SHMI was in place, however, this was a key metric for the Board, on which they were required to take assurance. **NM**

Non-executive Directors, Jo Gander and Kath Smart, reflected on previous work to strengthen clinical coding, as SHMI continued to increase and an impact was not being seen they supported the reassessment, recognising that a return to the threshold of 100 may not be realistic during 2026/27.

Non-executive Director, Kath Smart, noted a lack of improvement in the number of patients receiving antibiotics within one hour of a positive sepsis screening, despite ongoing sepsis education. In addition to the actions in the assurance report the Chief Nurse confirmed divisions were developing action plans to address Sepsis 6 as part of a quality improvement project.

In response to a question from Non-executive Director, Lucy Nickson, regarding any changes to the IQPR arising from the medium-term plan, the Acting Chief Executive confirmed that the report remained under review and was currently aligned with the contract requirements of commissioners. The volume of detail within the report was acknowledged, with the need for clarity on how the report was utilised to add value.

The Board:

- ***Noted the IQPR***

P26/03/D1 **<u>Maternity & Neonatal Safety Report (Enclosure D1)</u>**

The Director of Midwifery drew the Board's attention to the findings and associated learning from the Q3 Perinatal Mortality Report and the accompanying quality metrics.

In response to a question from Non-executive Director, Stephen Radford, the Director of Midwifery confirmed that the Trust had declared full compliance against the Year 7 Clinical Negligence Scheme for Trusts' standards. Validation of the submission was awaited.

In response to the deterioration in the neonatal death rate per 1000 births, the Director of Midwifery advised Non-executive Director, Stephen Radford that the rate had been impacted due to early gestational deaths, no trends had been identified.

Non-executive Director, Helen Best, acknowledged the full compliance CNST declaration and commended the Director of Midwifery and her colleagues for their work.

Year 8 CNST standards were expected to focus on six core areas, the detail of which was expected by 31 March 2026. Once received, reporting arrangements via the Quality Committee and Board would be confirmed.

Whilst the delivery of Year 7 CNST standards was recognised and feedback on local maternity services was positively reported, the impact of national maternity safety reviews and media coverage continued to be felt by midwifery and medial colleagues, as recognised by the Royal College of Midwifery.

The Board:

- ***Noted and took assurance from the Maternity and Neonatal Safety Report***
- ***Reviewed and approved the Q3 Perinatal Mortality Report***
- ***Reviewed the Trust's Quality Metrics***

P26/03/D2 **Learning from Deaths Report (Enclosure D2)**

The Medical Director for Operational Stability and Optimisation shared with the Board the key highlights from the Quarter 2 2025/26 Learning from Deaths report.

The number of in-hospital deaths were consistent with that seen in the previous quarter, however, the number of Structured Judgement Reviews (SJRs) had fallen, due to limited capacity. All hospital deaths had been subject to review by the Medical Examiner's Office.

The Summary Hospital-level Mortality Indicator remained higher than hoped, changes made to the coding of Emergency Department admissions and transfers of care from April 2026 were expected to impact SHMI and align the Trust's performance with that of its peers.

The report confirmed the learning from SJRs, which included the timely completion of mental capacity assessments and the application of Deprivation of Liberty Safeguards. Improvements were required in respect of blood culture sampling, sepsis management and the timely administration of antibiotics.

At the request of the Chief Nurse, the Board paused to acknowledge the significance of this report to family members observing the meeting.

During Q3, 46 SJRs had been completed, showing an improvement in overall numbers to this report, it should be noted there was no national guidance on the numbers required and where a death had been referred to HM Coroner completion of a SJR would not take place, due to the coronial process.

In response to a question from Non-executive Director, Jo Gander, regarding links to the Patient Safety Incident Response Framework, the Chief Nurse confirmed governance around the tracking of actions and thematic analysis from the Prevention of Future Deaths Reports had been strengthened. The Trust Executive Patient Safety Oversight Group monitored the closure of actions through validation of evidence. An increase in the number of Prevention of Future Deaths Reports was a national trend, and not unique to the Trust.

Despite ongoing work to address learning, it was acknowledged there was a need for more rapid improvement. The refresh of the Trust's Patient Safety Incident Response Plan would take into account incident themes.

