



BOARD MEETING - PUBLIC



BOARD MEETING - PUBLIC



7 July 2026



09:30 GMT+1 Europe/London



Boardroom, Bassetlaw Hospital Kilton Hill, Worksop S81 0BD



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Only PDFs are attached

 00 - Board of Directors Public Agenda - 7 July 2026 v6.pdf

**Board of Directors Meeting Held in Public
To be held on Tuesday 7 July 2026 at 9:30am
Boardroom at Bassetlaw Hospital**

		Purpose	Page	Time
A	OPENING ITEMS			9:30
A1	Welcome, apologies for absence and declarations of interest <i>Mark Bailey, Interim Chair</i> <i>Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known</i>			5
A2	Actions from previous meeting <i>Mark Bailey, Interim Chair</i>	Review		
B	STRATEGY			9:35
B1	Chair's Report including Partnership Update <i>Mark Bailey, Interim Chair</i>	Information		10
B2	Chief Executive's Report including Partnership Update <i>Zara Jones, Acting Chief Executive</i>	Information		10
B3	Reset Programme Update <i>Zara Jones, Acting Chief Executive</i> <i>Executive Directors</i>	Note		15
C	PERFORMANCE			10:10
C1	Integrated Performance Report <i>(including finance report)</i> <i>Executive Directors</i>	Assurance		10
	- Q3 Learning from Deaths Report <i>Dr Nick Mallaband, Chief Medical Officer</i>	Assurance		10

D	PATIENTS			10:30
D1	Research & Innovation Case Study <i>Zoe Lintin, Chief People Officer</i> <i>Professor Sam Debbage, Director of Education & Research</i> <i>Dr Jane Fearnside, Head of Research</i>	Note		10
D2	2025/26 Quality Accounts <i>Simon Brown, Deputy Chief Nurse</i>	Note		5
E	PEOPLE			10:45
E1	Guardian of Safe Working Hours Report <i>Zoe Lintin, Chief People Officer</i> <i>Dr Mohammad Khan, Guardian of Safe Working Hours</i>	Assurance		10
E2	Speaking Up 2025/26 Annual Report <i>Zoe Lintin, Chief People Officer</i> <i>Paula Hill, Freedom to Speak Up Guardian</i>	Assurance		10
E3	2025/26 Workforce Race & Disability Equality Standards <i>Zoe Lintin, Chief People Officer</i>	Note		5
BREAK 11:10– 11:25				
F	STATUTORY & REGULATORY			11:25
F1	Perinatal Safety & Quality Interim Report <i>Simon Brown, Deputy Chief Nurse</i> <i>Lois Mellor, Director of Midwifery</i>	Assurance		10
G	POUNDS			11:35
G1	2025/26 Estates Return Information Collection <i>Sam Wilde, Chief Finance Officer</i>	Decision		5
G2	Deficit Support Funding <i>Sam Wilde, Chief Finance Officer</i>	Note		5
H	GOVERNANCE & ASSURANCE			11:45
H1	Chair's Assurance Log - Finance & Performance Committee <i>Stephen Radford, Non-executive Director</i>	Assurance		5
H2	Chair's Assurance Log - Quality Committee <i>Jo Gander, Non-executive Director</i>	Assurance		5
H3	Chair's Assurance Log - People Committee <i>Lucy Nickson, Non-executive Director</i>	Assurance		5

H4	Chair's Assurance Log – Audit & Risk Committee <i>Kath Smart, Non-executive Director</i>	<i>Assurance</i>		5
H5	Governance Documents Review - Governance Manual - Trust Risk Appetite - Board Committee Terms of Reference - Executive Team Terms of Reference <i>Rebecca Allen, Associate Director of Strategy, Partnerships & Governance</i>	<i>Ratify</i>		10
I	INTEGRATED ASSURANCE			12:15
I1	Board Assurance Framework including Trust Risk Register <i>Rebecca Allen, Associate Director of Strategy, Partnerships & Governance</i> <i>Executive Directors</i>	<i>Approve</i>		10
I2	Triangulation of Information to Identify Agenda Item Themes <i>Mark Bailey, Interim Chair</i>	<i>Discuss</i>		5
I3	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? <i>Mark Bailey, Interim Chair</i>	<i>Discuss</i>		5
J	CLOSING ITEMS			12:35
J1	Minutes of the meeting held on 5 May 2026 <i>Mark Bailey, Interim Chair</i>	<i>Approve</i>		5
J2	Pre-submitted Questions <i>Mark Bailey, Interim Chair</i>	<i>Discussion</i>		10
J3	Board of Directors Work Plan <i>Rebecca Allen, Associate Director of Strategy, Partnership & Governance</i>	<i>Information</i>		-
J4	Any other business (to be agreed with the Chair prior to the meeting) <i>Mark Bailey, Interim Chair</i>	<i>Discussion</i>		10
J5	Date and time of next meeting: Date: Tuesday 1 September 2026 Time: 9:30am Venue: Boardroom, Doncaster Royal Infirmary	<i>Information</i>		

J6	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. <i>Mark Bailey, Interim Chair</i>	<i>Note</i>		
K	MEETING CLOSE			13:00

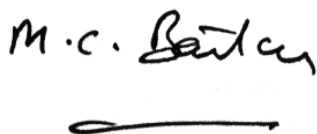
Governor Questions

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

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

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

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



Mark Bailey
Interim Chair

2607- A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

● Standing item

● Mark Bailey, Interim Chair

● 09:30

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

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

REFERENCES

Only PDFs are attached



A1 - Register of Interests & FPP (01.07.2026).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

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)

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
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Zara Jones	Acting Chief Executive
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Fit and Proper Person Declarations

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

- (i) am not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
- (ii) am not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- (iii) am not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- (iv) have not made a composition or arrangement with, or granted a trust deed for, my creditors and not been discharged in respect of it;
- (v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me;
- (vi) am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;
- (vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed;
- (viii) am able by reason of my health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which I am appointed or to the work for which I am employed;
- (ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- (x) am not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and
- (xi) am not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

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

(as at 1 July 2026)

2607 - A2 ACTIONS FROM PREVIOUS MEETING

● Standing item

👤 Mark Bailey, Interim Chair

🕒 09:30

5 minutes

REFERENCES

Only PDFs are attached

📄 A2 - BoD Action Log - 5 May 2026.pdf



Action notes prepared by:
Updated:

Angela O'Mara
18 June 2026



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

Action Log

Meeting	Public Board of Directors	KEY
Date of latest meeting:	5 May 2026	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. Action closed.
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 closed.

No.	Minute No.	Action	Responsibility	Target Date	Update
3.	P26/03/D3	<u>Speaking Up Reports</u> 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. Update 18/6/2026: included on the agenda @ item E2 – propose to close
4.	P26/03/D4	<u>Guardian of Safe Working</u> 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. Action closed.
5.	P26/05/H1	<u>Risk Appetite Statement</u> To bring the Trust's revised risk appetite statements for approval to the Board meeting of 7 July 2026	RA	July 2026	Update: included on the agenda @ item H5 – propose to close

2607 - B1 CHAIR'S REPORT INCLUDING PARTNERSHIP UPDATE

● Information Item

● Mark Bailey, Interim Chair

● 09:35

10 minutes

REFERENCES

Only PDFs are attached



B1 - Chair's Report including Partnership Update.pdf

Report Template					
Meeting Title:	Board of Directors			Meeting Date:	7 July 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 1-5 & 7				
Executive Summary – Key messages and Issues					
This report provides the Board of Directors with an insight into the Chair's reflections, areas of focus locally and nationally and activities since the last Board report in May 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 and a future focus on neighbourhood healthcare and Health on the High Street.				
People	This report recognises the vital role colleagues play in delivery of patient care and services and acknowledges their contribution.				
Partnerships	This report acknowledges the importance of working with partners, including educational institutes to grow local employment and skills development.				
Pounds	This report does not explicitly reference the efficient use of resource and the need to spend public money wisely, however, this remains a focus along with the quality of service provided.				
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	Highlight only where this report is outside of the Board Risk Appetite below.				
N/A	None	Minimal	Cautious	Open	Seek
			Regulatory Quality	Finance	People

Chair's Report



Mark Bailey
Interim Chair of the Board



Chair Report July 2026

As Chair, one of the privileges of the role is the opportunity to spend time with colleagues, partners and communities, listening to different perspectives and understanding the opportunities and issues that matter most to them.

Over the past month, this has included conversations with local partners about the future of Doncaster, engaging with national NHS leaders about the direction of healthcare, and time spent with colleagues delivering care within our hospitals.

Whilst very different in nature, each has reinforced the important role our Trust plays within both our communities and the wider health and care system.

The reflections within this report focus on some of those experiences and the themes they raise for our organisation as we continue the delivery of our Three-Year Plan and look to the future.

Our role in the community

During the month, I attended the Doncaster Chamber's What's Next? conference, which brought together leaders from business, education, local government and public services to discuss the opportunities and challenges facing our City.

A number of the themes discussed felt highly relevant to our own ambitions as a Trust.

Conversations around skills, workforce development, investment, innovation and place-making reinforced the important role organisations such as ours play within the wider local economy.

As one of the largest employers in Doncaster and Bassetlaw, our contribution extends beyond the delivery of healthcare alone.

This includes our work with schools, colleges and universities, our role in supporting local employment and skills development, and the opportunities created through research, innovation and digital transformation. Looking ahead, developments such as Health on the High Street, neighbourhood healthcare and emerging opportunities around data, analytics and shared records all have the potential to strengthen both health outcomes and economic growth across our communities.

As highlighted within the Chief Executive's Report, many of the ambitions set out within our Three-Year Plan are aligned with this broader vision for the future of Doncaster and Bassetlaw.

Delivering exceptional healthcare will always remain our core purpose, but the Trust also has an important role to play in helping create healthier, more prosperous communities for the future.

The national picture

I also attended the NHS Confederation Conference in Manchester, which provided an opportunity to hear directly from national leaders about the future direction of the NHS.

The keynote address from the new Secretary of State for Health and Social Care, James Murray MP, reinforced that the overall direction of travel remains unchanged. The ambitions set out within the 10-Year Health Plan, Medium Term Planning Framework and performance expectations for elective care, urgent and emergency care, and primary care continue to stand.

The message rightly recognised and appreciated the progress being made in the midst of a very challenging national and international environment however it was clear that there is an expectation and need for increased pace.

There was a particular focus on technology, digitisation and innovation, alongside a challenge to remove unnecessary barriers to change and embrace new ways of working. It is clear, there remains significant financial pressures facing the NHS and that organisations will have difficult decisions in balancing day-to-day operational delivery with longer-term transformation.

As reflected in the Chief Executive's report, many of these themes are already evident within our own plans and priorities. The challenge for all NHS organisations will be ensuring that we continue to improve services for today's patients whilst also building the foundations for the services of the future.

Time spent with colleagues

One of my priorities this year is to spend time with teams across our hospitals and services, listening and learning from colleagues about their experiences and the realities of delivering care in today's NHS.

Recently, I appreciated being given the opportunity to witness the morning multidisciplinary meeting of the Frailty Assessment Team at Doncaster Royal Infirmary. The experience was insightful and humbling.

What stood out most was the kindness, compassion and professionalism demonstrated by colleagues throughout. Whilst working within a busy and often pressured environment, there was a clear focus on understanding the needs of each individual patient and considering how care could best be delivered in line with their wishes and circumstances.

I was particularly struck by the emphasis on helping people remain independent and, wherever possible and safe to do so, return home. I know that it might be said 'this is what we do' but for me it emphasised that 'what we do is not ordinary it is extraordinary'.

On a personal level, the visit also brought back memories of my own parents, both of whom spent their final days at Doncaster Royal Infirmary after initially attending the Emergency Department.

Like many local families, we experienced first-hand the compassion and care shown by NHS colleagues during some of life's most difficult moments.

As the Acting Chief Executive reflects in her report, recent attention has understandably focused on the challenges facing urgent and emergency care. Whilst we must always acknowledge where improvement is required and continue to learn when things do not go as we would wish, visits such as this serve as an important reminder that exceptional care is delivered every day across our hospitals and services.

I look forward to spending time with more teams over the coming months and sharing some of those experiences in future reports.

A fond farewell

In June we announced the retirement of Richard Parker OBE, the Trust's Chief Executive.

Richard led the organisation through a period of significant challenge and change, whilst maintaining a deep commitment to patients, colleagues and the communities we serve.

I would like to place on record my sincere thanks, as well as those of the Board of Directors, for Richard's contribution to our Trust and the wider NHS throughout a career that spanned more than four decades. We wish him a long, healthy and happy retirement and thank him for the lasting legacy he leaves behind.

We will set out our next steps in terms of Chief Executive recruitment in due course, and in the meantime, I want to place on record my thanks to Zara, for her stewardship of the organisation as Acting Chief Executive.

Looking ahead

The themes running through this month's report are perhaps best summarised as partnership, innovation and people.

Whether discussing the future of services in the areas we serve, the national direction of the NHS, or spending time with colleagues delivering care on the frontline, I have been struck by the opportunities that exist when organisations and individuals work together towards a common purpose.

As both the Acting Chief Executive and I reflect in our respective reports, we have a clear strategy, a growing programme of improvement and a strong foundation on which to build. The challenge now is to maintain momentum, remain focused on delivery and ensure that the changes we make translate into meaningful improvements for patients, colleagues and communities across Doncaster and Bassetlaw.

I look forward to continuing these conversations in the months ahead and sharing further reflections through future reports.

2607 - B2 CHIEF EXECUTIVE'S REPORT INCLUDING PARTNERSHIP UPDATE

● Information Item

👤 Zara Jones, Acting Chief Executive

🕒 09:45

10 minutes

REFERENCES

Only PDFs are attached



B2 - Chief Executive's Report including Partnership Update.pdf

Report Template						
Meeting Title:	Board of Directors			Meeting Date:	7 July 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 – 5 & 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 the provision of patient care, including local and national developments and areas of focus.					
People	This report reinforces the importance of culture, leadership, psychological safety and ensuring that colleagues feel respected, valued and able to speak up.					
Partnerships	The report highlights the ways in which the Trust works in partnership with education providers and its contribution to neighbourhood health and prevention.					
Pounds	The report recognises the need for financial sustainability and delivery of the financial aspects of the Medium-Term Plan					
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 Trust remains committed to act upon regulatory feedback.					
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	Highlight only where this report is outside of the Board Risk Appetite below.					
YES/NO	None	Minimal	Cautious	Open	Seek	Significant
			Regulatory Quality	Finance	People	

Chief Executive's Report



Zara Jones
Acting Chief Executive



Progress, priorities and perspective

As both the Chair and I reflect in our respective reports, the NHS continues to operate within an environment of significant change and challenge. National expectations continue to evolve whilst operational, financial and workforce pressures remain considerable.

Against this backdrop, it is important that we periodically take stock of where we are as an organisation, the progress we are making and the areas where further improvement is required.

The national direction of travel continues to emphasise prevention, neighbourhood health, digital transformation, productivity and stronger organisational accountability. Whilst the overall direction of travel remains consistent, there is an increasing expectation that improvement and delivery are achieved at greater pace.

These themes align closely with the priorities already set out within [our Three-Year Plan](#) and reinforce the importance of improving services for today's patients whilst continuing to build the foundations for the future.

Recent national reports also provide important reflections for all NHS organisations. The publication of the Ockenden review relating to maternity services at Nottingham University Hospitals and Lord Mann's review into antisemitism within the NHS reinforce the importance of culture, leadership, psychological safety and ensuring that colleagues feel respected, valued and able to speak up.

These themes resonate strongly with the work already underway within DBTH through our independent reviews, colleague engagement activity and our focus on leadership behaviours, accountability and organisational culture.

Urgent and Emergency Care remains one of our most significant operational priorities. Over recent months our Emergency Department has been subject to increased external scrutiny and public attention, reinforcing the importance of maintaining momentum on improvement. As the Chair reflects following his recent visit to the Frailty Assessment Team, the compassion, professionalism and person-centred care demonstrated by colleagues every day remain among our greatest strengths. Our focus now is on ensuring that the systems, processes and environments supporting that care are equally effective, safe and sustainable.

The Urgent and Emergency Care Optimisation Programme remains our principal vehicle for improvement. The programme is focused on reducing avoidable admissions, improving patient flow, strengthening the first 72 hours of acute care, enhancing Same Day Emergency Care, reducing delays and supporting timely discharge.

Alongside this, we continue to implement learning arising from external review, regulatory feedback and our own local improvement activity to ensure that improvements are sustained and embedded.

Looking further ahead, we continue to progress a business case for approximately £32 million of capital investment to deliver a new purpose-built Urgent Treatment Centre, co-located Same Day Emergency Care facilities and wider improvements to the Emergency Department at Doncaster Royal Infirmary. Together, these developments have the potential to improve patient experience, operational resilience and patient flow.

More broadly, the recent period of exceptionally warm weather has demonstrated that operational pressures are no longer confined to winter months. Caring for patients during periods of extreme heat places additional demands on colleagues, patients and our estate and reinforces the importance of investment in modern facilities, resilient infrastructure and neighbourhood-based models of care.

Alongside our operational priorities, significant work continues to strengthen culture, leadership and organisational effectiveness. The insights gained through independent reviews, colleague feedback and ongoing conversations across the organisation continue to shape our priorities and reinforce the importance of listening, learning and acting on concerns early.

The Reset Programme, which we began at the start of this financial year, has provided an important vehicle for this work and is increasingly moving from diagnosis of the challenges into delivery of the solutions. In addition, recent agreement of three priority behaviours as part of [our DBTH Way approach](#) - Speaking Up for Patient Safety, Personal Accountability and Collaborative Relationships - provides greater clarity regarding the standards and expectations we hold for ourselves and each other.

This work sits alongside our continuing commitment to equality, diversity, inclusion and anti-racism. As referenced earlier in this report, the findings of Lord Mann's review provide an additional opportunity for reflection as we seek to ensure that all colleagues, irrespective of faith, ethnicity or background, feel respected, supported and able to thrive.

Creating an environment in which colleagues feel safe to speak up, challenge appropriately and contribute fully remains fundamental to both staff experience and patient safety.

Digital transformation also remains a significant strategic priority. Preparations for the Electronic Patient Record (known as ORBIT) continue to progress and represent one of the most important organisational changes we will undertake in the coming years. Alongside improving information, productivity and patient experience, this transformation work offers opportunities to strengthen clinical decision-making, reduce variation and support more integrated pathways of care.

As the Chair reflects following discussions with local and national partners, the Trust also has an important role to play beyond the direct delivery of healthcare. Our contribution to the health, economic and social wellbeing of Doncaster and Bassetlaw increasingly extends beyond our hospitals through our role as an anchor institution, our support for skills and employment, our partnerships with education and our contribution to neighbourhood health and prevention.

Whilst there are many positive developments, some aspects of our performance continue to present a mixed picture. Although Urgent and Emergency Care metrics are improving and the Trust continues to compare favourably nationally in certain areas, including corridor care, further improvement is required, particularly in reducing long waits and improving consistency across services and sites.

Financial sustainability also remains a significant challenge. Delivering recurrent improvements, improving productivity, reducing variation and delivering financial plans remain essential if we are to create a

sustainable organisation capable of meeting future demand whilst continuing to invest in services and infrastructure.

At the same time, it is important that we do not lose sight of the good quality of care that colleagues provide every day. During recent weeks I have received a number of letters, emails and comments from patients, families and members of the public describing outstanding care, compassion and kindness across our hospitals and services.

At times when performance challenges, operational pressures and external scrutiny can dominate our attention, these reflections provide important perspective. They remind us that whilst we must continue to address areas requiring improvement with honesty and urgency, excellent care is delivered every day by colleagues who remain deeply committed to our patients, each other and the communities we serve.

Progress against our strategic priorities

Patients

We continue to [invest in services and environments](#) that improve patient experience, access and outcomes. Recent developments include improvements within Medical Imaging at Doncaster Royal Infirmary, expansion of Diabetic Eye Screening services at Bassetlaw Hospital and the introduction of therapeutic activity devices funded by DBTH Charity to support patients with dementia, anxiety, learning disabilities and other additional needs.

Together, these initiatives support earlier diagnosis, improve patient flow and help deliver more personalised care. Alongside these developments, preparations for the Electronic Patient Record continue, representing a significant opportunity to improve patient safety, information sharing and clinical decision-making across the organisation.

People

Supporting, recognising and listening to our people remains central to delivery of the Three-Year Plan and the DBTH Way. Nominations are now open for the Star Awards 2026, whilst Governor elections have attracted strong interest, with more than 40 candidates standing across our constituencies.

Partnerships

Strong partnerships continue to support better outcomes for patients and communities. During Armed Forces Week, the Trust celebrated its Silver Award under the Defence Employer Recognition Scheme and continued work with local organisations to strengthen support for veterans and military families.

Our research partnerships continue to flourish, with DBTH recognised as one of the joint highest recruiters nationally to the TOPAZ lupus clinical trial.

As highlighted within the Chair's report, the Trust also continues to play an important role in supporting education, skills and economic growth across Doncaster and Bassetlaw, including through initiatives such as We Care into the Future, neighbourhood health and wider partnership working across our communities.

Pounds

Delivery of the Trust's financial plan remains a key priority. Expenditure on agency and bank staffing remains lower than the same period last year, reflecting ongoing work to improve workforce efficiency and reduce reliance on temporary staffing.

Alongside this, local schemes and divisional plans continue to support delivery of the Trust's financial improvement target, with significant savings opportunities identified through plans submitted to date.

Financial sustainability remains one of the most significant challenges facing both the Trust and the wider NHS. Continued focus on productivity, efficiency, service redesign and recurrent improvement will remain essential if we are to deliver a sustainable organisation capable of investing in future services.