In regards to the implementation of Martha's Rule, the Chief Nurse confirmed this was being rolled out in accordance with the national programme. The introduction of the Patient Wellness Questionnaire had alerted colleagues to a deterioration in patient wellbeing prior to this being seen in the National Early Warning Score following observations. Escalation processes in Martha's Rule would require further consideration due to the absence of a 24-hour critical care outreach team at the Trust.

The Chief Nurse recognised an increase in demand for the completion of mental capacity assessments and the Deprivation of Liberty Safeguards. Work to educate colleagues was ongoing, with the senior doctor in charge assessing this on admission to the ward, as part of determining a care plan.

In response to a reflection from Non-executive Director, Helen Best regarding statutory and mandatory training for adult safeguarding and learning disabilities. The Chief Nuse confirmed that training compliance was overseen by leaders across the organisation and reported through the governance structure, including at the Board's People Committee. Following the Care Quality Commission's inspection in 2023 two mental capacity assessment co-ordinators supported the process and safeguarding colleagues were proactive in their support of, and presence in, clinical areas.

Non-executive Director, Stephen Radford, enquired if capacity was assessed at the point of access, the Chief Nurse confirmed this may not be completed in the Emergency Department but should be assessed within 12-24 hours of admission on to a ward, as there would be an impact upon the individual's treatment plan. Capacity was decision specific and assumed and would be captured in a uniform way in accordance with the Accessible Information Standards to ensure the needs of the patient were understood. The Trust captured patient needs as part of "This is Me" documentation.

Non-executive Director, Lucy Nickson, enquired how she could be assured that learning from deaths was being implemented and the impact evidenced. In the Executive Medical Directors absence, the Chief Nurse noted ongoing improvement work, including plans within the Medical Directors report to recruit. The report had been considered at the Quality Committee and partial assurance taken, it was proposed to consider how the report could be developed to address gaps in assurance.

Non-executive Director, Kath Smart, confirmed that compliance with the Mental Capacity Act had been the subject of an internal audit approximately 18 months ago, which provided limited assurance and enquired if there was a need to reframe and refresh the risk assessment. It was proposed that this be considered by the Quality Committee on behalf of the Board. **KJ**

The increase in the number of completed SJRs in Q3 was noted by Non-executive Director, Kath Smart, in view of the reference in the paper that the majority were completed by staff with no protected time to do so, she enquired if the gain was fortuitous. The Chief Nurse confirmed that medical colleagues supporting the completion of SJRs now have Programmed Activities within their job plan, whilst nursing colleagues complete them within their existing job role.

Non-executive Director, Kath Smart, reflected on a recent visit to the Medical Examiners and Bereavement Team which highlighted the connections made between families and the Medical Examiner.

Reflecting on the Trust's performance in respect of administering antibiotics within one hour of a positive sepsis screening and the sepsis related learning from SJRs, it was proposed that a deep dive on sepsis management be undertaken and considered on behalf of the Board by the Quality Committee. **NM**

The Board:

- ***Noted the Learning from Deaths Report.***

P26/03/D3 **Focused Freedom to Speak Up Report (Enclosure D3)**

The Chair welcomed the Freedom to Speak Up (FTSU) Guardian to the meeting to provide an overview of the paper which reported the progress of deferred actions from the Speaking Up Reflection & Planning Tool 2024-2026. A more detailed version had been considered by the People Committee in February 2026, when significant assurance had been taken.

Non-executive Director, Stephen Radford, enquired how the findings of the peer review, triangulated with those from the staff survey and colleagues views of Speaking Up. The FTSU Guardian confirmed that the staff survey indicated colleagues felt safer in raising concerns related to patient safety. Colleagues across the organisation reported differing experiences of Speaking Up and the Chief People Officer acknowledged the need to understand this variation by area and professional groups.

Non-executive Director, Lucy Nickson recognised the volume of information provided and reflected on the need for this to be distilled and triangulated to understand the impact. In terms of the key programmes of work in the year ahead, the FTSU Guardian recognised the need to address inconsistencies in experience across the organisation, progress the learning from the peer review, development of detriment guidance and completion of a deep dive to understand the prevalence of bullying and harassment.

The use of a peer review was welcomed by the Chief Finance Officer.

The Chief Nurse noted a shift over time in the reasons for Speaking Up from the initial focus on patient safety and enquired if there was value in revisiting this. The link to wider cultural improvements, the requirements of the Care Quality Commission and the independence of the FTSU Guardian were referenced by the Guardian and Chief People Officer.

It was proposed that a discussion paper would be prepared for consideration by the People Committee to determine the focus and requirements of future Speaking Up reports to be received by the Board and People Committee. **ZL**

The Board:

- ***Noted the Focused Freedom to Speak Up Report***

P26/03/D4 **Guardian of Safe Working Report (Enclosure D4)**

The Chair of the Board welcomed the Guardian of Safe Working to the meeting to present exception reporting for the period 1 February 2025 31 January 2026.

A total of 533 exception reports had been made during this period, as compared to 335 in the same period of 2024/25. The majority of exception reports (86%) had been made by resident doctors working in General Medicine, Obstetrics & Gynaecology, General Surgery and Paediatrics in relation to additional hours worked, reflecting the high

workload which was often compounded by rota gaps. 6% of reports related to missed educational opportunities.

Changes to NHS Employers exception reporting framework had been fully implemented by the Trust and an increase in the number of reports was anticipated. A standardised report template was awaited.

Exception reports continued to be seen in urology due to a breach of the minimum rest period for the non-resident on call. Work was ongoing to identify actions to reduce the incidence of fines.

In response to a question from Non-executive Director, Stephen Radford, regarding the underlying reason for the increase in exception reports, the Guardian of Safe Working confirmed this was due to rota gaps, and mitigating actions were being worked through. Benchmarking of performance wasn't always possible, as like for like scenarios were not necessarily being compared, although discussions at national meetings provided high level insight.

The Medical Director for Operational Stability and Optimisation confirmed that soft intelligence suggested an increase in the number of exception reports was potentially linked to the industrial action negotiating position.

Non-executive Director, Kath Smart, enquired if there was any benefit in considering areas where persistent placement vacancies were seen, recognising these were determined by the Deanery and outside of the Trust's control. The Chief People Officer agreed to discuss this with the Acting Executive Medical Director. **ZL**

The Board:

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

P26/03/E1 **Paediatric Senior House Officer Business Case (Enclosure E1)**

The Board received the Paediatric Senior House Officer business case developed to increase staffing levels that would support the paediatric night on call rota in line with the British Association of Perinatal Medicine (BAPM) standards and Year 7 Clinical Negligence Scheme for Trust (CNST) requirements.

The case had been considered by the Corporate Investment Group prior to receipt by the Board's Finance and Performance Committee, which recommended the case to the Board for approval.

The Board:

- ***Approved the Paediatric Senior House Officer Business Case***

P26/03/F1 **Board Assurance Framework including Trust Risk Register (Enclosure F1)**

The Board Assurance Framework (BAF) was received following consideration by executive led discussions at each of the Board's assurance committees. As a live document the BAF continued to be iteratively developed, with work to be undertaken to ensure a read across to the medium-term plan.

In response to a question from Non-executive Director, Jo Gander, relating to risk ID 3246 (the risk of regulatory action relating to the poor application of the Mental Capacity Act and Deprivations of Liberty Safeguards), the Chief Nurse confirmed that the risk was reviewed at a divisional level and overseen by the Risk Management Group. Controls were in place and the operational detail would not form part of the BAF.

In respect of strategic risk 5, the Chief Finance Officer provided a verbal update from last week's Finance & Performance Committee, which proposed the current risk rating be reduced to 12 to reflect the on-target delivery of this year's financial plan. This would be included in the next iteration of the BAF.

The Board:

- ***Noted the Board Assurance Framework and Trust Risk Register and approved its current content, which enabled the Board to fulfil its duty to monitor its strategic risks.***

P26/03/F2 **Chair's Assurance Log – Finance & Performance Committee (Enclosure F2)**

The Board received the Finance & Performance Committee Chair's assurance log from February and March 2026's meetings, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

The Board:

- ***Noted the Chair's Assurance Logs***

P26/03/F3 **Chair's Assurance Log – Quality Committee (Enclosure F3)**

The Board received the Quality Committee Chair's assurance log from February 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

The Board:

- ***Noted the Chair's Assurance Log***

P26/03/F4 **Chair's Assurance Log – People Committee (Enclosure F4)**

The Board received the People Committee Chair's assurance log from February 2026's meeting summarised the assurance taken and decision made.