Looking ahead: Risks and priorities

Key risks

- Delivery of recurrent financial improvements at the pace required to achieve long-term sustainability.
- Continued variation in performance and patient outcomes across services and sites.
- Risk of improvement programmes not delivering benefits at the scale or pace required.
- Sustained long waits within a small number of challenged specialties.
- Capacity and capability required to deliver significant organisational, workforce and digital transformation.
- Failure to consistently embed the behaviours, accountability and culture required to support improvement.
- Delivery risks associated with major programmes including the Electronic Patient Record.

Key priorities to support addressing our risks

- Delivery of the Three-Year Plan as the Trust's primary vehicle for improvement.
- Continued delivery of the Urgent and Emergency Care Optimisation Programme.
- Continued focus on patient flow, reducing delays and improving urgent and emergency care.
- Reduction of the underlying deficit through productivity, efficiency and service redesign.
- Strengthening governance, assurance and organisational grip through enhanced oversight and scrutiny.
- Embedding the DBTH Way, leadership expectations and agreed organisational behaviours.
- Preparing for implementation of the Electronic Patient Record.
- Translating improvement activity into measurable benefits for patients, colleagues and communities.

Leadership and transition

This month also marks the retirement of Richard Parker OBE following 44 years of NHS service and almost a decade as Chief Executive of DBTH.

Throughout his time as Chief Executive, Richard has led the organisation through a period of considerable challenge and change, including the COVID-19 pandemic and the wider pressures facing the NHS in recent years. Throughout this time, he remained deeply committed to patients, colleagues and the communities we serve, maintaining a visible presence across the organisation and taking a genuine interest in the experiences of those delivering and receiving care.

Many colleagues will have their own memories of working with Richard, whether through departmental visits, conversations during walkabouts or his ongoing engagement with staff across the Trust. His leadership has helped shape both the organisation and many of the people who have worked alongside him.

On behalf of colleagues across the organisation, I would like to thank Richard for his contribution to DBTH and the wider NHS and wish him a long, healthy and happy retirement.

As the Trust looks to the future, we do so with a clear strategy, a growing programme of improvement and strong foundations on which to build. The opportunities and challenges facing the NHS remain considerable, requiring us to continue strengthening quality, culture, productivity, partnership working and financial sustainability.

The next phase for the organisation is one of delivery: Maintaining momentum, continuing to learn and ensuring that the improvements we make translate into meaningful benefits for patients, colleagues and communities across Doncaster and Bassetlaw.

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

- The Trust continues to make progress across a number of strategic priorities, with increasing evidence that improvement activity is beginning to translate into operational and organisational improvement.
- Recent national reports reinforce the importance of culture, leadership, psychological safety and speaking up, strengthening the relevance of work already underway within DBTH.
- Urgent and Emergency Care remains a key organisational priority, supported by the continued delivery of the Optimisation Programme and longer-term investment in services and infrastructure.
- The organisation continues to strengthen leadership expectations, accountability and culture through the implementation of agreed behaviours and wider organisational development work.
- Digital transformation and preparation for the Electronic Patient Record represent significant opportunities to improve patient care, productivity and organisational effectiveness.
- Financial sustainability, productivity and reducing variation remain critical challenges requiring sustained attention.
- The Trust continues to play an important role as an anchor institution, supporting the wider health, social and economic wellbeing of Doncaster and Bassetlaw.
- The commitment, compassion and professionalism of colleagues continue to provide confidence as the organisation moves into the next phase of improvement and delivery.

2607 - B3 RESET PROGRAMME UPDATE

● Information Item

👤 Zara Jones, Acting Chief Executive & Executive Directors

🕒 09:55

10 minutes

REFERENCES

Only PDFs are attached



B3 - Reset Programme Update.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Reset Programme: Three-Year Plan and Month 2 Update			
Sponsor:	Zara Jones, Acting Chief Executive			
Authors:	Sarah Perkins, Director of Reset			
Appendices:	None			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (For assurance papers only)	N/A - information paper			
Assurance Rationale	N/A - information paper. The Board is asked to note progress, the financial position, risks and planned next steps.			
Impacts on Strategic Risks (BAF 1-7)	BAF 1-7: supports mitigation of strategic risks relating to quality and access, financial sustainability, workforce, service configuration, partnerships and delivery of transformation.			
For decision papers only: Is this in line with Current risk appetite YES				
Executive Summary – Key messages and Issues				
The Reset Programme is the delivery mechanism for the 2026-29 Three-Year Plan, aligning service configuration, access and flow, workforce, productivity and culture. At month 2 shows strong mobilisation: elective care workstreams are operational, urgent and emergency care actions are progressing, workforce reviews are underway and core culture and leadership development actions are embedded. In-year delivery is £5.452m, on plan: a £1.497m shortfall across the Reset pillars shortfall being offset by £1.497m of additional delivery from Local schemes. The full-year in-year forecast remains £46.290m, although £23.733m is the risk adjusted value derived using the NHSE risk and programme maturity methodology. Recurrent delivery is behind early phasing, so validation, QIA, engagement and implementation remain priorities.				
Recommendations				
The Board is asked to note the programme overview, early delivery evidence and risks, and to receive future updates through Reset Board and existing Board assurance routes.				
Healthier together – delivering exceptional care for all				
Patients	Improves urgent, elective, diagnostic and cancer access, patient flow and care closer to home.			
People	Sets clear behavioural expectations, supports leaders and reduces reliance on temporary staffing through clinically safe redesign.			
Partnerships	Supports work with ICBs, primary and community care and regional clinical partners on site roles, neighbourhood health and service models.			
Pounds	Coordinates a £46.290m in-year efficiency programme for 2026/27 and supports financial balance by 2028/29.			
Health Inequalities	Focuses on equitable access and care closer to home. Individual changes will be informed by EQIA.			
Legal/ Regulation:	No decision is requested. Individual schemes will follow relevant statutory, regulatory, quality, equality and consultation requirements.			
Partner ICB strategies	Aligns with neighbourhood health, left shift and community access priorities, and requires ongoing system partner engagement.			

Assurance Route	
Previously considered by - including date:	Supporting papers reviewed at June Reset Board.
Any outcomes/next steps / time scales	Monthly Reset Board review.

1. Overview of the Reset Programme, Three-Year Plan and national alignment

The Reset Programme is DBTH's integrated delivery programme for its 2026-2029 Three-Year Plan. It translates the Trust strategy, Healthier Together - Delivering Exceptional Care for All, into a coordinated set of actions across five pillars: Shape of DBTH, Workforce and Organisational Design, Access and Flow, Productivity and Financial Reset, and Culture and Leadership. A linked Local schemes programme captures opportunities owned by divisions and corporate departments.

The Three-Year Plan is designed to meet the national direction described in the NHS 10 Year Health Plan: improving outcomes, strengthening care closer to home, using digital innovation and securing financial sustainability. The programme combines service redesign and partnership working with operational recovery, workforce change, productivity improvement and stronger leadership. The DBTH Dozen and enabling plans provide the wider improvement framework and ensure that change is clinically led, professionally informed and measured in terms of quality, workforce and financial impact.

2. Patient and people outcomes

At Month 2, an extensive programme of work has been mobilised with green shoots in terms of patient outcome improvement. The Reset Board will track whether these changes translate into sustained improvement through the Trust's established performance, quality, workforce and financial reporting arrangements, and track the e

Area	Early progress	Three-year delivery ambition
Urgent and emergency care	Model Acute, UTC front door and first 72-hour models undergoing approval. EEMAC PDSA commenced, standardised ward and discharge processes progressing.	Four-hour performance to improve to 86% by 2028/29, 12-hour waits to reduce from 4% to around 1%, ambulance handovers over 45 minutes to reduce from 3.5% to zero.
Elective care and RTT	Theatre, outpatient and diagnostic optimisation workstreams mobilised, 6-4-2 outpatient implementation plan agreed, specialty engagement and theatre/POA observations underway. Positive RTT 18-week movement at Month 2.	RTT performance to reach national standards of 92%, waiting list to reduce from over 54,000 to around 51,000 while activity grows. Improved clinic utilisation, attendance rates and empowered patient access through single point of access and patient initiated follow up will support.
Diagnostics	Endoscopy tracker and protocols are being developed, radiology demand/capacity gap is being validated. Improved DM01 performance for Q1.	Improved DM01 performance, utilisation and reporting effectiveness.

Area	Early progress	Three-year delivery ambition
Cancer care	The programme provides the access, diagnostics and pathway foundations required for recovery, relevant actions will be monitored through existing cancer governance.	62-day performance to improve from 68% to 85%, Faster Diagnosis Standard maintained at at least 80%, 31-day performance sustained at 96%.

Early progress on our programme of culture and leadership work includes embedding the “I will” behavioural statement in appraisal documentation, including medical appraisal, agreement of three DBTH Way focus behaviours for 2026/27 - Speaking Up for patient safety, personal accountability and collaborative relationships, and a strengthened Board engagement and visibility framework. Targeted support on civility, Just Culture, speaking up and bullying and harassment is also underway.

The workforce programme is progressing controls on agency and bank usage, rostering and sickness, corporate workforce reviews have progressed through validation and workforce processes, and the divisional support and administration review has completed substantial discovery work. The longer-term aim is a more stable substantive workforce, lower reliance on temporary staffing, clearer roles and development opportunities, and simpler processes that allow colleagues to spend more time on patient care.

The programme recognises that organisational change can affect colleagues' experience in the short term. People outcomes will therefore be monitored through staff survey, pulse feedback, Freedom to Speak Up, employee relations, sickness, turnover, workforce and safe staffing data. The Culture and Leadership pillar has specifically identified the risk that some people measures may not improve immediately and will use visible leadership, targeted organisational development support and triangulated feedback to identify and respond to concerns early.

3. Financial position and delivery

The Reset Programme is the principal vehicle for delivering the 2026/27 efficiency requirement. The full-year in-year forecast remains in line with the £46.290m plan. At Month 2, year-to-date in-year delivery is also on plan, stronger Local delivery has offset slower delivery in the core Reset pillars.

Measure (£m)	Plan	Actual / forecast	Variance	Notes
Total in-year delivery - Month 2 YTD	£5.452m	£5.452m	£0.000m	Overall programme delivery is on plan.
Reset pillars - in-year YTD	£4.284m	£2.787m	£(1.497)m	Slower early delivery within the core pillars, with most schemes forecast to recover later in the year. YTD actual includes £1.0m of unplanned delivery from the Technical scheme within the Productivity & Financial Reset pillar.
Local schemes - in-year YTD	£1.169m	£2.666m	£1.497m	Greater Local delivery offsets the Reset pillar variance. Includes reported pay/non-pay budget underspends.
Full-year in-year forecast	£46.290m	£46.290m	£0.000m	Forecast remains on plan, risk-adjusted forecast using NHSE risk and maturity assessment is £23.733m.

The three-year plan sets a wider trajectory of reducing the in-year deficit and reaching financial balance by 2028/29, supported by approximately £90m of recurrent savings over the period. Priority areas are converting agency and bank controls into Finance-validated cash benefit, developing detailed procurement, drug-cost and estates plans, moving access and flow initiatives from mobilisation into measurable benefits, and ensuring that Local schemes have sufficiently developed, costed pipelines. All schemes will remain subject to quality assessment, financial validation and control of double counting.

4. Pillar updates

4.1 Culture and Leadership

The pillar is embedding consistent behavioural expectations and visible leadership. It recognises and is actively managing the risk of short-term pressure on colleague experience during wider change.

The “I will” statement is now embedded in appraisal and medical appraisal documentation. The Trust has agreed three focus behaviours for 2026/27, and communications and leadership conversations are progressing through the Line in the Sand approach. Work is underway on civility, Just Culture, bullying and harassment, and speaking up, with targeted external organisational development support planned for priority teams. The Board and Executive Team will continue to play a visible role in reinforcing behavioural expectations, listening to colleagues and acting on feedback.

4.2 Shape of DBTH

The pillar is moving from exploratory work into structured partnership driven clinical change, with data capture, financial appraisal, estate review and partner engagement progressing. The focus is on clearer site roles, care closer to home and resilient clinical models.

Key work includes review of our services at Bassetlaw, Mexborough and Retford sites, Neighbourhood Health and Waterdale development, paediatric partnership working, left shift services and inpatient models. Future changes will follow the appropriate clinical validation, engagement, consultation and decision processes.

4.3 Workforce and Organisational Design

Agency and bank optimisation is progressing across rate, booking, rostering and sickness controls. The next requirement is to reconcile run-rate change with ledger savings and budget baselines, while monitoring fill rates and safe staffing. Corporate workforce reviews are progressing through Executive design review. Divisional support and administration is completing its baseline and will move into options appraisal for receptionists, ward clerks and typists, protecting patient access, ward flow and clinical correspondence.

4.4 Access and Flow

All elective care workstreams have been mobilised, Trust engagement is strong and data/reporting development is progressing. The UEC programme has detailed plans and is progressing against its first 30- and 60-day milestones.

Urgent and emergency care work is progressing the UTC front door, Model Acute and first 72-hour models, alongside standardised ward and discharge processes. Inpatient redesign is progressing plans to reduce acute bed footprint safely. In elective care, Productive Partners observations and specialty engagement are underway to identify theatre, pre-operative assessment, booking and productivity opportunities. Outpatient

optimisation has established weekly specialty-based reviews and dashboard development. Diagnostics work includes endoscopy controls and radiology demand/capacity validation, with clinical referral and reporting risks being actively managed.

4.5 Productivity and Financial Reset

Technical adjustments and 2025/26 roll-over schemes are delivering in line with plan, including a further £1.018m non-recurrent technical adjustment released in Month 2. Procurement opportunities are being scoped through contract review, benchmarking, product rationalisation, supply-chain route switching and collaboration with system partners. Drug-cost work is developing biosimilar, wastage and contract-review opportunities, while Estates and Facilities is building a pipeline and prioritising work. The Board should note the key risks: capacity in procurement, pharmacy and estates, the need for detailed, costed plans, and the need to avoid reliance on short-term releases where sustainable recurrent savings are required.

4.6 Local schemes and divisional delivery

The Local programme covers income generation and contract review, supplies and services efficiency, and vacancy management. The immediate next step is for divisions and corporate departments to complete standard templates covering recurrent and in-year benefit, WTE and risk. This will quantify gaps to target and enable additional opportunities to be identified, costed and tracked. The programme needs sustained divisional engagement and capacity so that it moves from budget underspends and central releases towards developed, sustainable schemes.

5. Governance, risks and next steps

The Reset Board provides the central delivery forum, with executive sponsorship, defined milestones, named workstream ownership and reporting through quality, performance, workforce and finance routes. The programme will continue to use a single benefits tracker, finance validation, quality impact assessment, equality impact assessment where required, clinical and professional engagement, and clear escalation of interdependencies and risks. The support of NEON solutions to provide an enhanced board to floor programme reporting

The principal programme level risks are: the conversion of early in-year benefit into recurrent savings, staff capacity and pace of workforce and cultural change, clinical engagement and partner decision-making for complex service redesign, potential access and diagnostics risks, including data alignment and referral processes, and the ability of divisions to develop fully costed Local schemes. These risks are known, are owned by the relevant pillars and will be actively managed through the Reset Board and established executive governance.

The next reporting period will focus on securing approvals for urgent and emergency care models, completing theatre, outpatient and diagnostics reviews and translating findings into implementation plans, validating recurrent financial benefits, agreeing workforce implementation routes, progressing clinical option appraisal and partner engagement for service redesign, and strengthening Local scheme development. Board reporting will continue to distinguish between mobilisation, verified delivery and outcome impact.

2607 - C1 BOARD INTEGRATED PERFORMANCE REPORT (INCLUDING FINANCE REPORT)

 Discussion Item

 Executive Directors

 10:10

10 minutes

REFERENCES

Only PDFs are attached

-  C1 - Board Integrated Performance Report.pdf
-  C1 - Appendix 1 - IPR.pdf
-  C1 - Appendix 2 - Finance & Activity Report 26-27 Month 2.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Board Integrated Performance Report			
Sponsor:	Denise Smith, Chief Operating Officer			
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 - IPR Appendix 2 - Trust Board Finance & Activity Report 26-27 Month 2			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (For assurance papers only)	Moderate Assurance			
Assurance Rationale	The Board is asked to take Moderate Assurance that whilst some controls exist they are not embedded and therefore objectives may not be fully met			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF3, BAF5			
Executive Summary – Key messages and Issues				
The May 2026 Integrated Performance Report shows the Trust operating under sustained demand and capacity pressure, with the most significant risks concentrated in urgent and emergency care, elective care and workforce compliance. 4-hour performance, RTT, diagnostics and cancer faster diagnosis standard are below trajectory. 12 hour performance, average ambulance handover times, 31 day cancer performance and 62 day cancer performance are above trajectory. Quality indicators show mixed assurance. Mortality remains within national control limits, and governance has strengthened around mortality review and infection prevention; however, sepsis antibiotic administration remains materially below the 90% trajectory, at 53.2% in A&E and 70.0% for inpatients, requiring continued Board attention on reliability of time-critical care processes. People performance is a cross-cutting constraint. Turnover is within target at 9.8%, but sickness absence remains above target at 5.7%, SET compliance is below trajectory at 84.1%, and medical appraisal completion (rolling 12 months) is below standard at 82.8% vs 95%. Key Themes - Access to care is below plan in a number of areas across urgent and emergency care, elective and cancer. - Quality governance is maturing, but sepsis reliability remains a priority safety concern. - Workforce availability and compliance are constraining performance, particularly sickness, training and appraisal completion. Finance Summary 1 Financial Risks The financial risks have been updated following the 26/27 plan and there has been an improvement of £7.6m in the gross risk since the planning submission (£45.7m to £38.1m). The main risk is centred around the efficiency				

programme. Mitigations have improved by £9.6m (£6.8m to £16.4m) since plan submission, with the main mitigations being related to contract negotiations with SY ICB and the Reset Programme. The net risk has reduced by £17.2m to £21.7m.

2 Delivering financial sustainability by addressing our underlying deficit over time

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At month 2 the current underlying deficit is estimated at £52.1m and the 26/27 exit rate is estimated at £10.1m in line with plan.

Latest published data (to January 2026) shows that Implied productivity is 3.4% (per £) and 1.0% (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 £6.8m going forward and a 1.2 WTE recurrent reduction in the funded establishment.

3 Delivering the 2025/26 committed plan

The Trust is reporting a £4.3m year to date deficit, which is £2.6m adverse to plan due to year to date deficit support funding not being confirmed by NHS England as yet. Excluding deficit support funding performance is on plan.

Daycase and Elective activity are above plan in month and Outpatient activity is below plan.

Analysis of agency costs versus the required 40% year on year reduction is included within the pack. Agency costs in month were £1m, a £0.2m increase from M1. Bank costs in month are £1.6m, a £0.1m increase from month 1. Latest benchmarking data (M10 YTD 2025/26) shows the Trust ranks poorly on agency spend, well on bank spend and middling on overall temporary staff spend.

The funded establishment has increased by 8.6 Whole Time Equivalents (WTE) in month 2 medicine due to alignment of medics spend. However this level of funded establishment is below plan. Based on the number of contracted staff, there is a 'vacancy' rate of 6.0% gross (down from 6.9% last month) or 0.2% net of temporary staffing (down from 1.6% 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 (to January 2026 year to date) shows that Implied productivity is 10.1% (per £) and 10.7% (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 (£5.5m) and forecast to be so in the full year (£46.3m).

The cash balance is £18.9m and is adverse to plan by £8.1m mainly due to the payment profile of the year end capital creditors.

Capital expenditure (excluding charitable funds) is £0.5m against a plan of £2.3m YTD.

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.
Health Inequalities	Health inequality data is not currently broken down in the IQPR.
Legal/ Regulation:	CQC (reg 12) - Safe Care and Treatment NHSE - National Quality Board staffing reporting requirements
Partner ICB strategies	The document has no positive or negative impact on ICB Strategies.
Assurance Route	
Previously considered by - including date:	Contents shared with Finance & Performance Committee, Quality Committee and People Committee
Any outcomes/next steps / time scales	



Integrated Performance Report

May 2026



NHS Oversight Framework 2025/26 Key performance indicators - Access

▼ Access to Services

8 KPIs Mean Score: 2.11

Key Performance Indicator	Period	Target	🏆	SPC	Segment Position	Score
... Cancer - Patients treated within 62 of referral QTD	Q4 25/26	75.00%	75.84%			1.00
... Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q4 25/26	80.0%	81.7%			1.00
... Community Services - Patients waiting over 52 weeks	Mar 26	-	0.00%			1.00
... ED - Attendances managed within 4 hours QTD	Q4 25/26	78.00%	72.13%			2.84
... ED - Attendances over 12 hours in department QTD	Q4 25/26	-	5.2%			1.47
... RTT - Patients waiting 18 weeks or less	Mar 26	-	61.85%			3.39
... RTT - Patients waiting over 52 weeks	Mar 26	1.00%	1.90%			3.23
... RTT - Planned v actual 18 week performance	Q3 25/26	0.0%	-2.4%			2.96



Key performance indicators - Access

Metric	Source & Description	Latest month reported	Current month		
			Local trajectory	Actual	Variance
4 hour in A&E department	NHS Oversight Framework Operational Planning Guidance NHS Standard Contract	May-26	76.0%	71.1%	-4.9%
12 hours in A&E department	NHS Oversight Framework Operational Planning Guidance NHS Standard Contract	May-26	5.4%	4.3%	-1.1%
Ambulance handovers within 15 minutes	NHS Standard Contract	May-26	65.0%	55.6%	-9.4%
Ambulance handovers within 30 minutes	NHS Standard Contract	May-26	95.0%	88.2%	-6.8%
Ambulance handovers over 60 minutes	NHS Standard Contract	May-26	0.0%	0.8%	0.8%
Diagnostic waiting times	NHS Oversight Framework Operational Planning Guidance NHS Standard Contract	May-26	77.9%	75.8%	-2.1%
Percentage of patients waiting less than 18 weeks from referral to treatment	NHS Oversight Framework Operational Planning Guidance	May-26	64.8%	62.6%	-2.2%
Referral to treatment percentage waits over 52 weeks for incomplete pathways	NHS Oversight Framework Operational Planning Guidance	May-26	0.8%	2.5%	1.6%
Percentage of patients waiting no longer than 18 weeks for a first appointment	NHS Oversight Framework Operational Planning Guidance	May-26	75.9%	74.4%	-1.4%
Percentage of under 18 year old patients waiting less than 18 weeks from referral to treatment	NHS Oversight Framework	May-26	64.8%	68.8%	4.0%
28 day Faster Diagnosis Standard	NHS Oversight Framework Operational Planning Guidance NHS Standard Contract	Apr-26	81.2%	69.9%	-11.3%
31 day decision to treatment for all cancer patients	Operational Planning Guidance NHS Standard Contract	Apr-26	95.2%	96.3%	1.1%
62 day referral to treatment for all cancer patients	NHS Oversight Framework Operational Planning Guidance NHS Standard Contract	Apr-26	71.1%	80.0%	8.9%
Cancelled operations not rebooked within 28 Days	NHS Standard Contract	May-26	0	2	2
Mixed Sex Accommodation - nationally reported breaches in month	NHS Standard Contract	May-26	0	Overall page 39 of 397	

Assurance report

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

Summary of challenges & risks

In May 2026, 71.1% of patients were in ED > 4 hours from arrival before admission, discharge or transfer, against the plan of 76%. The Trust ranked 86th out of 150 acute providers. Attendances were 18,854, against the plan of 18,732 (0.6% above plan).