In response to a question from Non-executive Director, Lucy Nickson, the Medical Director for Operational Stability & Optimisation confirmed the year end position on job planning was expected to be between 90-95% due to levels of completion in general surgery.

The Board:

- ***Noted the Chair's Assurance Log***

P26/03/F5 **Chair's Assurance Log – Audit & Risk Committee (Enclosure F5)**

The Board received the Audit & Risk Committee Chair's assurance log from March 2026's meeting, which summarised the assurance taken, areas of ongoing work, and matters of concern.

As part of a review of year end processes the committee had considered the going concern assumption and received the cyber security internal report which provided significant assurance and recognised the expertise in the team and work to remain connected with ongoing threats.

The Board:

- ***Noted the Chair's Assurance Log***

P26/03/F6 **Board of Directors Work Plan (Enclosure F6)**

The Board:

- ***Noted the Board of Directors Work Plan***

P26/03/G1 **Minutes of the meeting held on 27 January 2026 (Enclosure G1)**

The Board:

- ***Approved the minutes of the meeting held on 27 January 2026, subject to minor amends to C1 and D1 and to capture the presence of Non-executive Director, Helen Best***

P26/03/G2 **Pre-submitted Governor or public Questions regarding the business of the meeting (verbal)**

The following questions were received from the Council of Governors, responses were provided during the meeting and added to the database of governor questions and answers.

What consultation process was undertaken regarding the change of title to Chief Medical Officer from Executive Medical Director does it imply that there will be a restructuring of the medical directors office.

The decision to change the title of the Executive Medical Director to Chief Medical Officer was undertaken by the Trust's Board of Directors' Nomination & Remuneration Committee. This is in line with other executive director job titles and medical director roles elsewhere. No wider consultation is required to make changes to Executive Director roles. There has been no restructuring of the Medical Director's team. Once the new post holder is recruited it will be their responsibility to review the structure and make any changes should they wish, in line with Trust HR processes and procedures.

There is ongoing dependence on agency locums in the orthopaedic department contributing to high locum costs why have efforts not been completed to get these posts filled with regular staff. One of the agency locums has been here for over 4 years.

There are two parts to this: the wider context and the specific position in Trauma & Orthopaedics (T&O).

Wider workforce context - there is a national shortage of appropriately skilled and experienced surgical staff, particularly in some specialties, which has persisted for a number of years. As a result, many organisations, including ours, have had to rely on temporary workforce solutions to maintain safe service delivery.

We have actively reviewed long-standing locum arrangements and, where individuals have been in post for extended periods, we have approached them about moving to substantive contracts. In a number of cases, including those referenced, individuals have chosen not to convert to substantive roles for personal reasons.

Alongside this, over recent years we have taken a range of actions to improve recruitment and retention to key medical posts, and more recently have undertaken detailed work on medical rotas and job planning to ensure roles are structured in a way that is sustainable and attractive.

Specific factors in T&O - the level of locum usage in T&O has increased since the pandemic, driven by a combination of workforce capacity gaps within the rota. These include reduced availability of some senior staff to undertake on-call duties, alongside training-related gaps and less than full-time working within the trainee workforce. Taken together, this has created sustained rota gaps that have required locum cover to maintain safe service provision.

Actions to reduce reliance on locums - we are now moving from managing gaps to addressing the underlying structure:

- Proposed recruitment of two post-CCT fellows (doctors who have completed their specialist training and are qualified to work at consultant level), funded through reductions in locum expenditure
- Changes to the Bassetlaw SAS on-call rota to create a more sustainable model

These changes are planned for implementation in 2026/27. A business case for the fellow posts is in development and is expected to go to the vacancy control panel by late April.

The reliance on long-term locums reflects a combination of national workforce constraints and structural rota gaps, rather than a lack of action. We now have a clear plan to reduce this reliance through rota redesign and targeted recruitment, with actions progressing this year.

The following questions were received from members of the public, responses were provided in the meeting and the following written responses provided post meeting

The Learning from Deaths report highlights repeated failures in fundamental safety, and care, highlighting practices including incomplete fluid balance monitoring, missed recognition of deterioration, and unclear escalation decisions, as identified in Structured Judgement Reviews and Prevention of Future Deaths reports.

What specific actions is the Board taking to address these critical safety concerns and how will the Board monitor impact and whether the quality of basic care and culture is genuinely improving at ward level? What further steps will you take if the data shows these behaviours are not changing?

The Board recognises the seriousness of the repeated themes highlighted through the Learning from Deaths (LfD) process, particularly around fluid balance monitoring, recognition of deterioration, and escalation decision-making. These are core safety fundamentals and addressing them remains a priority focus for the organisation.

1. What specific actions is the Board taking to address these safety concerns

Strengthening review, learning and governance

- Q3 report - 93% of cases reviewed were graded as adequate, good or excellent care, with 6.5% identified as poor care.
  All instances of poor care are escalated to the specialty governance lead and senior divisional team for review, discussion with clinical teams, and targeted learning.
- The monthly Trust wide Mortality Governance group reviews in detail the findings of Structured Judgement Reviews (SJRs) and shares cross divisional learning and any themes identified from the medical examiner's office.
- The Learning from Deaths report is reviewed at each divisional governance meeting, with themes and actions allocated to divisions to ensure accountability for improvement.
- SJRs have been completed for a number of sepsis-related deaths as part of the Recognition of Deterioration Action Plan, ensuring specific learning is identified and acted upon.

Focused improvement on deterioration, sepsis and Acute Kidney Injury (AKI)

- Under Patient Safety Incident Response Framework (PSIRF) recognition of deterioration was agreed as a key local priority, the current PSIRF plan is being evaluated with thematic analysis underway to consolidate learning and inform future improvement plans.
- The Sepsis Action Group is overseeing divisional improvement plans and has already demonstrated progress, including better blood culture sampling in the Emergency Department.
- The AKI Steering Group provides targeted training and supports improved fluid balance monitoring.
  The AKI bundle went live on Nervecentre on 15 February, giving clinicians digital prompts and tools to support fluid intake/output monitoring and timely biochemistry checks.

Ward-level assurance and quality monitoring

- The Trust uses Tendable, a digital audit tool, to monitor compliance with fundamental standards at ward level. This includes the review of fluid balance chart completion.
  From April, the audit schedule has been strengthened with a specific focus on fluid balance chart completion.
- Sepsis and AKI performance indicators are monitored through the Patient Safety Assurance Group, enabling Board-to-Ward oversight.

2. How will the Board monitor whether fundamental care and culture are genuinely improving?

The Board will receive assurance through:

- Regular triangulation of data including LfD findings, PSIRF insights, Tendable audits, quality metrics, and patient safety incident themes.
- Divisional governance reporting, holding divisions to account for addressing deterioration, sepsis and AKI improvement actions.
- Safety walkarounds and clinical engagement, enabling the Board and executive leaders to assess cultural and behavioural change directly at ward level.
- Monitoring of Tendable audit outcomes, focusing on fluid balance, escalation documentation, and basic care reliability.
- Evidence of sustained improvement trends within sepsis, AKI, and deterioration indicators discussed at the Patient Safety Assurance Group.

3. What further steps will be taken if the data shows these behaviours are not changing?

If monitoring shows that fundamental behaviours are not improving, the Board will consider:

- Targeted executive-led improvement interventions for specific wards or specialties.
- Enhanced clinical supervision and support, including buddying with high-performing areas.
- Escalation through performance and quality management processes, including:
  - strengthened divisional accountability plans
  - mandated action plans with clear timeframes
  - enhanced oversight via the Patient Safety Assurance Group.
- Focused training or competency assessment, particularly for escalation, fluid balance and recognition of deterioration.
- Re-prioritisation of quality improvement resources to support areas where behaviour change is not embedded.