Performance in May 2026 shows a 3.47% deterioration compared to April 2026. This deterioration is driven by under performance at the Doncaster site in both admitted and non admitted performance. Non admitted performance deteriorated by 4.1%, from 73.6% in April to 69.5% in May. Admitted performance deteriorated by 7.8% reduction, from 28.4% in April to 20.6% in May.

Key Challenges: at Doncaster, maintaining consistent wait times to see a senior decision maker over the 24/7 period and reviews by speciality teams taking place within the Emergency Department.

Risks: demand continuing to be above plan, delays to decision making regards admission and delays to discharge

Actions to address risks, issues and emerging concerns relating to performance and forecast

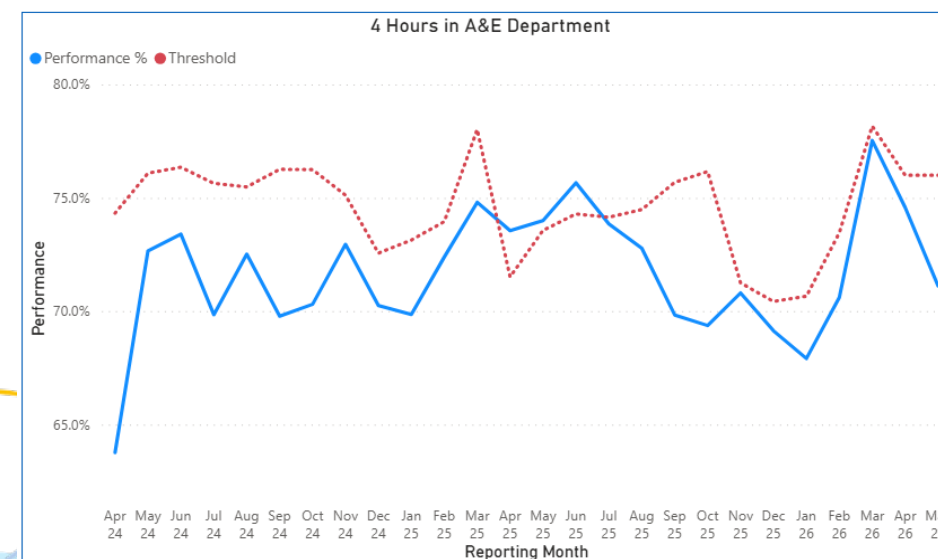
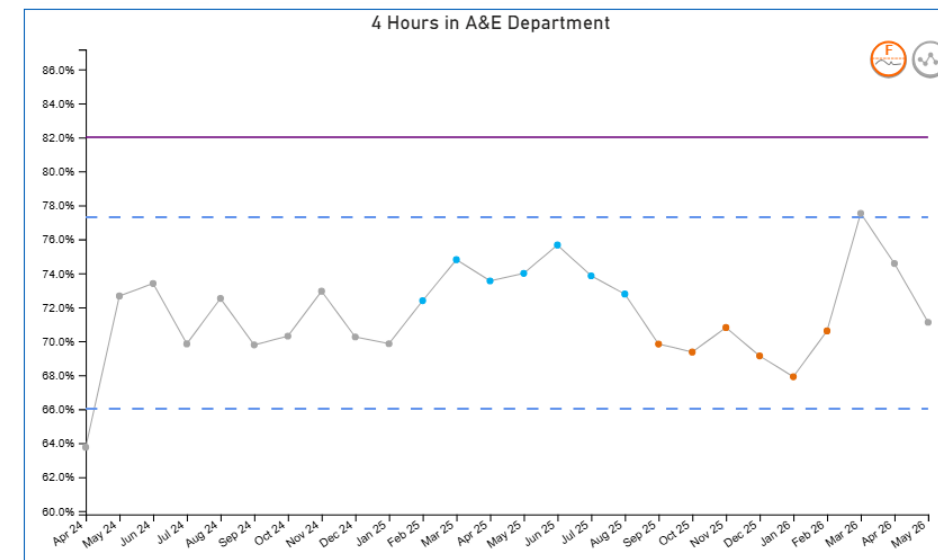
1. Wait to be seen time to senior decision maker- increasing the proportion of patients seen within 60 minutes of arrival, focusing on Early Senior Assessment on arrival and early management plans with timely decisions to admit.
2. Non admitted pathway –most patients are discharged from ED therefore a continued focus on improving the non admitted pathway, reducing delays to assessment / diagnostics / treatment and review by speciality has a significant impact on overall performance. A further review of the medical staff rota will be undertaken to ensure this is aligned to the demand profile. In addition, the Hospital Leadership Team has approved the proposal to implement Extended Emergency Medicine Ambulatory Care (EEMAC) at Doncaster and Bassetlaw. This will go live at Doncaster in June 2026 and is forecast to have a positive impact on non-admitted performance
3. Admitted pathway- increasing the proportion of patients managed through SDEC will reduce the impact of patients waiting for beds in ED
4. Operational focus- operational touchpoints and tracking all patients over 3 hours with improved escalation
5. 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

Risk register

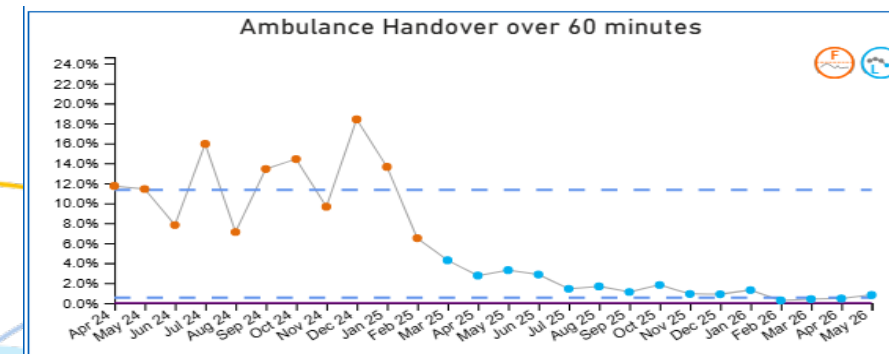
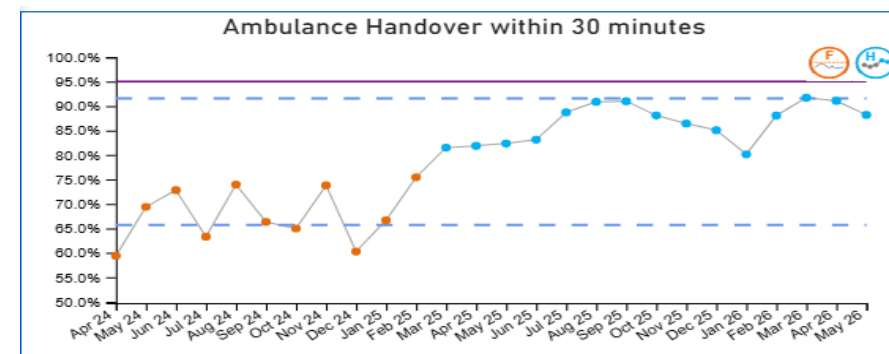
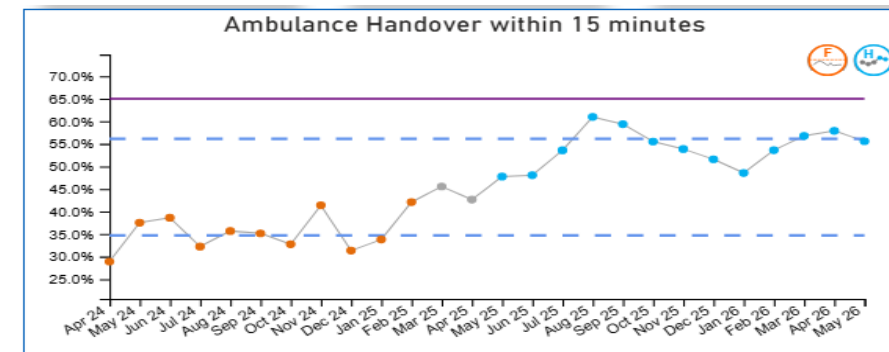
Risk register Risk 3437 Timely Access to Emergency Care



Assurance report

Ambulance handover within 15/30/60 mins

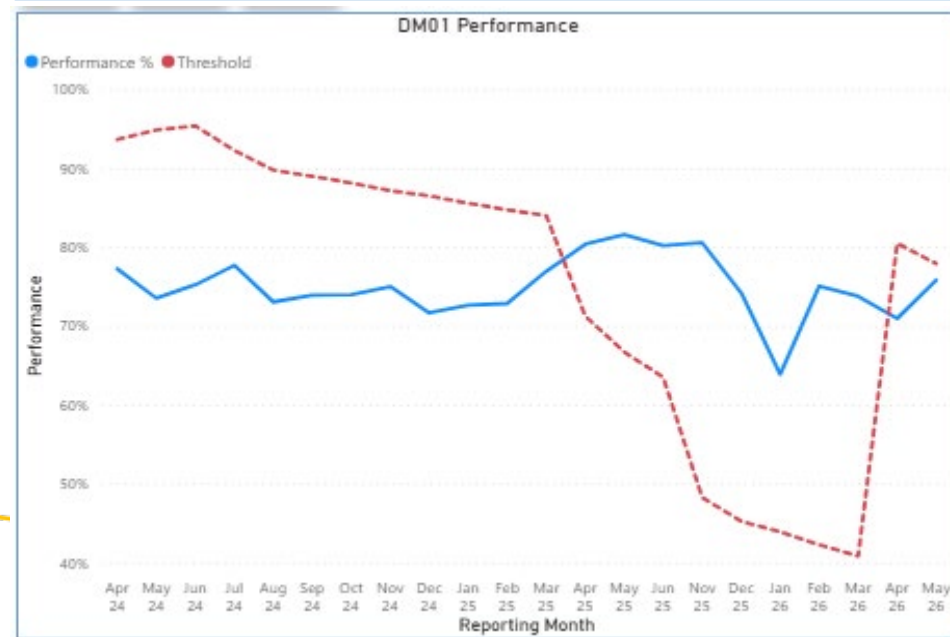
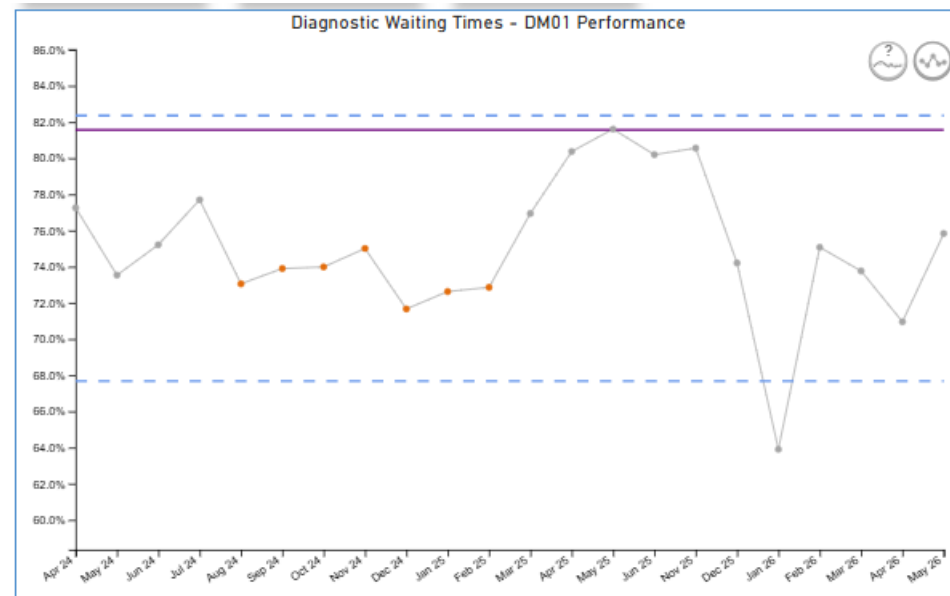
Summary of challenges & risks	In May 2026, there were 4017 ambulance arrivals to Doncaster and Bassetlaw in total, representing an increase of 205 compared with the previous month. Improvements in ambulance handover performance are noted overall and the Trust is above plan for average handover time. However, the contractual standards for 15 minute, 30 minute and 60 minutes are not achieved. Performance in May against contractual standards are summarised below: • 55.5% of handovers were completed within 15 minutes, against the contractual standard of 65% • 88.2% of handovers were completed within 30 minutes, against the contractual standard of 95% • 99.2% of handovers were completed within 60 minutes, against the contractual standard of 100%. 97% were within 45 minutes. 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: sustained high rate of conveyance to the Emergency Department, with low conveyance rates to non-ED destinations.
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 2. Acute medical conditions. 3. Increase in ambulance handover capacity – escalation capacity remains in place to support peaks in demand 4. Daily validation of >45-minute ambulance arrivals, with feedback provided to ambulance trusts where data quality issues are identified 5. Transfer of Care 45 - further standard work to embed the ToC 45 culture at Bassetlaw.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee
Risk register	Risk 3437



Assurance report

Diagnostic Waiting Times

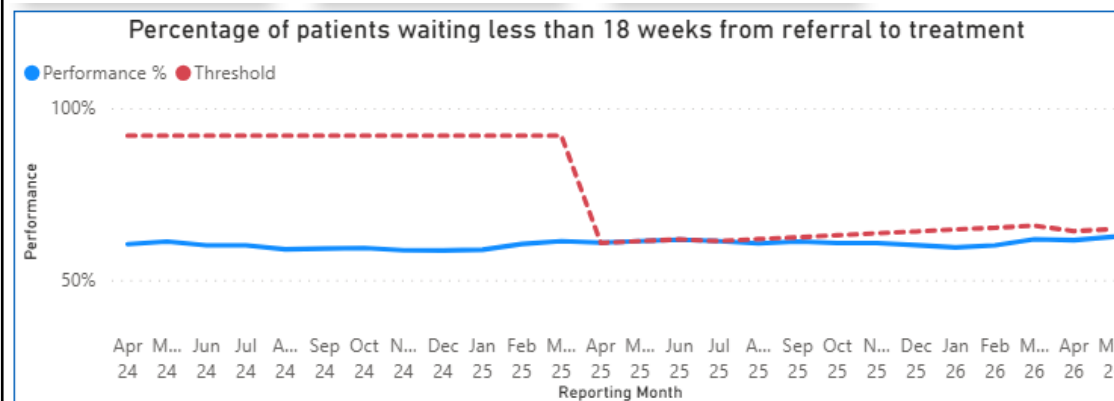
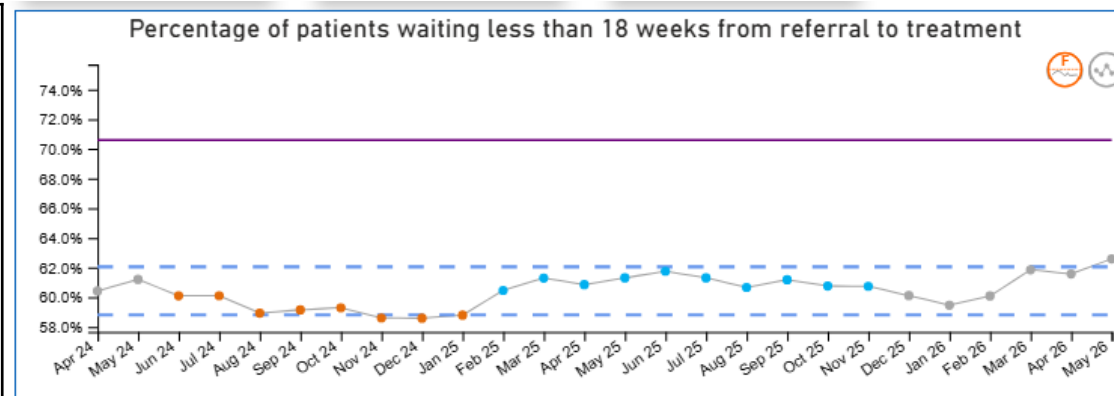
Summary of challenges & risks	In May 2026 DM01 performance was at 75.8% against a trajectory of 77.9%. The Trust ranked 110 out of 154 Acute Trusts. A total of 3,438 patients waited > 6 weeks, of these 1,618 were in MRI, 874 were in Audiology and 628 were in Non obstetric ultrasound (NOUS). - MRI accounts for 25% of the total diagnostic waiting list and 46% of all patients waiting > 6 weeks. - NOUS accounts for 37% of total waiting list and 18% of all patients waiting > 6 weeks. - Audiology accounts for 9% of the total waiting list and 25% of all patients waiting over 6 weeks NOUS performance improved from 74.6% in April to 88.5% in May.
Actions to address risks, issues and emerging concerns relating to performance and forecast	- External support is in place for the diagnostic improvement work stream, focussed on optimisation of all diagnostic capacity, with a particular focus on Radiology and Endoscopy - Plans progressing to replacing aging MRI scanners with a potential date to go live with new equipment in Oct 2026. - Text messaging reminders commenced in May to help reduce DNA rates for Ultrasound patients. This is also being planned to be extended to MRI patients.. - Mexborough CDC criteria being reviewed to explore use of elective contrast slots to help improve utilisation.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee.
Risk register	



Assurance report

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

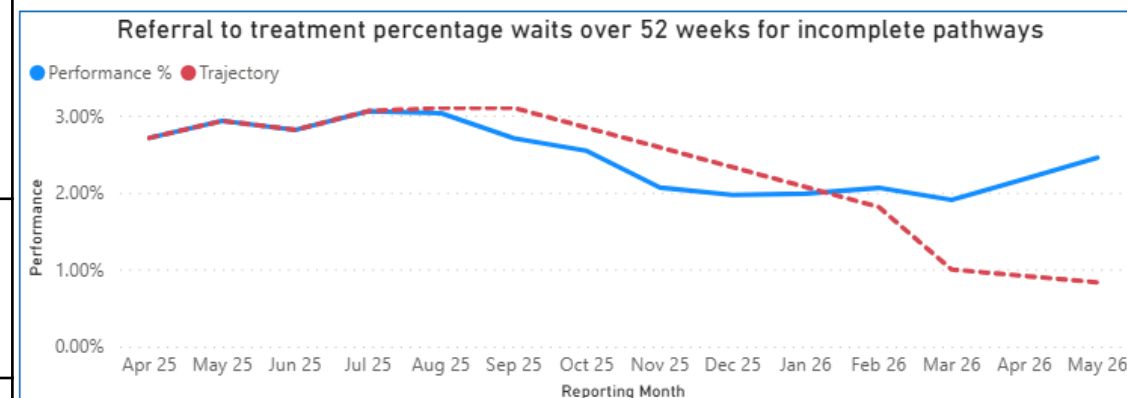
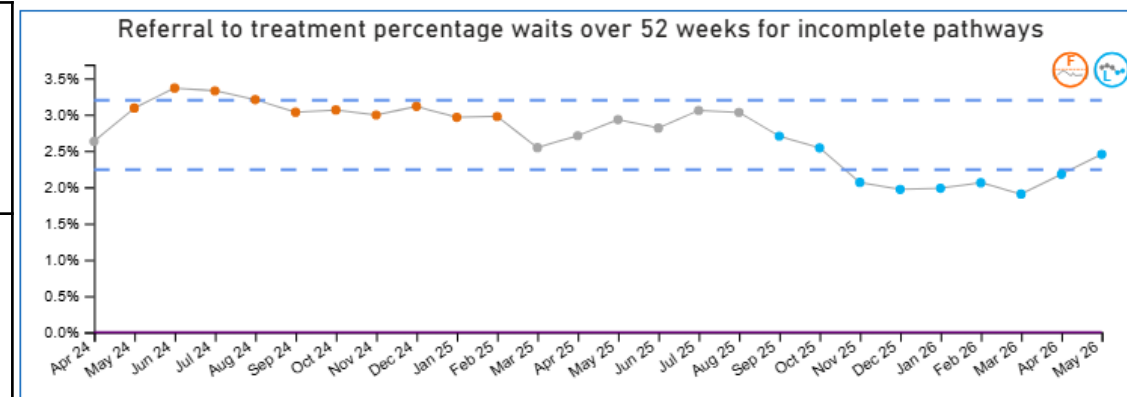
Summary of challenges & risks	In May 2026, 62.6% of patients were waiting < 18 weeks from referral to treatment, against the planning trajectory of 64.8%. Referral to Treatment (RTT) performance is comprised of admitted and non-admitted pathways, with notable performance variation between the two. Admitted performance in May 2026 was 39.3% and non-admitted performance was at 68.1%. 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 May was 51.6%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Key actions to improve performance include: 10 priority specialties have been agreed for the single point of access national programme. The priority specialties are ENT, General surgery, Max Fax, Ophthalmology, Pain - management, Gynaecology, Respiratory, Gastroenterology, Dermatology and Diabetes. - Expressions of interest are being sought for clinical leadership roles to support outpatient and theatres programmes of work. - Non-admitted RTT: Continuing to improve on validation levels for patients using text messaging: 12w validation performance end of May was 53.4%. Opportunities to reduce data quality issues on the waiting list through technical validation is being strengthened. Improving booked and actual clinic utilisation through the new clinic 642 process which is planned to commence in June. - Admitted RTT : Actual Theatres utilisation in May remained over 80%. To further improve theatre utilisation, further work is being undertaken to optimise pre assessment capacity. Process of patients being pre-called prior to surgery is being strengthened in addition to text messaging.
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

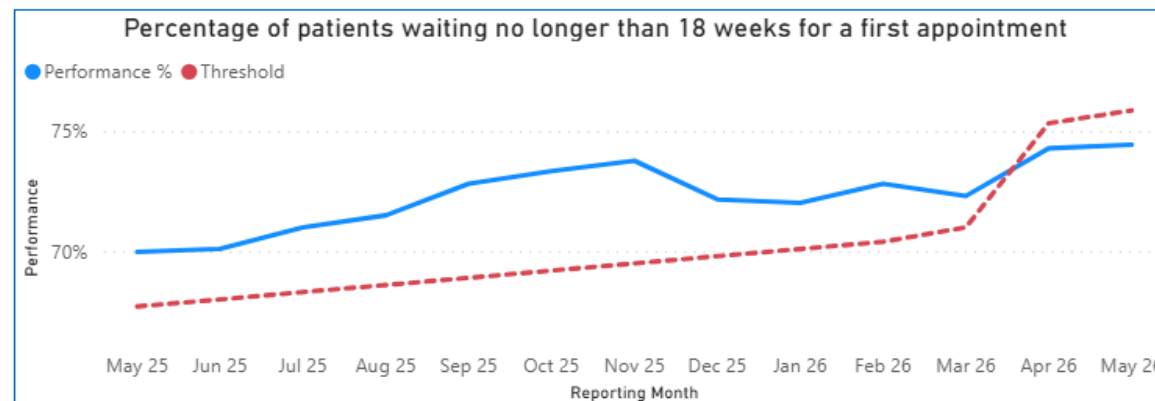
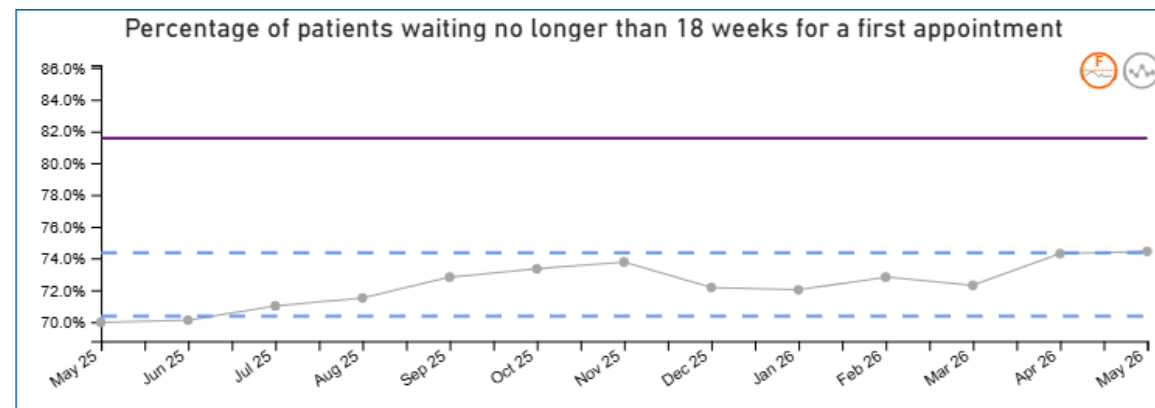
Summary of challenges & risks	In May 2026, 2.5% of patients on incomplete RTT pathways had been waiting over 52 weeks, against the plan of 0.4%. A total of 1,067 patients were waiting longer than 52 weeks at month-end, with Trauma and Orthopaedics (T&O) and ENT accounting for c. 96% of these. Trauma & Orthopaedics remains the Trust's highest-risk specialty, and improvement in this specialty 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 delivery plan in place for RTT across all specialties and an elective recovery action plan specific to T&O. The T&O recovery action plan is structured around six 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. Demand and capacity modelling for T&O demonstrates the additional capacity required to clear the current backlog and the additional capacity required to deliver sustainable improvements.
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

Percentage of patients waiting no longer than 18 weeks for a first appointment

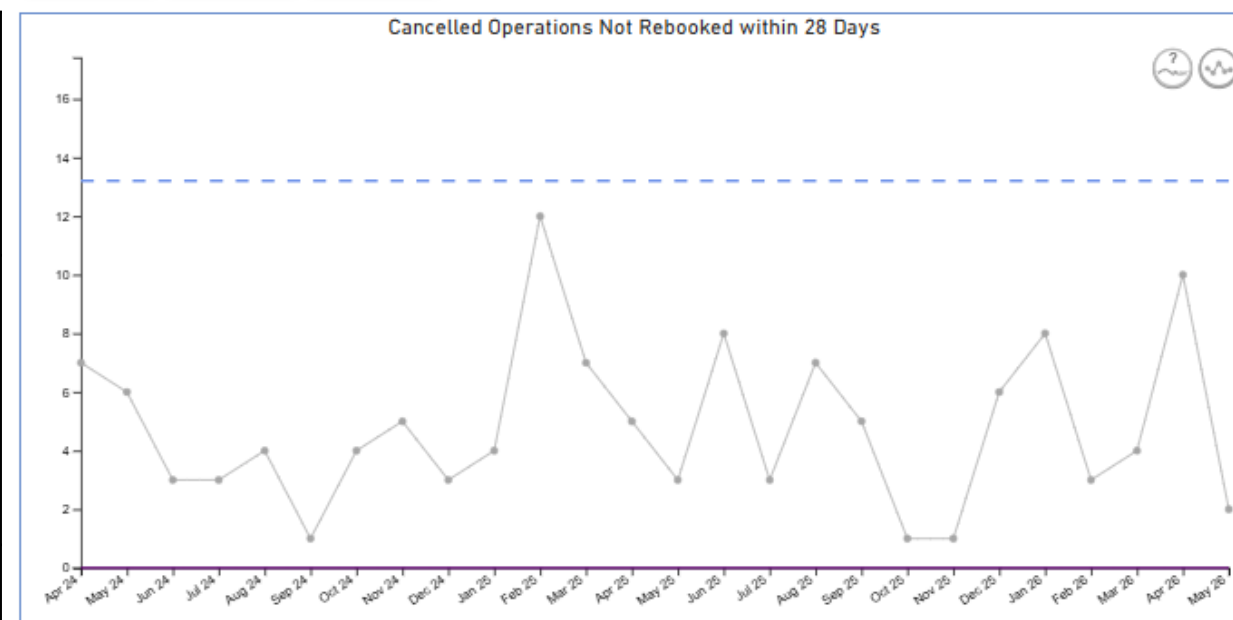
Summary of challenges & risks	In May 2026 74.4% of patients were waiting no longer than 18 weeks for a first appointment, against the trajectory of 75.9%.
Actions to address risks, issues and emerging concerns relating to performance and forecast	External support is in place for the outpatient improvement work stream, this is focussed on standardised clinic templates and improving booked utilisation, which will improve the waiting times for first outpatient appointment Revised clinic 642 clinic planning meeting will be launched in June which will run weekly with a revised Terms of reference and SOP As part of the Single point of Access programme, the process for advance and guidance is being standardised.
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

Cancelled operations not rebooked within 28 days

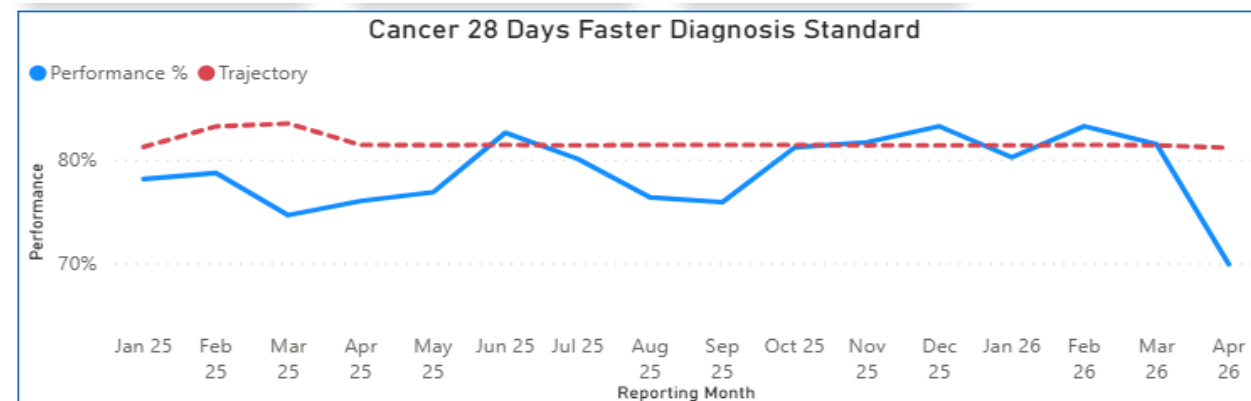
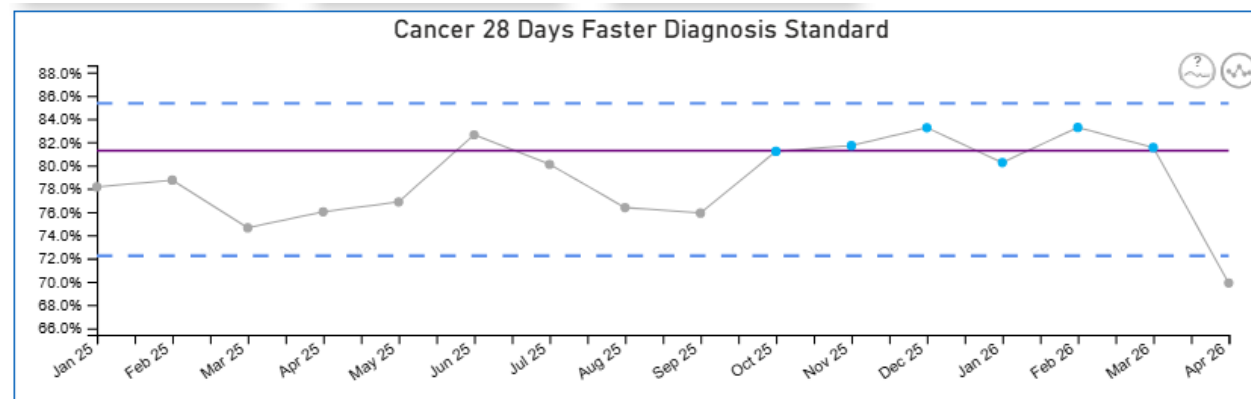
Summary of challenges & risks	There were 2 breaches of the 28-day guarantee in May 2026 against the standard of 0. The breaches were in the following specialties: 1 x Trauma & Orthopaedics Cancelled due to Surgeon unwell and insufficient capacity 1 x Ophthalmology Cancelled due to lens not available and Emergency patient took priority
Actions to address risks, issues and emerging concerns relating to performance and forecast	Oversight of cancelled operations and re-booking within 28 days is included in the Trust Access Group, chaired by the Head of Elective Care.
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

Cancer 28 Days Faster Diagnosis Standard

Summary of challenges & risks	In April 2026, the Trust performance was 69.9%, against the plan of 81.2%. A total of 542 patients breached the 28 day faster diagnosis standard. Performance deterioration was largely attributable to the Breast pathway, with performance of 48.7 in April 2026, a deterioration of 35.9% compared to March 2026. This was primarily due to limited capacity to provide one-stop clinics in conjunction with radiology services, leading to delays in the diagnostic pathway.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Additional funding received from the Cancer Alliance to increase capacity within Radiology and Breast outpatients.
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: 2.30

Key Performance Indicator	Period	Target	🏆	SPC	Segment Position	Score
⋮ Avg Days Ready Date to Discharge (inc 0 day delays)	Mar 26	-	0.2	📉		1.33
⋮ CQC inpatient survey satisfaction rate	2024	-	4.0	📉		2.00
⋮ Summary Hospital Mortality Indicator	Dec 25	-	1.15	📉		3.56

▼ Patient Safety

5 KPIs Mean Score: 2.67

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	Mar 26	0	4	📈		2.81
⋮ Proportion of C-Difficile infections against threshold	Mar 26	1.00	1.38	📈		3.41
⋮ Proportion of E-Coli bacteraemia against threshold	Mar 26	1.00	1.03	📉		2.06
⋮ Staff Survey - Raising Concerns sub-score	2024	-	6.53	📉		2.08

Key performance indicators - Quality

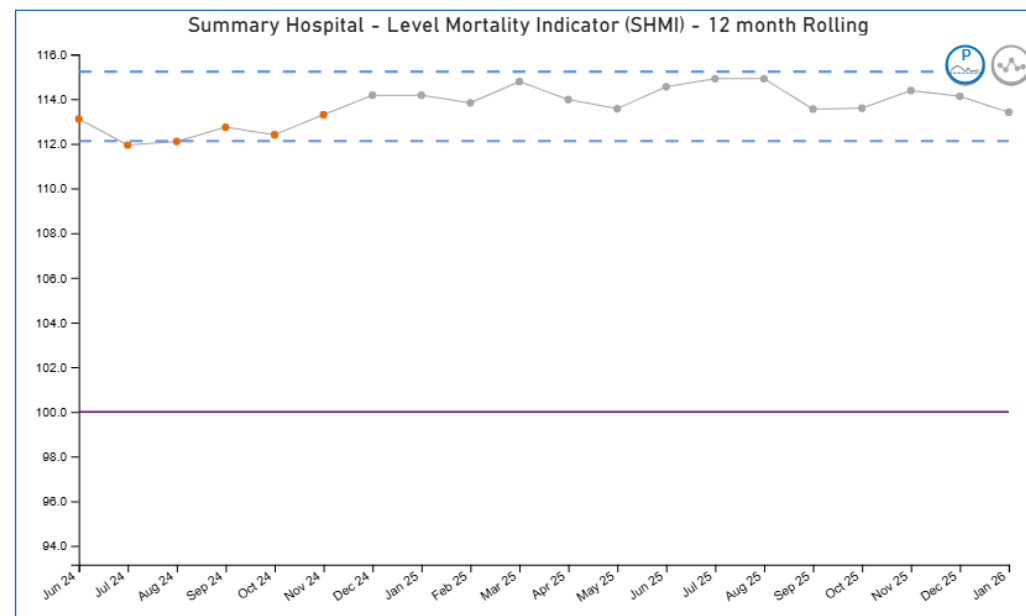
Metric	Month	Current Period			Year to date		
		Threshold	Actual	Variance	Threshold	Actual	Variance
Summary Hospital - Level Mortality Indicator (SHMI) - 12 month Rolling	Jan-26	100	113.4	13.4	100	113.4	13.4
Summary Hospital - Level Mortality Indicator (SHMI) - Monthly	Jan-26	100	99.1	-0.9	100	99.1	-0.9
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Colonisation) cases reported in Month	May-26		0			0	
Hospital Acquired Methicillin-resistant Staphylococcus aureus (MRSA, Bacteraemia) Cases Reported in month	May-26		0			2	
Number of Hospital Onset Healthcare associated (HOHA) Clostridioides difficile cases in month	May-26		3			12	
Number of Community Onset Healthcare associated (COHA) Clostridioides difficile cases in month							
Overall Number of HAPUs / 1000 bed days	May-26		1.2			1.06	
Escherichia coli	May-26		16			16	
Complaints Not Signed Off In Agreed Timeframe	May-26		0			1	
Percentage over 18 in-hospital deaths scrutinised by Medical Examiner Team	May-26	100%	100.0%	0.0%	100%	100.0%	0.0%
Venous Thromboembolism - percentage of patients having a Risk Assessment	May-26	95%	96.0%	1.0%	95%	96.9%	1.9%
National Institute for Health and Care Excellence (NICE) Guidance Response Rate Compliance	May-26	90%	97.8%	7.8%	90%	97.9%	7.9%
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	May-26	90%	53.2%	-36.8%	90%	52.3%	-37.7%
Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis	May-26	90%	70.0%	-20.0%	90%	63.0%	-27.0%
Emergency readmissions within 30 days of discharge from hospital (Rolling 12 month)	May-26		11.5%			11.5%	



Assurance report

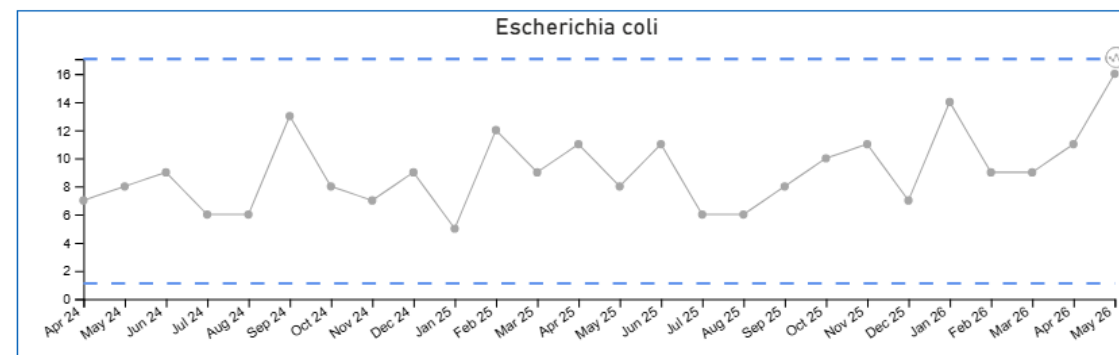
Summary Hospital - Level Mortality Indicator (SHMI)

Summary of challenges & risks	The 12 month rolling SHMI in January 2026 was 113.4 against a trajectory of 100. Monthly SHMI in January 2026 was 99.1 against a trajectory of 100. SHMI (12 month rolling) The SPC chart shows typical month-to-month variation, with performance consistently above the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	- The Trust has now remained within national control limits for a prolonged period, providing assurance that mortality outcomes are not exhibiting special cause variation. - In response to Trust Board and Quality Committee discussions, further strengthening of mortality surveillance, divisional scrutiny and use of specialty-level data has been progressed. - 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.
Action timescales and assurance group or committee	Ongoing monitoring of performance and improvement work, overseen by the Mortality Data Assurance Group and Mortality Governance Group, with assurance provided to Effective Assurance Group and Quality Committee.
Risk register	No



Assurance report

Escherichia Coli

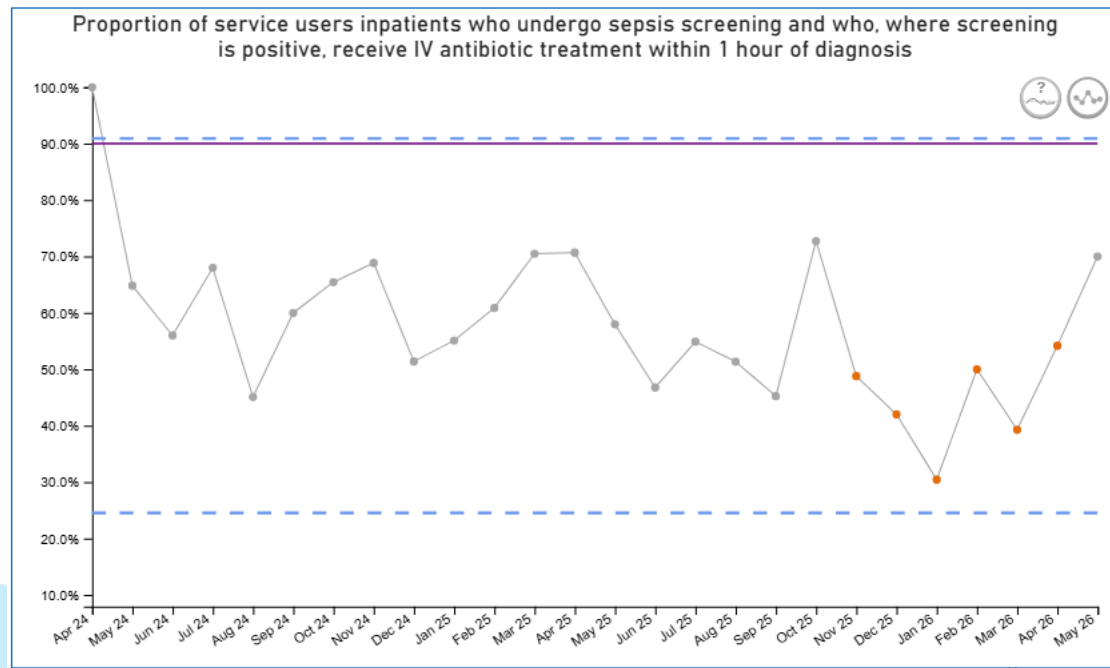
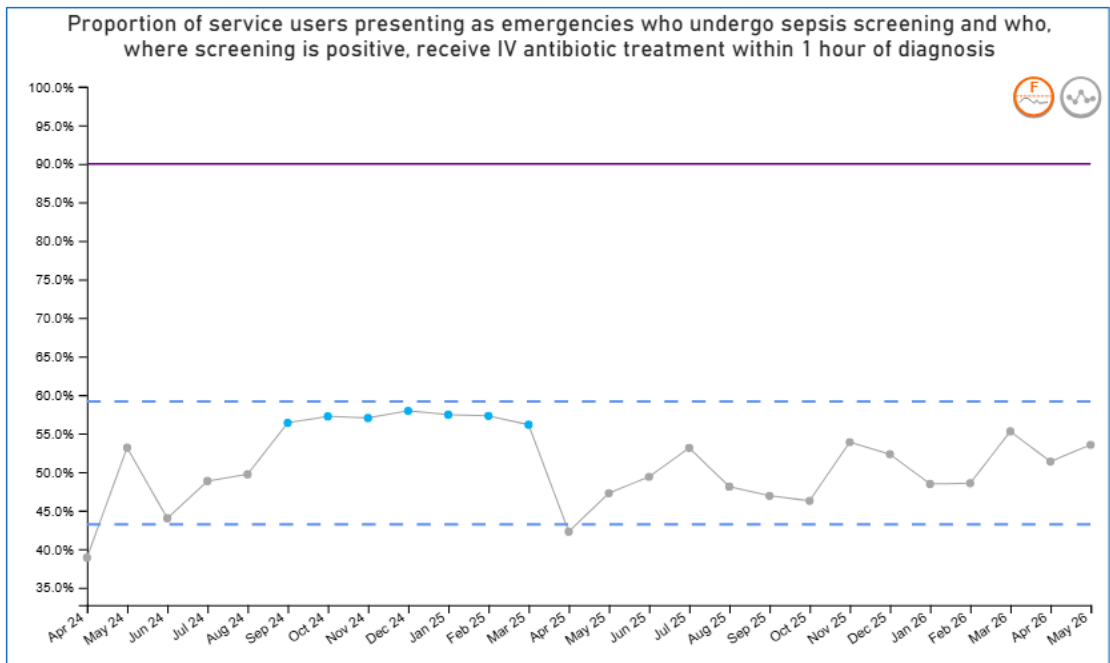