I am submitting a question today on behalf of a concerned group of healthcare workers and patients regarding the intended adoption of the Federated Data Platform (FDP). The issues specifically relate to the involvement of the private company Palantir Technologies Inc. in operating the FDP. Doncaster and Bassetlaw Teaching Hospitals have outlined their intentions to support the adoption of the FDP in their Annual Operational Planning guidance. Whilst we appreciate that the expectation from NHS England is that trusts adopt the FDP, there are sufficient concerns for DBTH to pause it's implementation in order to address these concerns. Considering the grave concerns regarding the partnering of DBTH with technologies associated with Palantir, we have the following questions:

1. Was the trust aware of the ethical issues surrounding the complicity of Palantir in genocide?

2. Was the trust aware of the harms associated with the FDPs potential for future inter-agency data sharing and the public's perceived security of NHS data?

3. Is the trust willing to revisit the decision to use the FDP?

4. Would members of the board be willing to meet with us to discuss these concerns further?

The Trust continues to be clear that the Federated Data Platform is a national programme, led and procured by NHS England, including the involvement of Palantir and is not a local Trust procurement decision. Patient data remains under NHS control with strict role-based access, relevant legal safeguards and full auditability and our responsibility locally is to ensure it is used safely to support improvements in patient care.

The Chief Finance Officer agreed to meet, as executive lead for digital transformation.

P26/03/G3 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were raised.