Summary of challenges & risks	In May 2026 there were 16 cases of E.coli in month. The SPC charts show typical month-to-month variation, with performance consistently better than the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Current controls provide a structured and multi-layered approach: Infection Prevention & Control (IPC) Focused programme of prevention and control measures targeted at key contributory factors. Oversight of catheter care practice through reinforcement of best practice standards, targeted audit and feedback to clinical areas. Hand hygiene compliance monitored monthly by the IPC Team. Continued focus on improving bare below the elbows compliance where this remains variable. Surveillance and Monitoring Ongoing education, surveillance and monitoring of IPC interventions are in place. Findings are reviewed and fed back to services to support timely corrective action where required. Targeted Improvement Actions Targeted work continues to strengthen catheter care and improve compliance with Prontoderm foam use in relevant clinical areas. Antimicrobial stewardship work remains active, including focused improvement support in Ward 19 (Urology), AMU and Ward 27. The importance of hydration continues to be promoted as part of the wider preventative approach to reducing infection risk. A Kurin lock trial is scheduled to commence in ED and Paediatrics in June to support reduction in blood culture contamination and strengthen diagnostic reliability.
Action timescales and assurance group or committee	Governance and Oversight - Assurance is provided through ongoing IPC audit activity, with results routinely fed back to ward areas to support local accountability and improvement. - The IPC real-time dashboard continues to be used to monitor trends across divisions, enabling earlier identification of variation and targeted intervention where required. - Performance, themes and mitigating actions are overseen through established governance routes, including Divisional Governance, ICOG and TWIG, providing continued organisational scrutiny and assurance. Assurance Controls are actively monitored through established audit, dashboard and governance arrangements, providing ongoing organisational oversight and assurance.

Assurance report

Sepsis antibiotics completed within 1 hour

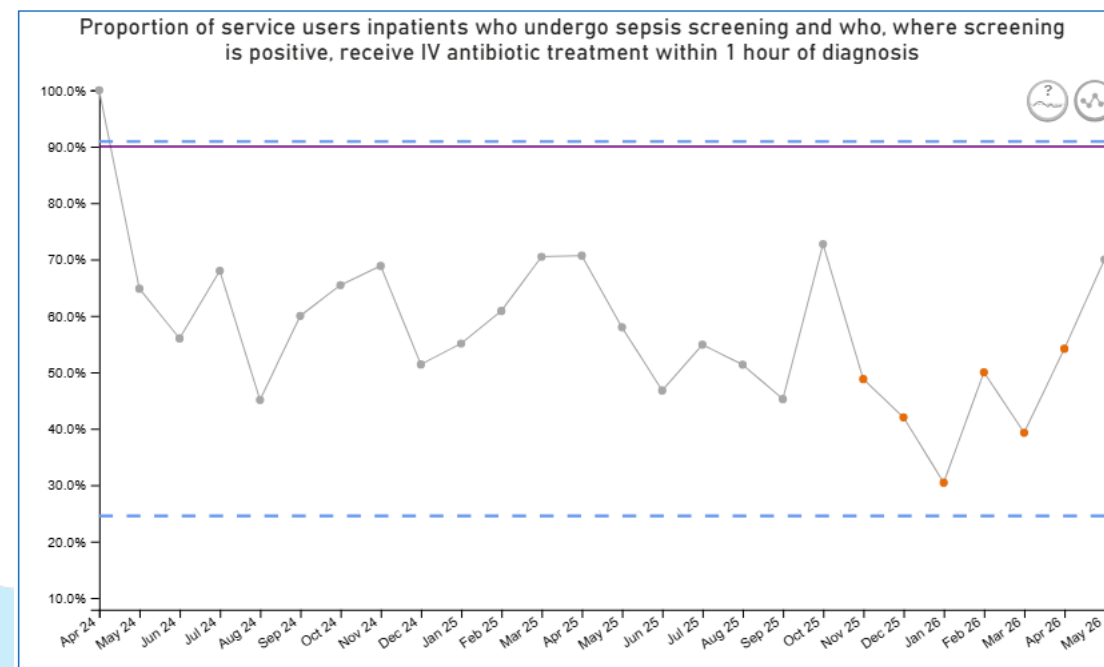
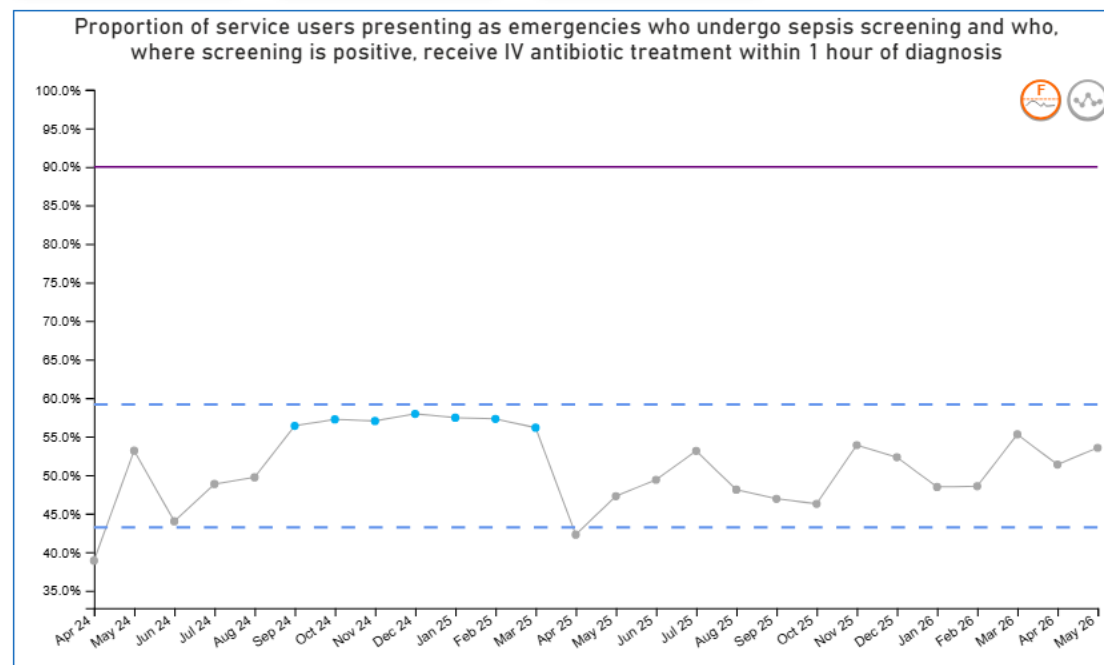
Summary of challenges & risks	For May 2026, the Proportion of service users inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within 1 hour of diagnosis in A&E was 53.2% against a trajectory of 90%, as an Inpatient performance was 70.0% against a trajectory of 90%. The SPC charts for A&E show typical month-to-month variation, consistently performing below the expected level. The SPC charts for inpatients show 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	Sepsis deep dive report presented to Quality Committee in June, with assurance that the Trust has a robust and mature approach to sepsis management, underpinned by a comprehensive learning system, effective governance arrangements, and sustained Quality Improvement (QI) activity. • All sepsis-related deaths are systematically reviewed through Structured Judgement Reviews (SJRs) and oversight by the Sepsis Action Group (SAG). • Outcomes, measured through Summary Hospital-level Mortality Indicator (SHMI), remain within expected range with no sustained outlier signal. • Clinical practice demonstrates consistent strengths in early recognition and escalation, providing a solid foundation for ongoing improvement. • Risks are identified, understood and actively managed, particularly in relation to timely antibiotic administration and system pressures.



Assurance report

Sepsis antibiotics completed within 1 hour

Summary of challenges & risks	For May 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 53.2% against a trajectory of 90%, as an Inpatient performance was 70.0% against a trajectory of 90%. The SPC charts for A&E show typical month-to-month variation, consistently performing below the expected level. The SPC charts for inpatients show 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	Key priorities for 2025/26 include: • Increase IPOC utilisation to >50% to promote comprehensive sepsis care and improve data reliability • Increase compliance with antibiotics within 1 hour for high risk sepsis to >50% on AMU and SAU • Improve compliance with antibiotics within 1 hour for febrile neutropenia to >50% in ED/SDEC • Establish SDEC pathway for low risk febrile neutropenia • Improve recognition of sepsis in deteriorating patients • Improve blood culture sampling rates • Strengthen balance between sepsis care and antimicrobial stewardship • Work with colleagues in Digital and Information teams to ensure electronic systems are aligned with national guidelines in Sepsis reporting by risk categorisation
Action timescales and assurance group or committee	Ongoing April 2026-March 2027 Work driven by Sepsis Action Group who report into Mortality Governance Group



Key performance indicators - Finance

Metric	Latest month reported	Plan £'000	Actual £'000	Variance £'000	
YTD Surplus/(Deficit) excluding DSF	May-26	4,263	4,261	2	●
YTD ERF Income	May-26	(20,500)	(20,467)	33	●
YTD IDP	May-26	5,452	5,452	0	●
YTD Total pay spend	May-26	73,283	73,243	(39)	●
<i>Included within above overall pay position:</i>					
YTD Bank pay	May-26	2,364	3,035	671	●
YTD Agency pay	May-26	1,196	1,808	612	●
YTD Capital Investment	May-26	2,265	533	(1,732)	●
Cash balance (1)	May-26	26,985	18,899	(8,086)	●
YTD Payment policy (BPPC metrics) (2)	May-26	95.0%	73.0%	-22.0%	●

(1) Variance is as a result of phasing of capital creditors from March 2026 and DSF, therefore timing difference. If continued, assurance statement will be produced

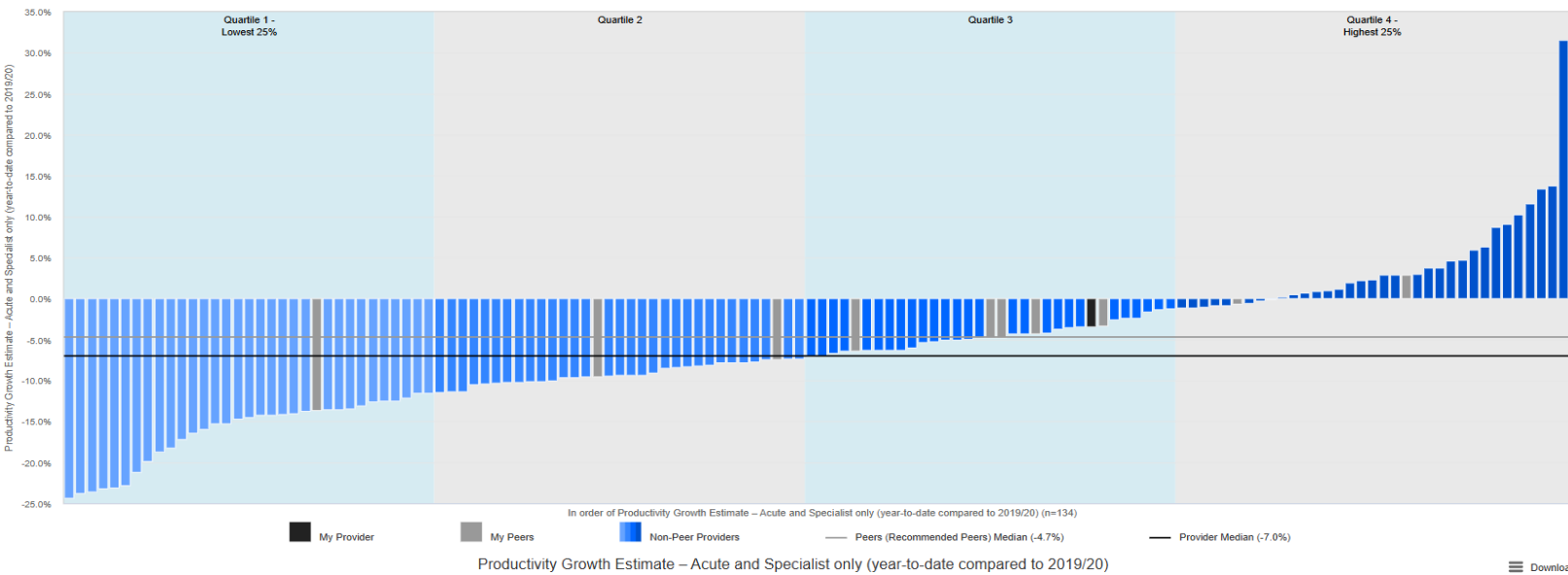
(2) This covers both NHS and Non NHS invoices and is calculated on a value basis



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

Productivity Growth Estimate – Acute and Specialist only (year-to-date compared to 2019/20), National Distribution

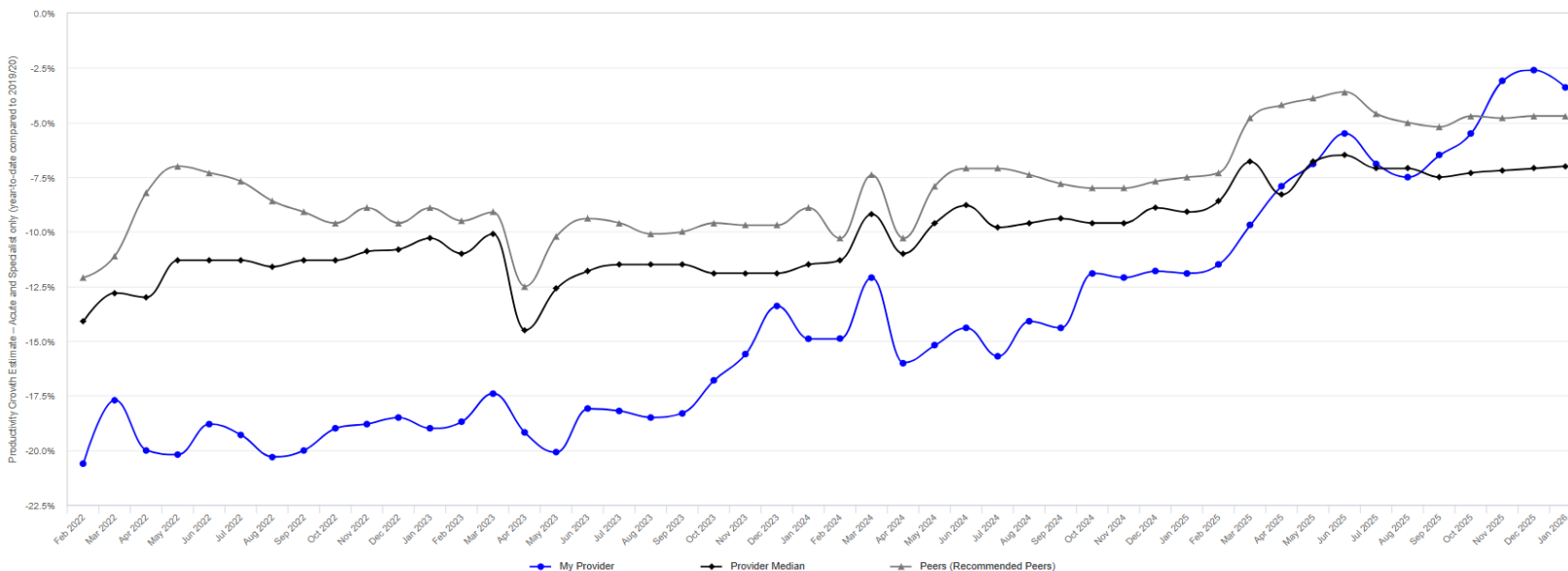
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The most recently published data (year to M10 25/26 YTD) shows DBTH implied productivity is 3.4% below pre-covid (2019/20) levels (last month: 2.6%). This places the Trust in the second-best quartile of performers nationally and is better than the national median (-7.0%) but worse than the median of the group of peer Trusts selected by NHS England (-4.7%).

The peer group is:

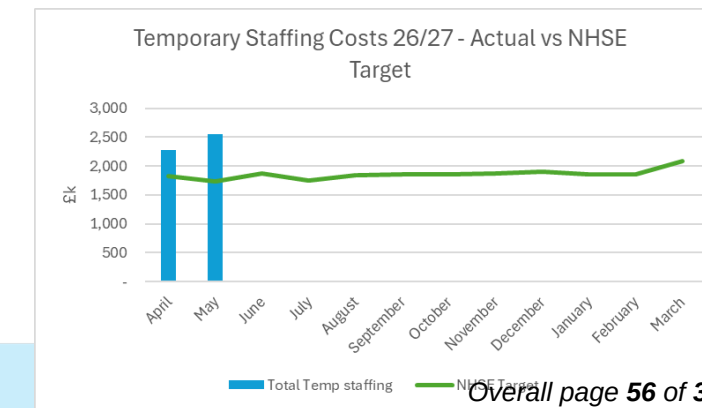
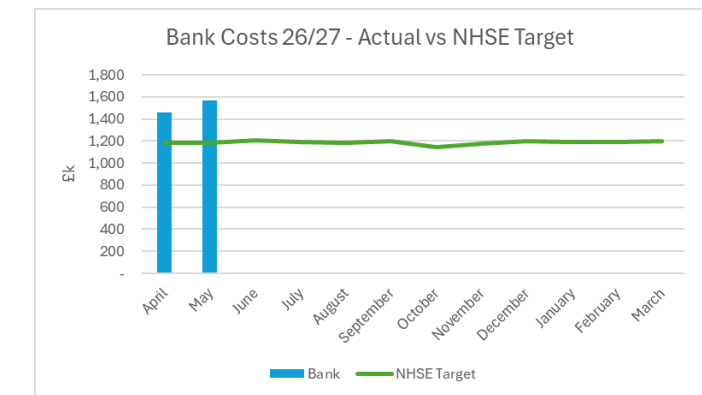
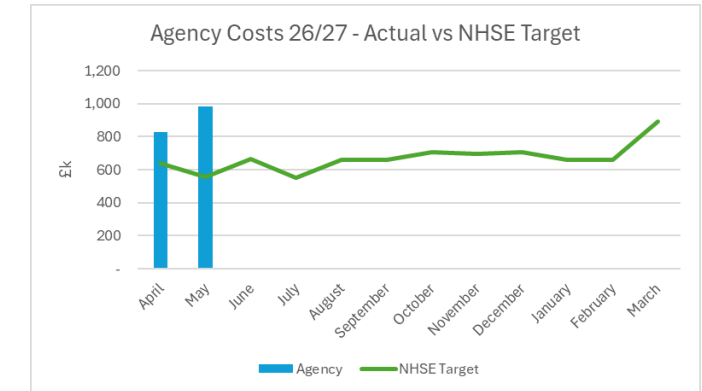
- Bradford Teaching Hospitals (-13.6%)
- Sherwood Forest Hospitals (-9.5%)
- Barnsley Hospital (-7.4%)
- Bolton Hospital (-6.4%)
- Northern Lincolnshire & Goole (-4.7%)
- North Tees and Hartlepool (-4.7%)
- Wrightington, Wigan and Leigh Hospitals (-4.3%)
- DBTH (-3.4%)**
- Wirral University Hospital (-3.4%)
- County Durham & Darlington (-0.6%)
- East Sussex (+2.9%)



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 The Monthly Agency and Bank Workstream Steering Group contributes to the Workforce and Organisational Pillar, which in turn informs the Reset Board as a component of the Reset programme. Monthly tracking of all actions via Monday.com F&P monthly updates
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 be monitored at Cash Committee on a monthly basis and reported in the monthly Finance Report at Finance and Performance Committee.
Risk register	Failure to achieve cash releasing savings in line with plan leads to failure to generate sufficient cashflow 4x4=16.

Invoice Turnaround							
Average days	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Between date of invoice and date available on system	16.6	12.6	16.3	18	16.7	12.5	14.6
Between being available on system and approval	13.4	12.1	25.7	12.7	8	8.1	8.05
Between approved date and payment date	18.8	16.5	18.6	18.9	24.1	21.1	22.6
Total	48.8	41.2	60.6	49.6	48.8	41.7	45.25
Total that the Trust has control over	32.2	28.6	44.3	31.6	32.1	29.2	30.65
<i>Number of invoices</i>	<i>10,728</i>	<i>7,054</i>	<i>7,474</i>	<i>9,726</i>	<i>8,981</i>	<i>7,645</i>	<i>8,313</i>
Better Payment Practice Code (In month)							
Average days	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
NHS - %age based on invoice count	85.85%	59.09%	86.61%	90.34%	63.89%	86.96%	75.43%
NHS - %age based on invoice value	92.50%	50.37%	88.02%	86.94%	77.26%	84.89%	81.08%
Non NHS - %age based on invoice count	34.23%	40.95%	34.95%	39.08%	35.99%	31.80%	33.90%
Non NHS - %age based on invoice value	80.47%	65.41%	78.77%	79.04%	75.08%	69.76%	72.42%
Overall - %age based on invoice count	36.01%	41.18%	36.50%	40.15%	37.25%	32.87%	35.06%
Overall - %age based on invoice value	82.79%	64.97%	79.92%	79.63%	75.31%	70.69%	73.00%



Assurance report

ERF

Summary of challenges & risks	Year to date, the Trust was 33k below plan for the associated ICB in relation to ERF activity. Although the Trust delivered 111 cases above plan overall, this overperformance was driven by new outpatient appointments and outpatient procedures. Performance in elective activity remained below plan, with elective procedures 17 cases below plan and day case procedures 48 cases below plan.
Actions to address risks, issues and emerging concerns relating to performance and forecast	Theatre Improvement Programme (Supported by GIRFT) commenced in Q4 of 2025/26. The Trust's theatre utilisation remained above 80% in May, demonstrating continued efficient use of theatre capacity. To further improve utilisation and maximise elective activity, work is underway to optimise pre-assessment capacity. In addition, processes for pre-operative patient contact are being strengthened through enhanced pre-operative telephone calls alongside text message reminders, with the aim of reducing avoidable on-the-day cancellations and improving theatre productivity.
Action timescales and assurance group or committee	Monthly reporting to the Finance and Performance Committee
Risk register	Risk 3435 Timely access to elective care

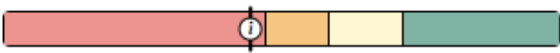
ICB	ERF	Plan M2	Actual M2	Variance	Notes
South Yorkshire	(91,652)	(14,770)	(14,199)	571	No variance transacted
Nottinghamshire	(31,100)	(5,012)	(4,897)	115	
Lincolnshire	(758)	(122)	(104)	18	
Derbyshire	(1,036)	(167)	(168)	(1)	
West Yorkshire	(749)	(121)	(177)	(56)	
Humber & North Yorkshire	(1,911)	(308)	(351)	(43)	
Total	(127,206)	(20,500)	(19,896)	33	



NHS Oversight Framework 2025/26 Key performance indicators - People

▼ People & Workforce

2 KPIs Mean Score: 3.31

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
⋮ Sickness Absence Rate QTD	Q4 25/26	-	5.99%			3.48
⋮ Staff Survey - Engagement Theme Score	2024	-	6.74			3.14



Key performance indicators - People

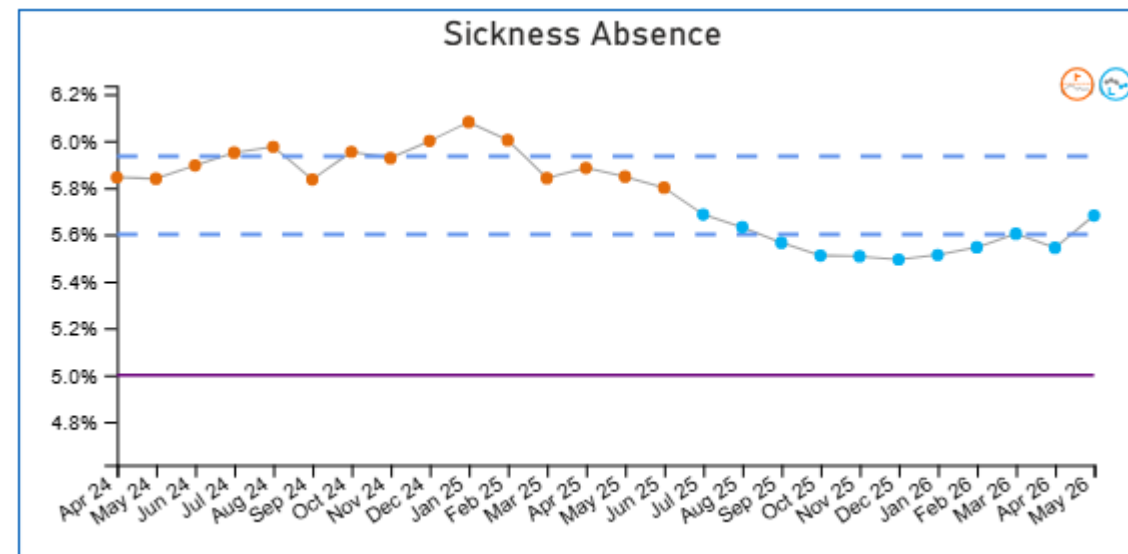
Metric	Standard 25/26	Source & Description	Latest month reported	Current month		
				Local trajectory	Actual	Variance
Employee Turnover	10%	NHS Long Term workforce plan	May-26	10.0%	9.8%	-0.2%
Overall Sickness Absence	5%	DBTH Trust agreed	May-26	5.0%	5.7%	0.7%
Completed Statutory and Essential Training (SET)	90%	DBTH Trust agreed	May-26	90.0%	84.10%	-5.9%
Medical Appraisals completed (rolling 12 months)	95%	NHS England	May-26	95.0%	82.8%	-12.2%



Assurance report

Sickness Absence

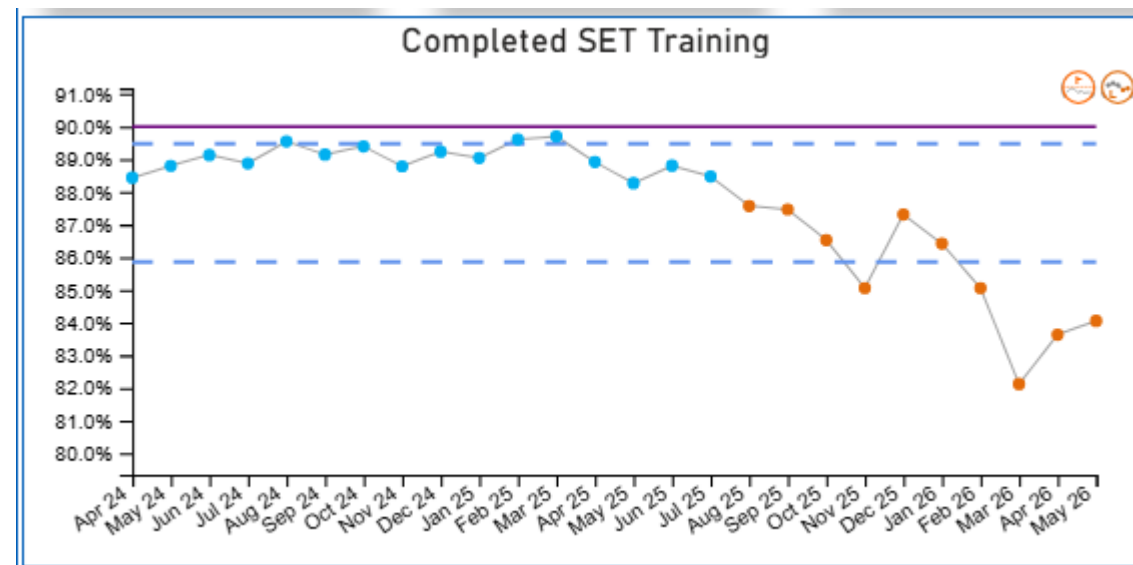
Summary of challenges & risks	Trust wide Sickness absence in May 2026 was 5.6% against at target of 5% The SPC chart shows results outside the expected range but still below the expected level. The trend continues to show an improving position and shows a reduction.
Actions to address risks, issues and emerging concerns relating to performance and forecast	- Continued development of the revised sickness absence policy with a refreshed focus on managing attendance, supportive discussions with staff side colleagues in terms of the approach. On track to go to Policy Formulation Group in June 2026. - Planned launch and implementation of new policy in Q2 supported by refreshed training and guidance for line managers - Continued support for managers through absence workshops - Regular KPI clinics/absence workshops for managers being provided through People & OD. - Overall rates reviewed with Exec oversight at the Performance Review Meetings. Divisional and corporate targets confirmed in Q1. - Improvement work ongoing supporting absence management for medical colleagues with input from medical leaders - DBTH identified by NHS England as an example of good practice in relation to the management of sickness absence and supporting wellbeing.
Action timescales and assurance group or committee	- Policy due for discussion and ratification at Policy Formulation Group (PFG) in June 2026 - All actions with deadlines in relation to improving attendance and sickness absence management are tracked on Monday.com and monitored through the Bank & Agency Optimisation Group workstream with monthly steering group meetings, chaired by the CPO/CFO
Risk register	2554



Assurance report

Completed Statutory and Essential Training (SET)

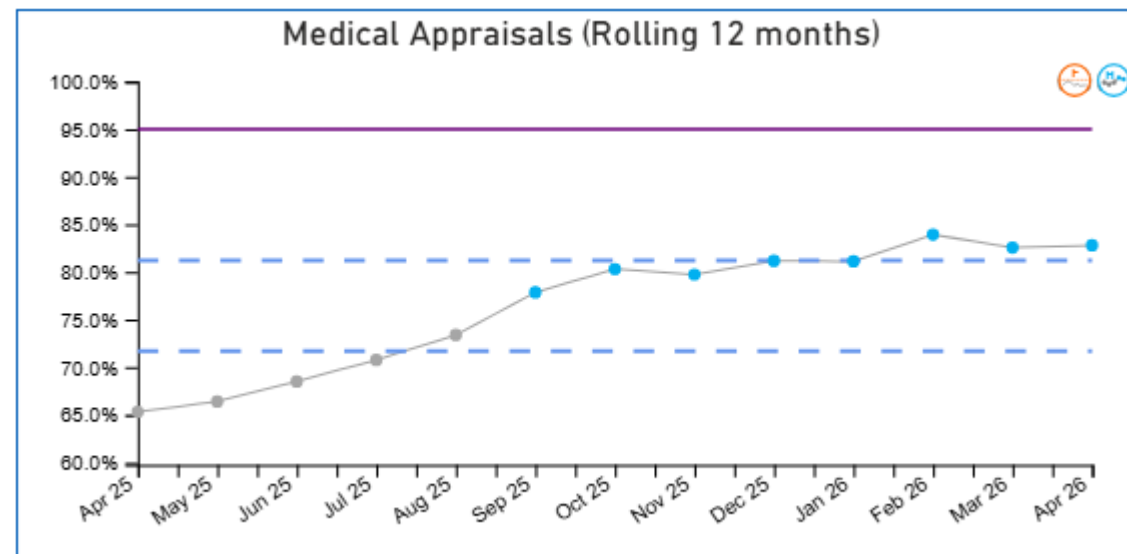
Summary of challenges & risks	In May 2026 Trust SET training compliance was 84.1% against a trajectory of 90% The SPC chart shows typical month-to-month variation — performance naturally moves around the expected level.
Actions to address risks, issues and emerging concerns relating to performance and forecast	• 360 Assurance audit commissioned and report received in June 2026 - Significant Assurance audit. • Audit actions to be completed with deadlines Q2/3 • New Mandatory and Learning Oversight Group (MLOG) introduced and oversight process through Hospital Leadership Team agreed in Q1 (aligning to the national timelines). • Findings from Resus deep dive work supported at Hospital Leadership Team in June 2026. Review undertaken due to this being an area of lower compliance. • Executive oversight of compliance rates at Performance Review Meetings. • 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 June 2026 and at every meeting • NHSE project work in line with national timescales • Workforce & Education Group reports – every meeting • 360 Assurance audit – Q1 completion Significant Assurance, actions Q2/3
Risk register	16



Assurance report

Medical Appraisals (Rolling 12 months)

Summary of challenges & risks	In May 2026 the rolling 12 month performance for medical appraisals was 82.8% against a trajectory of 95%
Actions to address risks, issues and emerging concerns relating to performance and forecast	As of May 2026, the rolling 12-month performance for medical appraisals stands at 82.8%, below the 95% trajectory. While this metric tracks monthly compliance, it does not fully reflect year-end performance. Notably, as of 31 March 2026, we achieved 100% compliance for medical appraisals for the 25/26 year. However, monthly compliance fluctuates due to the alignment of appraisal dates with individual start dates across the year.
Action timescales and assurance group or committee	To ensure continued compliance and mitigate risks, we are actively monitoring appraisal completions each month. Appraisers and appraisees have one month to finalise their appraisals, so current figures may improve as outstanding appraisals are signed off. Any medics who do not participate in the appraisal process will be managed in line with our Medical Appraisal Policy, which initiates a non-participation process. We anticipate maintaining 100% compliance at year end for 26/27, and will continue to review and escalate any concerns promptly.
Risk register	Monthly monitoring and reporting are in place, with figures updated as appraisals are completed. The Medical Appraisal Policy is strictly followed, and any non-compliance is reported to the relevant assurance committees (People Committee). May 2026 figures will be submitted in July, reflecting the finalised appraisals.





Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust





Finance And Activity Report

May 2026



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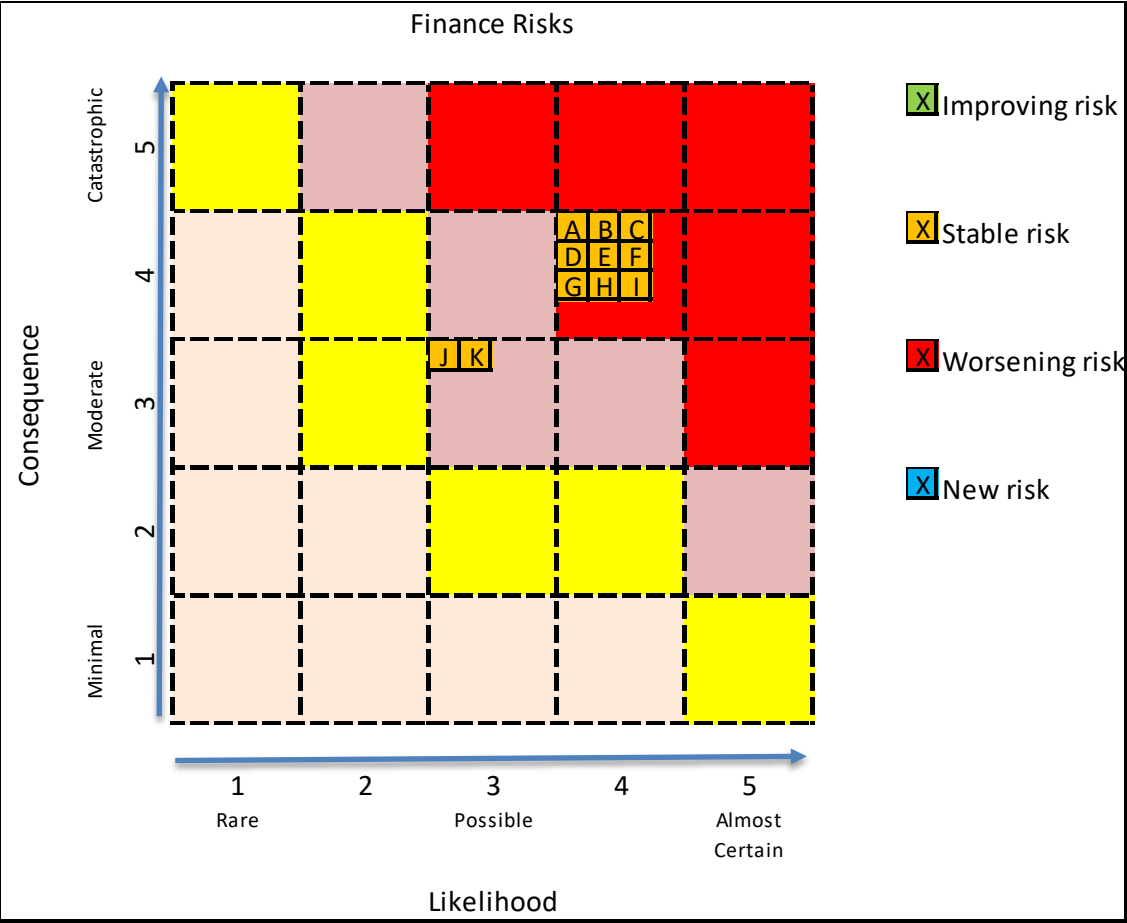
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SECTION 1

Financial Risks

Financial Risks



Ref	Title
A	Failure to develop fully developed recurrent schemes leads to failure to deliver recurrent savings at the required rate
B	Failure to redesign services leads to failure to improve implied productivity at the required rate
C	Failure to develop workforce models and job plans results in failure to improve implied workforce productivity at required rate
D	Failure to secure income, deliver funded activity and demand schemes results in failure to improve implied workforce productivity
E	Failure to control establishment, drift and industrial action costs leads to failure to maintain pay costs within planned levels
F	Failure to manage inflationary pressures, variable costs and capitalisation leads to failure to maintain non pay costs within plan
G	Failure to secure clinical ownership and develop schemes leads to failure to deliver planned levels of savings
H	Failure to develop business cases and secure funding and MOUs leads to failure to deliver the capital programme
I	Failure to achieve cash releasing savings in line with plan leads to failure to generate sufficient cash flow
J	Failure to verify mandate changes may lead to fraudulent payments and financial loss to the Trust
K	Incomplete counter fraud checks may lead to hiring unsuitable staff, risking financial and reputational harm

Updates

- All risks have been refreshed and reassessed for 2026/27.
- The risks are higher than during the second half of 2025/26 because of the significant efficiency programme within the financial plan and the length of time to year end, which increases the scope for downsides to occur.
- Industrial Action costs have been mitigated in the position.

SECTION 2

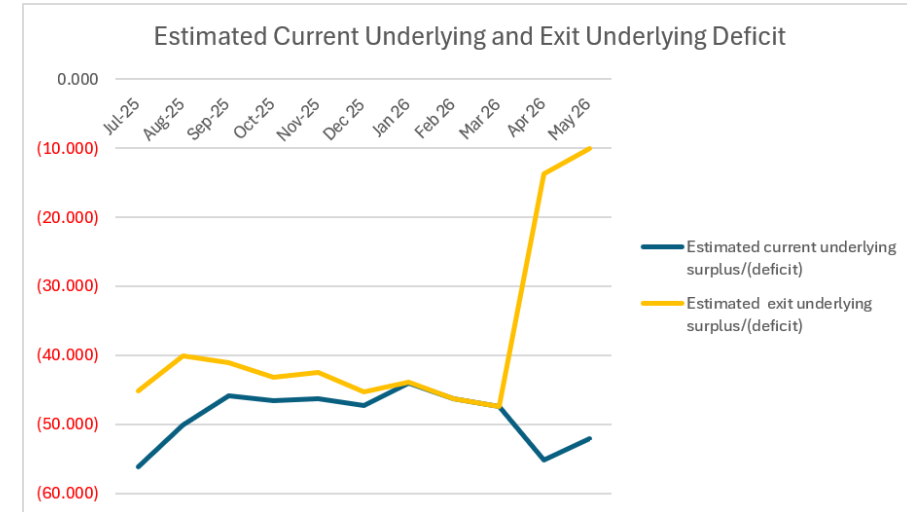
**Delivering financial sustainability by
addressing our underlying deficit over
time**

Underlying Deficit

The analysis shows the current estimated underlying deficit as well as the estimated exit rate for each financial year.

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At month 2 the current underlying deficit is estimated at £58.9m and the 26/27 exit rate is estimated at £10.1m.

The financial model is particularly volatile during the early months of the financial year.