P26/03/G4 **Date and time of next meeting (verbal):**

Date: 5 May 2026
Time: 9:30am
Venue: Boardroom, Doncaster Royal Infirmary

P26/03/G5 **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.***

P26/03/H **Close of meeting (Verbal)**

The meeting closed at 12:35

2605 - H2 PRE-SUBMITTED QUESTIONS

Discussion Item | Mark Bailey, Interim Chair | 14:25

10 minutes

2605 - H3 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING

Discussion Item | Mark Bailey, Interim Chair | 14:35

10 minutes

2605 - I4 BOARD OF DIRECTORS WORK PLAN

Information Item

Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

REFERENCES

Only PDFs are attached

I4 - Board Work Plan (4Ps).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								
				27/01/2026	24/03/2026	05/05/2026	07/07/2026	01/09/2026	03/11/2026	05/01/2027	02/03/2027
OPENING ITEMS											
Welcome, apologies for absence and declarations of interest	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Actions from Previous Meetings	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Chair's Report (including partnership updates and impact on DBTH)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Chief Executive's Report (including partnership updates and impact on DBTH)	Chief Executive	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
BOARD LEARNING & REFLECTION											
Various (topics to be agreed by Executive Team)	Executive Lead & Presenter	As Req'd	As Req'd	x							
PATIENTS											
Maternity & Neonatal Update	Director of Midwifery	Every meeting	Mar-26	x	x	x	x	x	x	x	x
Clinical Negligence Scheme for Trusts Board Declaration	Director of Midwifery	Annual	Jan-27	x							
Learning from Deaths	Executive Medical Director	Quarterly	Jul-26		x		x	x		x	
Patient Experience Annual Report	Chief Nurse	Annual	Sep-26					x			
Winter Plan	Chief Operating Officer	Annual	Sep-26					x			
Quality Accounts	Chief Nurse	Annual	Jul-26				x				
Safeguarding Annual Report	Chief Nurse	Annual	Sep-26					x			
Infection Prevention & Control Annual Report	Chief Nurse	Annual	Sep-26					x			
Antimicrobial Resistance (PRN02235)	Chief Nurse	Annual	Mar-26		TBC						
PEOPLE											
Guardian of Safe Working Report	Chief People Officer/Executive	Quarterly	Jul-26		x		x		x	x	x
Workforce Race Equality Standards	Chief People Officer	Annual	Jul-26				x				
Workforce Disability Equality Standards	Chief People Officer	Annual	Jul-26				x				
Freedom to Speak Up Bi-annual Report	Chief People Officer	6 monthly	Jul-26		x		x			x	
Staff Survey Results	Chief People Officer	Annual	May-26			x					
Maternity Workforce	Director of Midwifery	Bi-annual	#NAME?	x							
Research & Innovation Case Study	Chief People Officer	Annual	Jul-26				x				
DBTH Way in Action & Well-led Review Progress Update	Acting Chief Executive	Quarterly	May-26			x		x		x	x
PARTNERSHIP											
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	May-26			x	x		x		x
Wider Partnership updates	DCEO	As required	As Req'd								
POUNDS											
Financial Plan	Chief Financial Officer	Annual	TBC		x						
Going Concern	Chief Financial Officer	Annual	May-26			x					
Delegation for the Approval of Annual Accounts and Annual report	Chief Financial Officer	Annual	May-26			x					
Annual Report & Accounts including Annual Governance Statement	Chief Financial Officer	Annual	Jul-26				x				
Annual Business Plan	Chief Financial Officer	Annual	Jan-26		x						
Estates Return Information Collection	Chief Financial Officer	Annual	Jul-26				x				
ASSURANCE & GOVERNANCE											
Integrated Quality & Performance Report (**to include financial position wef January 2026**)	COO/CN/EMD/CPO	Every Meeting	May-26	x	x	x	x	x	x	x	x
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	May-26	x	x	x	x	x	x	x	x
Board Risk Appetite	Deputy Chief Executive	Annual	Jul-26				x				
Review of Strategic Risks	Deputy Chief Executive	Annual	Jul-26				x				
~~2026/2027 Strategic Priorities Success Measures~~ Delivery against Medium Term Plan	Deputy Chief Executive	Annual	May-26			x	x	x	x	x	x
Delivery Update 2025/26 Strategic Priorities Success Measures	Deputy Chief Executive	6 monthly	May-26			x		x			x
The NHS Premises Assurance	Chief Financial Officer	Annual	Sep-26					x			
Emergency Preparedness, Resilience & Response - Compliance against the National Core Standards	Chief Operating Officer	Annual	Nov-26						x		
Chair's Assurance Log - Finance & Performance Committee	F&P Chair	Post Committee	May-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	May-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	May-26	x	x	x	x	x	x	x	x
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	May-26		x	x	x	x			x
Annual Report - Audit & Risk Committee	Chair of ARC	Annual	Jul-26								
Board Work Plan (approval)	AD of Strategy, Partnerships & C	Annual	Jan-27	x							x
Fit & Proper Persons Declarations	AD of Strategy, Partnerships &	Annually	Nov-26	x					x		
Trust Seal	AD of Strategy, Partnerships &	Annually	Nov-26						x		
Provider Licence - self certification of condition CoS7	AD of Strategy, Partnerships & C	Annual	May-26			x					
Board Effectiveness	AD of Strategy, Partnerships & C	Annual	2027								
Terms of Reference - Finance & Performance Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - Quality & Effective Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - People Committee	AD of Strategy, Partnerships & C	Annual	May-26			x					
Terms of Reference - Audit & Risk Committee	AD of Strategy, Partnerships & C	Annual	May-26				x				
Innovation & Transformation Programme (Green Plan, health inequalities, major schemes/projects)	Deputy Chief Executive	As Req'd	As Req'd			x (HI)			x (HI)		
Mortuary Annual Report	Executive Medical Director	Annual	Nov-26						x		
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								
Digital Enabling Plan	Chief Finance Office		2029								
TRUST POLICIES											
CORP/FIN 1 - B Standing Financial Instructions	AD of Governance	Annual	Sep-26					x			
CORP/FIN 1 - C Reservation of Powers to the Board and Delegation of Powers	AD of Governance	Annual	Sep-26					x			
CORP/FIN 1 - E Constitution	AD of Strategy, Partnerships & C	3 yearly	Mar-28								
INFORMATION											
Work Plan	AD of Strategy, Partnerships & C	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Appointment of External Auditors	Chief Financial Officer	As Req'd	As Req'd								
Appointment of Internal Auditors	Chief Financial Officer	As Req'd	As Req'd								
CLOSING ITEM											
Minutes of the Previous Meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Governor Questions (regarding the business of the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Any other Business (to be agreed with the Chair prior to the meeting)	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Date and time of the next meeting	Chair of the Board	Every Meeting	Every Meeting	x	x	x	x	x	x	x	x
Withdrawal of Press and Public	Chair of the Board	As Req'd	As Req'd	x	x	x	x	x	x	x	x

2605 - I4 DATE AND TIME OF THE NEXT MEETING

Information Item | Mark Bailey, Interim Chair | 14:45

Date: Tuesday 7 July 2026
Time: 09:30am
Venue: Boardroom, Doncaster Royal Infirmary

2605- I5 WITHDRAWAL OF PRESS AND PUBLIC

Information Item | Mark Bailey, Interim Chair | 14:45

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.