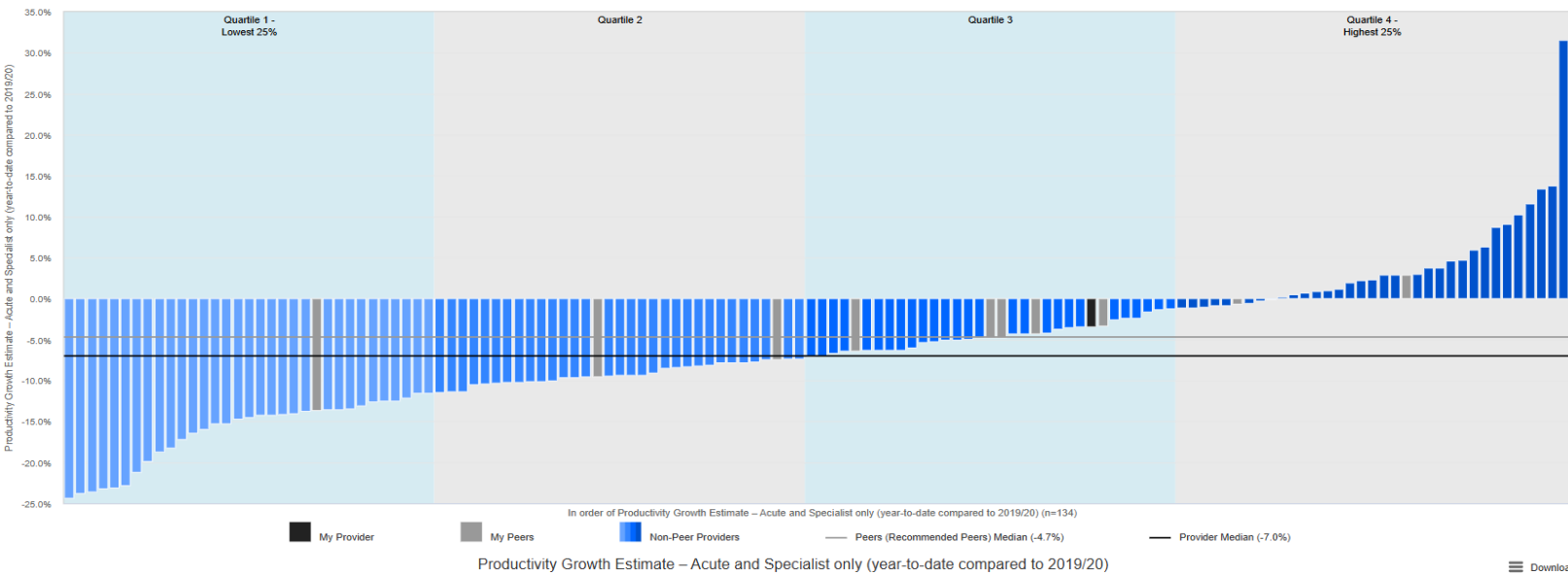


Estimated Underlying surplus/(deficit)	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	
YTD reported adjusted surplus/(deficit)	(1.856)	(1.708)	1.182	1.737	1.368	1.070	(0.625)	(2.360)	0.017	(1.189)	(4.260)
Less YTD DSF (£17M - 25/26, £15.7m, 26/27)	(5.667)	(7.083)	(8.500)	(9.917)	(11.333)	(12.750)	(12.750)	(12.750)	(17.000)	(1.308)	0.000
Less YTD NHSE 24/25 brokered support (£10m 25/26, £0m 26/27)	(5.502)	(6.063)	(6.624)	(7.184)	(7.745)	(8.305)	(8.866)	(9.426)	(9.986)	0.000	0.000
Less YTD CIP	(9.349)	(12.826)	(16.181)	(19.383)	(22.117)	(24.426)	(26.730)	(29.056)	(31.397)	(2.712)	(5.452)
Other Non-Recurrent Support/Pressures	(0.146)	(0.510)	(2.429)	(4.247)	(5.023)	(7.507)	(7.507)	(9.273)	(11.393)	0.000	(0.110)
Subtotal	(22.520)	(28.190)	(32.552)	(38.994)	(44.850)	(51.918)	(56.478)	(62.866)	(69.760)	(5.209)	(9.822)
Extrapolated to full year	(67.559)	(67.657)	(65.104)	(66.846)	(67.275)	(69.224)	(67.774)	(68.581)	(69.760)	(62.510)	(58.934)
Add Recurrent CIP FYE (implemented already)	11.400	17.500	19.300	20.200	21.000	22.000	23.800	22.300	22.300	7.400	6.800
Estimated current underlying surplus/(deficit)	(56.159)	(50.157)	(45.804)	(46.646)	(46.275)	(47.224)	(43.974)	(46.281)	(47.460)	(55.110)	(52.134)
Remove Recurrent CIP FYE (implemented already)	(11.400)	(17.500)	(19.300)	(20.200)	(21.000)	(22.000)	(23.800)	(22.300)	(22.300)	(7.400)	(6.800)
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	48.829	48.829
Estimated exit underlying surplus/(deficit)	(45.121)	(40.030)	(41.136)	(43.164)	(42.556)	(45.308)	(43.900)	(46.248)	(47.460)	(13.681)	(10.105)

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

Productivity Growth Estimate – Acute and Specialist only (year-to-date compared to 2019/20), National Distribution

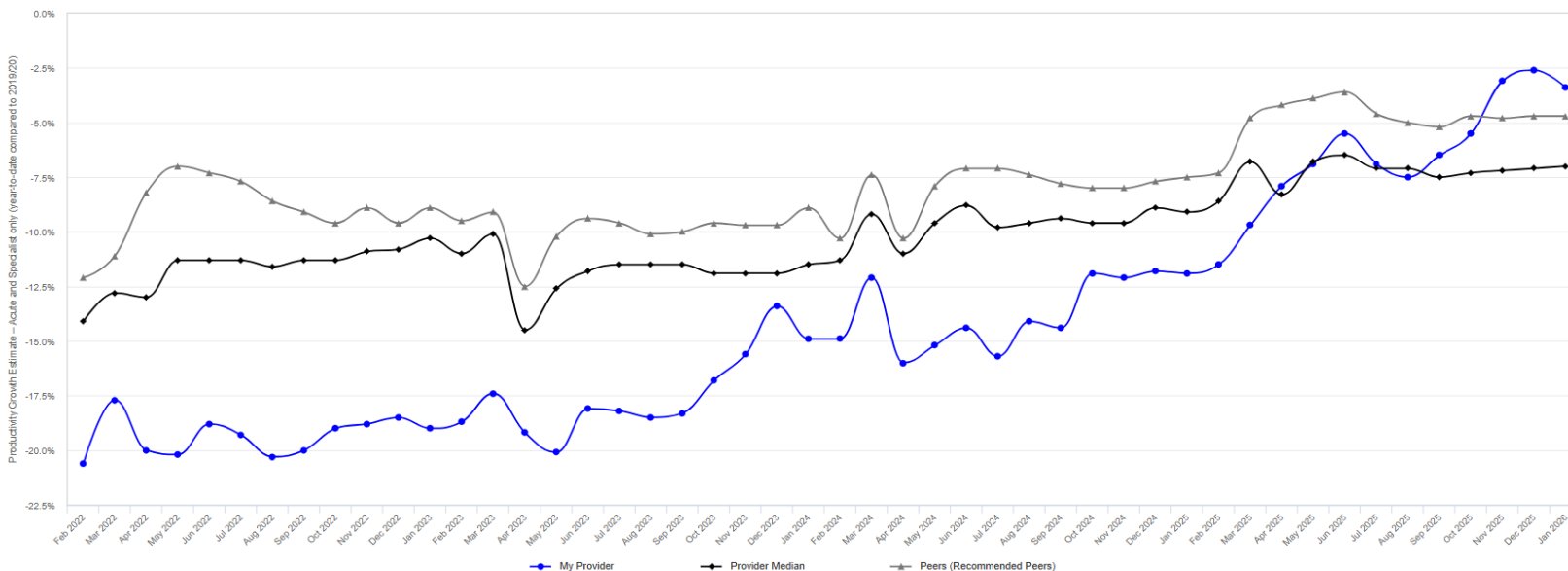
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The most recently published data (year to M10 25/26 YTD) shows DBTH implied productivity is 3.4% below pre-covid (2019/20) levels (last month: 2.6%). This places the Trust in the second-best quartile of performers nationally and is better than both the national median (-7.0%) and the median of the group of peer Trusts selected by NHS England (-4.7%).

The peer group is:

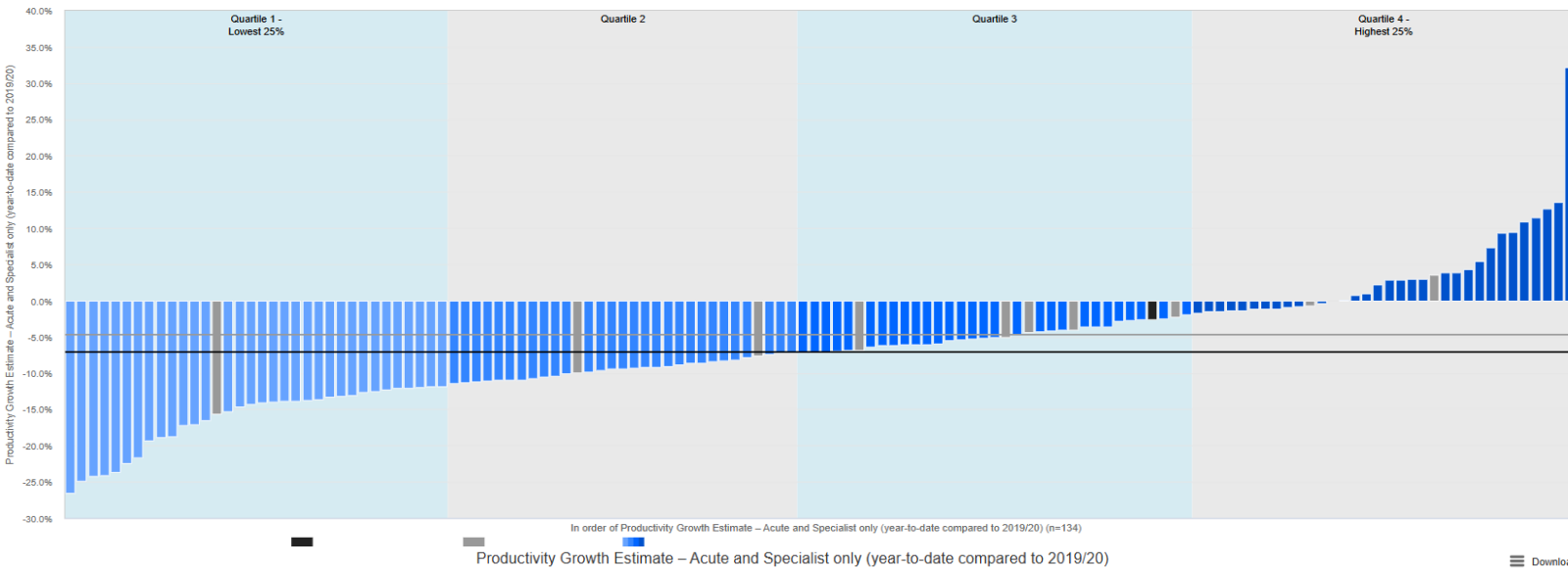
- Bradford Teaching Hospitals (-13.6%)
- Sherwood Forest Hospitals (-9.5%)
- Barnsley Hospital (-7.4%)
- Bolton Hospital (-6.4%)
- Northern Lincolnshire & Goole (-4.7%)
- North Tees and Hartlepool (-4.7%)
- Wrightington, Wigan and Leigh Hospitals (-4.3%)
- DBTH (-3.4%)**
- Wirral University Hospital (-3.4%)
- County Durham & Darlington (-0.6%)
- East Sussex (+2.9%)



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

Productivity Growth Estimate – Acute and Specialist only (year-to-date compared to 2019/20), National Distribution

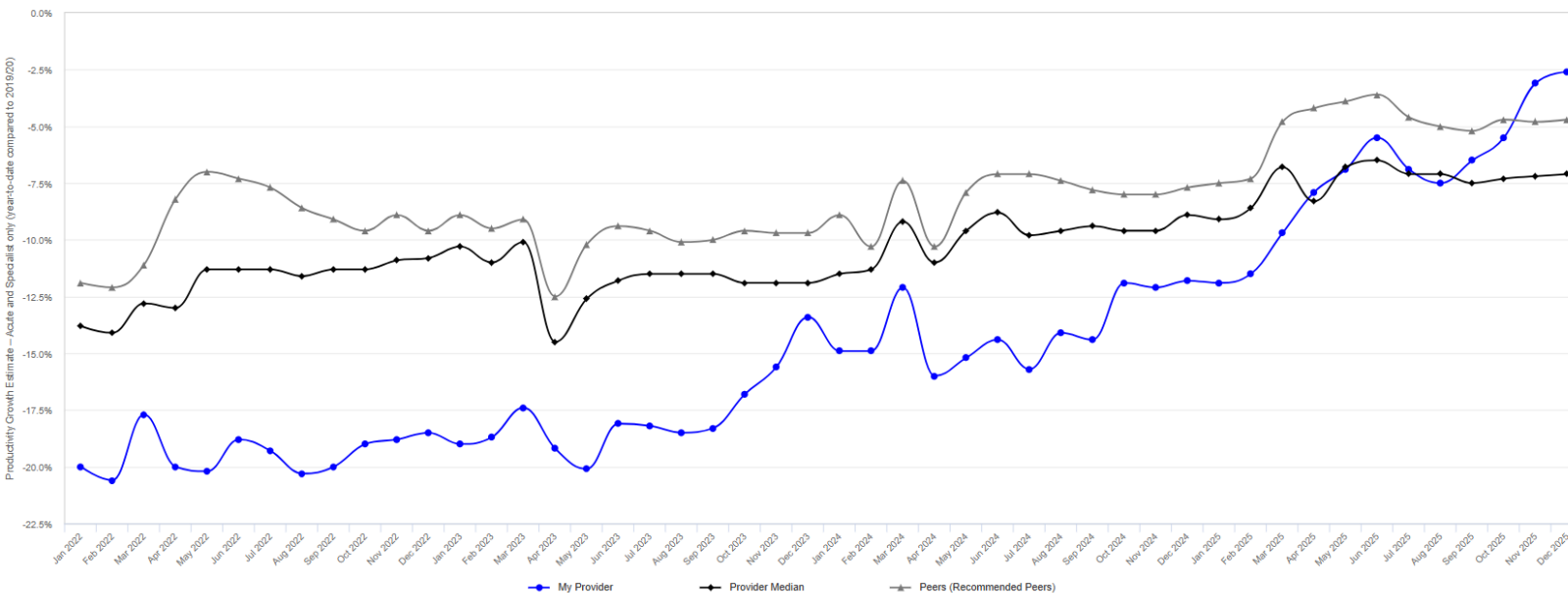
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The most recently published data (year to M10 25/26) shows DBTH implied workforce productivity 1.0% below pre-covid (2019/20) levels (previously -2.6%). This places the Trust in the second-best quartile of performers nationally and is better than both the national median (-6.3%) and the median of the group of peer Trusts selected by NHS England (-5.3%).

The peer group includes:

- Bradford Teaching Hospitals (-17.3%)
- Barnsley Hospital (-10.9%)
- County Durham & Darlington (-10.0%)
- Sherwood Forest Hospitals (-9.9%)
- Wrightington, Wigan and Leigh Hospitals (-6.2%)
- Wirral University Hospital (-4.4%)
- North Tees and Hartlepool (-3.8%)
- Northern Lincolnshire & Goole (-3.5%)
- DBTH (-1.0%)**
- Bolton Hospital (+0.6%)
- East Sussex (+10.5%)



IDP Programme

NB Includes both the Reset Programme and Local Schemes

In terms of recurrent full year effect:

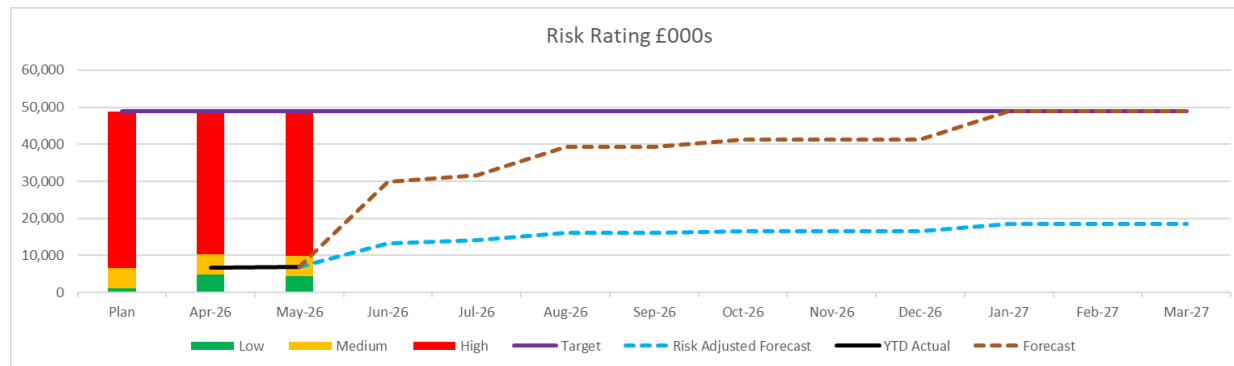
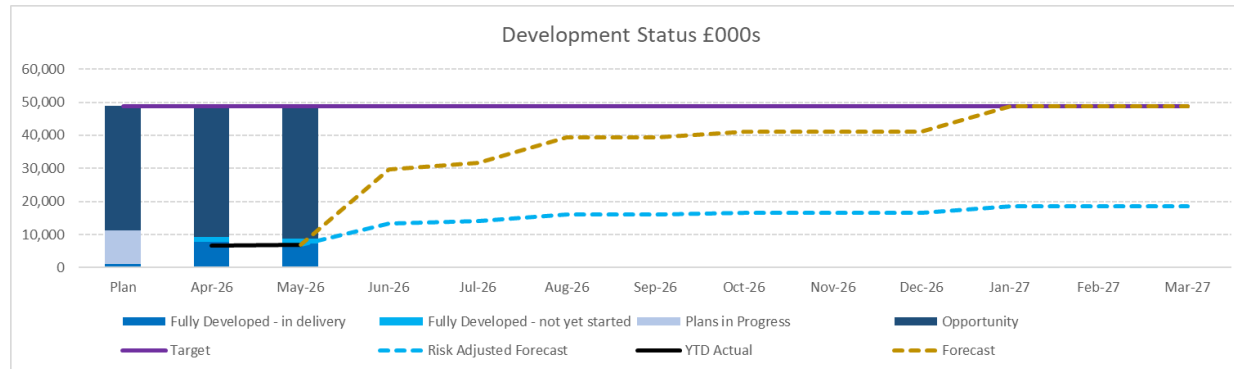
- Schemes implemented in the year to date will yield a recurrent full year effect of £6.8m.
- Forecast delivery by the end of the year is in line with plan of £48.8m.
- The risk adjusted forecast stands at £18.5m, but as at month 2 most schemes have a status of 'opportunity', so this is expected to grow as schemes mature.
- The committed plan is to reduce recurrent establishment by 507.4 WTE recurrently. At the end of month 2 we have delivered a recurrent reduction of 1.2 WTE, this is forecast to rise to 508.6 WTE by the end of the year.

IDP Programme – Recurrent FYE (£)

Recurrent FYE £000's	April Plan Submission	Month 1	Month 2	Increase (Decrease)
Fully Developed - in delivery	1,000	7,857	7,363	(494)
Fully Developed - not yet started	0	1,448	1,490	42
Plans in Progress	10,311	0	0	0
Opportunity	37,518	39,525	39,976	452
Unidentified	0	0	0	0
Total	48,829	48,829	48,829	(0)

Recurrent FYE £000's	April Plan Submission	Month 1	Month 2	Increase (Decrease)
High	42,329	38,564	39,066	502
Medium	5,500	5,465	5,465	0
Low	1,000	4,800	4,297	(502)
Total	48,829	48,829	48,829	0

At the end of month 2 we have delivered a recurrent FYE of £6.8m and are forecasting delivery of £48.8m in line with plan by the end of the year. The risk adjusted forecast is £18.5m.



Workstream / Scheme	Movement from prior	Value £000's	Risk as per Month 1	Risk as per Month 2	Status as per Month 1	Status as per Month 2
Local - Supplies & Services	Reserves releases in month 1 phased to be paid back as Reset schemes come on board	1,000	Low	High	Developed in Delivery	Opportunity
Local - Vacancy Management	Salary Sacrifice scheme added in month	540	High	Low	Opportunity	Developed in Delivery

Pillar	Recurrent FYE - Year to Date £000s			Recurrent FYE - Full Year £000s		
	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	1,500	-	(1,500)	9,165	9,165	0
Workforce & Organisational Design	5,426	-	(5,426)	14,594	14,594	0
Access & Flow	5,786	1,073	(4,713)	8,763	8,763	0
Productivity & Financial Reset	6,500	5,035	(1,465)	6,500	6,500	(0)
Sub Total	19,212	6,108	(13,104)	39,022	39,022	(0)
Local	-	732	732	9,807	9,807	(0)
Grand Total	19,212	6,840	(12,373)	48,829	48,829	(0)

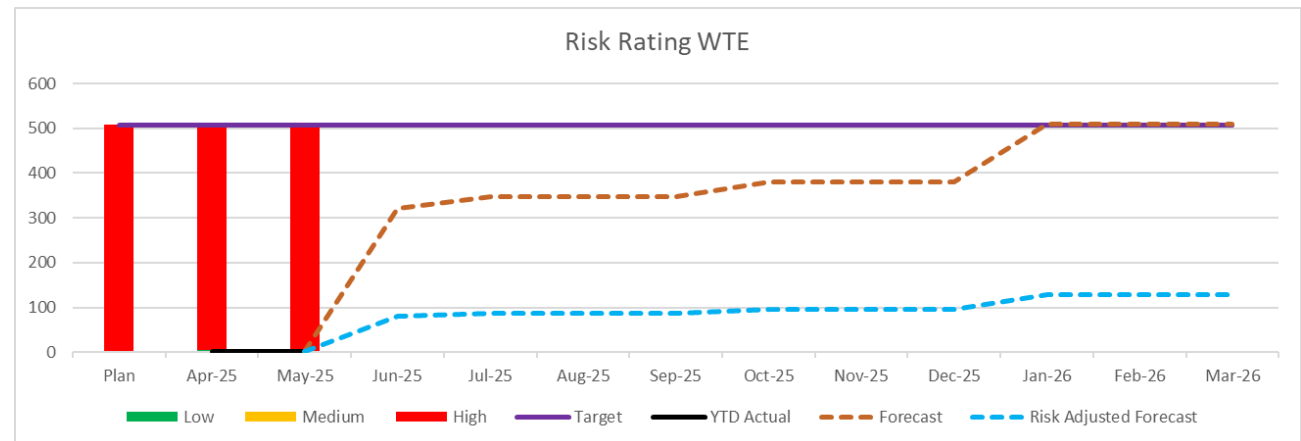
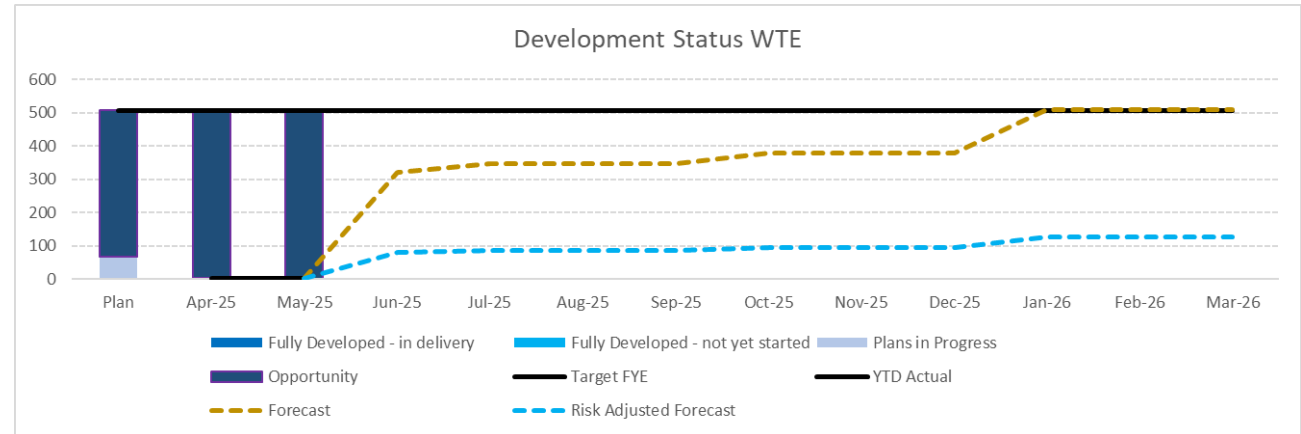
IDP Programme – Recurrent FYE (WTE reduction)

Our committed plan is to reduce by 507.4 WTE recurrently in the year. At the end of month 2 we have delivered a recurrent FYE WTE reduction of 1.2 and are forecasting delivery of 508.6 WTE by the end of the year.

WTE - FYE	April Plan Submission	Month 1	Month 2	Increase (Decrease)
Fully Developed - in delivery	0.0	4.5	1.2	(3.3)
Fully Developed - not yet started	0.0	0.0	0.0	0.0
Plans in Progress	66.5	0.0	0.0	0.0
Opportunity	440.9	507.4	507.4	0.0
Unidentified	0.0	0.0	0.0	0.0
Total	507.4	511.9	508.6	(3.3)

WTE - FYE	April Plan Submission	Month 1	Month 2	Increase (Decrease)
High	507.4	507.4	507.4	0.0
Medium	0.0	0.0	0.0	0.0
Low	0.0	4.5	1.2	(3.3)
Total	507.4	511.9	508.6	(3.3)

Pillar	Recurrent FYE - Year to Date WTE			Recurrent FYE - Full Year WTE		
	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	0.0	0.0	0.0	127.8	127.8	0.0
Workforce & Organisational Design	86.1	0.0	(86.1)	320.0	320.0	0.0
Access & Flow	0.0	0.0	0.0	59.5	59.5	0.0
Productivity & Financial Reset	0.0	0.0	0.0	0.0	0.0	0.0
Sub Total	86.1	0.0	(86.1)	507.4	507.4	0.0
Local	0.0	1.2	1.2	0.0	1.2	1.2
Grand Total	86.1	1.2	(84.9)	507.4	508.6	1.2



SECTION 3

Delivering the 2026/27 committed plan

Executive Summary

In month surplus/deficit (May 2026)

The Trust is reporting a year to date performance of £4.3m deficit, £2.6m adverse to plan, mainly due to the deficit support funding not yet received. However excluding the deficit support funding the Trust is on plan.

Activity

Daycase and Elective activity are above plan in month and Outpatient activity is below plan.

Efficiencies

Schemes implemented in month will yield recurrent full year savings of £6.8m every year going forward. In-year savings (which also include non-recurrent) are in line with plan in-month (£2.7m) and full year forecast (£46.3m).

Cash

The cash balance is £18.9m and is adverse to plan by £8.1m mainly due to the payment profile of the year end capital creditors.

Capital

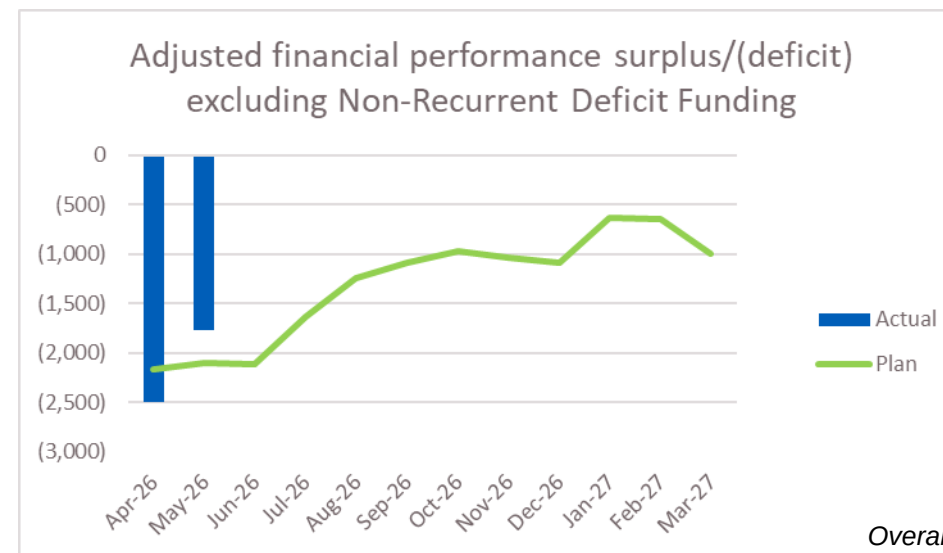
Capital expenditure (excluding charitable funds) is £0.3m in month against a plan of £1.2m and £0.5m against a plan of £2.3m YTD.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust								
M02 May 2026								
Income and Expenditure vs. Budget								
Performance Indicator	Annual budget	Monthly Performance			YTD Performance			
		Budget	Actual	Variance to budget	YTD Budget	YTD Actual	Variance to budget	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Income	(645,452)	(53,525)	(50,948)	2,577 A	(106,958)	(104,165)	2,792 A	
Pay	432,451	37,026	36,660	(366) F	73,283	73,243	(39) F	
Non Pay	204,333	16,567	16,848	282 A	33,876	34,210	333 A	
Financing Costs	9,455	788	581	(207) F	1,576	1,111	(465) F	
(Profit)/Loss on Asset Disposals	0	0	0	0 F	0	0	0 F	
(Surplus)/Deficit for the period	787	856	3,141	2,285 A	1,777	4,398	2,621 A	
Donated Asset Adjustment	(787)	(66)	(69)	(3) F	(131)	(137)	(6) F	
Impairment Adjustment	0	0	(0)	(0) F	0	(0)	(0) F	
Adjusted Financial Performance (Surplus)/Deficit	0	790	3,072	2,282 A	1,646	4,261	2,615 A	
<i>Remove Deficit Support Funding</i>	<i>15,700</i>	<i>1,308</i>	<i>(1,308)</i>	<i>(2,617) F</i>	<i>2,617</i>	<i>0</i>	<i>(2,617) F</i>	
Adjusted Financial Performance (Surplus)/Deficit excluding Non-Recurrent Deficit Funding	15,700	2,099	1,764	(335) F	4,263	4,261	(2) F	

Income
Over-achieved **F**

Expenditure
Under-achieved **A**

Key
Underspent **F** Overspent **A** F = Favourable A = Adverse



Key Risks and Mitigations to delivery of in-year plan

Key Risks	Risks (R)				Key Mitigations	Mitigations (M)				26/27 Plan Net Risk £'000	M2 Net Risk £'000	(Increase) Decrease in month £'000
	26/27 Plan	M1	M2	(Increase) Decrease		26/27 Plan	M1	M2	Increase (Decrease)			
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000			
Efficiency risk	(32,659)	(25,312)	(24,463)	849	Demand management system	6,786	6,786	6,786	0	(25,873)	(17,677)	849
Commissioner Growth and clawback	(8,700)	(8,700)	(8,700)	0	Negotiation with SY ICB	0	6,525	6,525	0	(8,700)	(2,175)	0
Delays to acceleration of structural changes	(3,700)	(3,700)	(3,700)	0	Reset Programme	0	1,850	1,850	0	(3,700)	(1,850)	0
Incremental drift	(500)	(500)	(500)	0	Non Recurrent technical	0	500	500	0	(500)	0	0
Potential error in estimation of revenue to capital transfer	(100)	(100)	(100)	0	Non Recurrent technical	0	100	100	0	(100)	0	0
Industrial Action	0	(340)	(680)	(340)	Non Recurrent technical	0	340	680	340	0	0	0
Total	(45,659)	(38,652)	(38,143)	509	Total	6,786	16,101	16,441	340	(38,873)	(21,702)	849

- The Trust identified a number of key strategic and operational financial risks during planning. These risks and action plans have been added to the corporate risk register and will be monitored and reviewed throughout the year.
- There has been a £7.6m improvement in the gross risk profile since the plan was set.
- The Industrial Action risk that was identified in M1 has been managed within the M2 position. However, as further Industrial Action is expected in M3, the level of risk has increased. There are mitigations in place should this take place.
- Deficit Support Funding (DSF) of £15.7m is due to be paid quarterly. However, this is payable only if the Trust meets the conditions set out by NHSE (separate paper on the Agenda).

Surplus/Deficit – Graphs M02

In month/Year to Date

- In month £3.1m deficit, a £2.3m adverse to plan mainly due to Deficit Support Funding (DFS).
- Year to date £4.3m deficit, £2.6m adverse to plan mainly due to the DSF.
- As per NHSE guidance, the Trust is only able to recognise Deficit Support Funding at quarter end and is only included when paid.

Income

- The Clinical Income position is showing a deficit position of £2.5m to plan mainly due to Deficit support funding of £2.6m. Operating income is adverse to plan £0.2m mainly due to HEE offset by a reduction in expenditure.

Pay

- Pay is £0.3m favourable to plan in month mainly due to additional funding received for the pay award relating to prior month.
- Pay is in line with plan year to date.
- Bank/agency and additional medical sessions spend in month is £4.0m (previous month: £3.7m) due to operational pressures, cover for vacant posts and sickness cover.

Non-Pay

- Non pay is £0.3m adverse to budget in month and YTD mainly due to unachieved CIP being offset by the release of reserves.

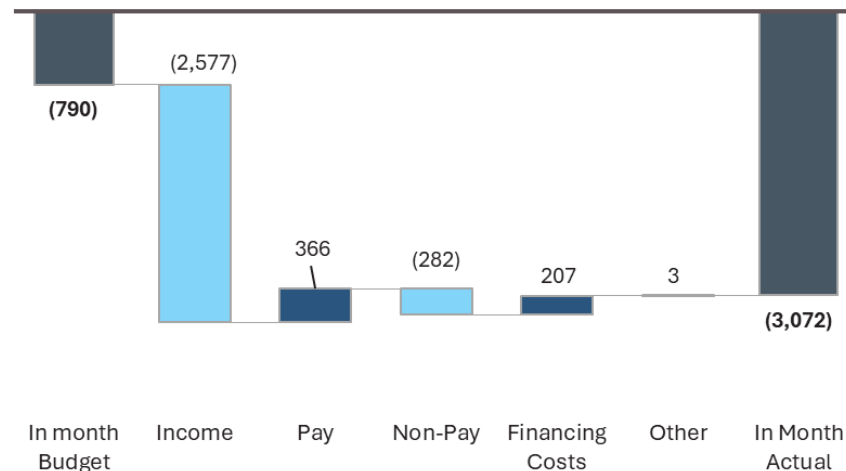
Other

- Adjustments donated assets are broadly in line with plan.

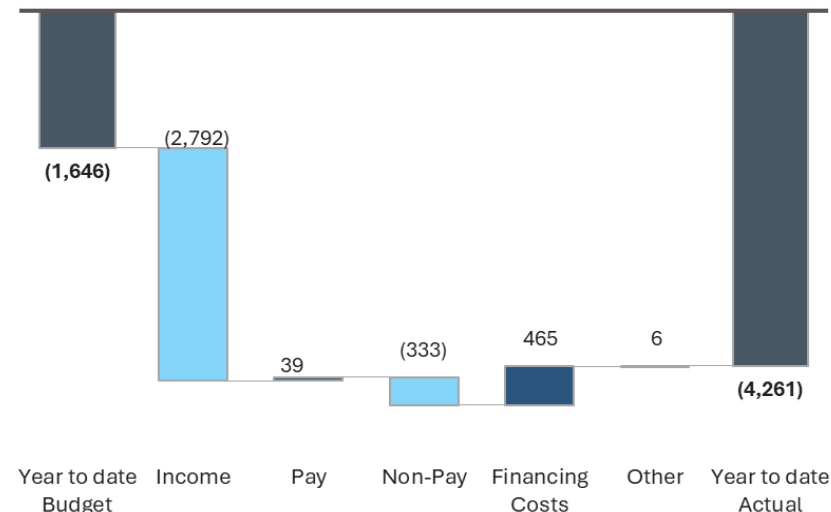
Financing Costs

- Higher cash balance than planned has increased interest income.

Month 2 Waterfall Chart (£k)



Year to date Waterfall Chart (£k)



Financial Performance – Income

Clinical Income Position Month 2

	Plan - M2 YTD	Actuals - M2 YTD	Variance
	£'000	£'000	£'000
ICB			
NHS South Yorkshire ICB	(66,218)	(65,635)	583
NHS Nottingham and Nottinghamshire ICB	(20,141)	(20,167)	(26)
NHS Humber and North Yorkshire ICB	(1,507)	(1,479)	28
NHS Derby and Derbyshire ICB	(1,051)	(1,051)	(0)
NHS West Yorkshire ICB	(687)	(687)	(0)
NHS Lincolnshire ICB	(382)	(382)	0
LVA	(225)	(224)	1
ERF	0	33	33
CDC	0	307	307
UEC	0	(152)	(152)
API variable	825	645	(180)
ICB sub total	(89,385)	(88,792)	594
NHS England			
Support Funding / Armed Forces / Retained Block	(2,617)	(21)	2,596
Drugs and Devices	(1,799)	(2,347)	(548)
Offender Health	(276)	(280)	(4)
Public Health	(780)	(788)	(9)
NHS England sub total	(5,472)	(3,436)	2,035
other Clinical Income (see below)	(78)	(216)	(138)
Grand Total	(94,935)	(92,444)	2,491
other income - RTAs, PPs, OSV, CIP	(1,002)	(997)	5
	(95,937)	(93,441)	2,495

Month 2

The Clinical Income position is showing a deficit position of £2.5m to plan mainly due to Deficit support funding of £2.6m. Operating income is adverse to plan £0.2m mainly due to HEE offset by a reduction in expenditure. Deficit support funding has not been assumed in month 2 as per the NHSE guidance for Month 2 reporting, no payment has been made in cash terms.

ERF Performance

The activity has not yet been fully coded with estimated case mix applied which will be reviewed in year for accuracy given the new tariff structure in place. Below is a table showing the ERF position at Month 2 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying ERF performance.

ICB	ERF	Plan M2	Actual M2	Variance	Notes
South Yorkshire	(91,652)	(14,770)	(14,199)	571	No variance transacted
Nottinghamshire	(31,100)	(5,012)	(4,897)	115	
Lincolnshire	(758)	(122)	(104)	18	
Derbyshire	(1,036)	(167)	(168)	(1)	
West Yorkshire	(749)	(121)	(177)	(56)	
Humber & North Yorkshire	(1,911)	(308)	(351)	(43)	
Total	(127,206)	(20,500)	(19,896)	33	

Financial Performance – UEC Position

Urgent and Emergency Care Income Position Month 2

Change in Commissioning Approach 2026-27

For 2026/27, urgent and emergency care (UEC) activity is commissioned and reimbursed through the NHS Payment Scheme using the Aligned Payment and Incentive (API) model. Under this approach, providers receive a fixed annual payment alongside an activity-based adjustment for emergency care services. Planned emergency activity is funded using nationally published unit prices and agreed activity plans, with providers sharing financial risk and reward for activity levels above or below plan. Where actual emergency activity exceeds planned levels, providers receive a proportion of the additional value (20%) rather than full payment for every extra attendance or admission, supporting system-wide management of demand while maintaining incentives for appropriate care delivery.

UEC Performance

The activity has not yet been fully coded with estimated case mix applied which will be reviewed in year for accuracy given the new tariff structure in place. Below is a table showing the UEC position at Month 2 by Commissioner. The table reflects the current known agreements by commissioner in terms of paying UEC performance. For the associates, the YTD month 2 performance was £0.2m favourable after applying the marginal rate. SY ICB is monitoring in shadow form whereas the other commissioners are implementing it fully.

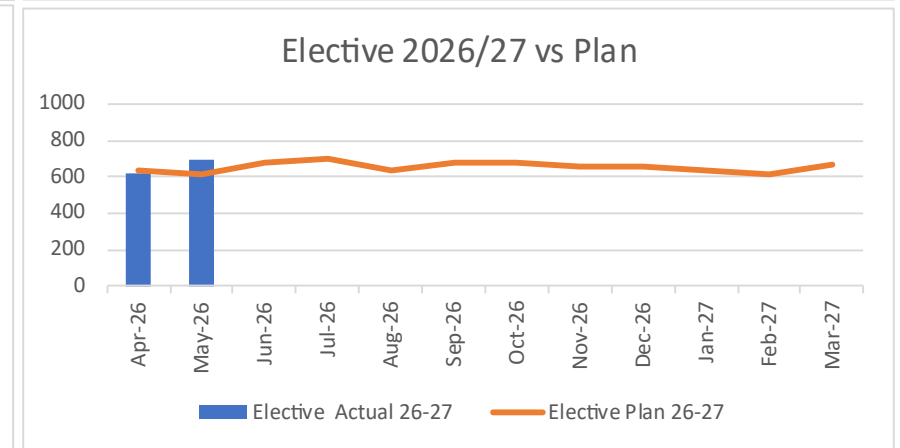
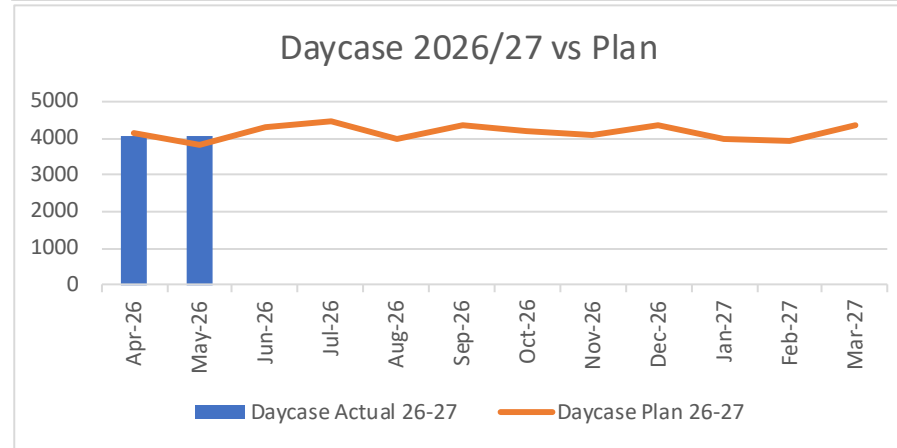
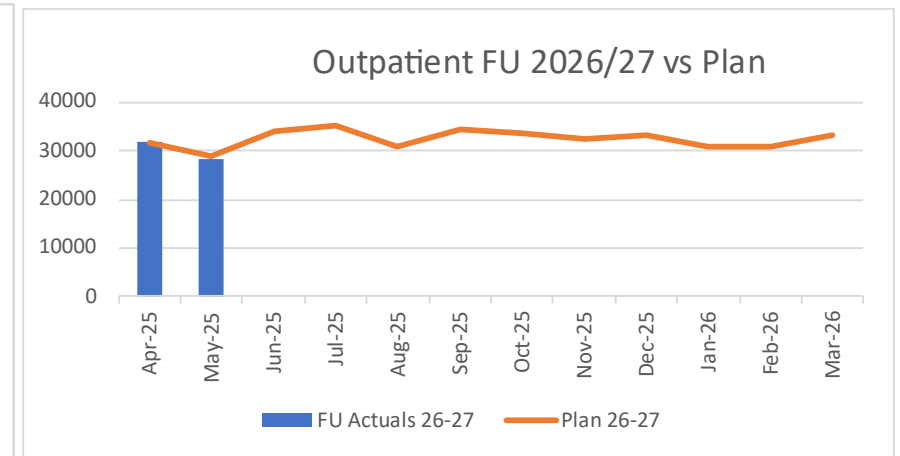
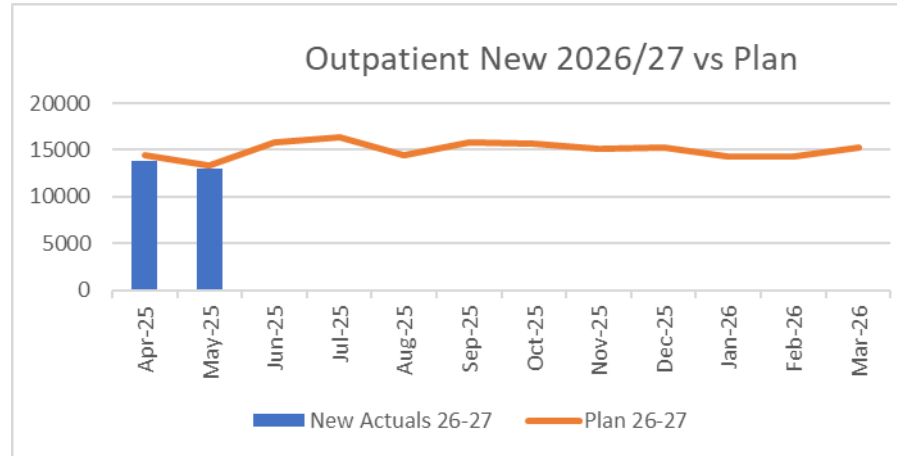
ICB	UEC	Month 2 Plan	Month 2 Actual	Variance	UEC Marginal Rate	Notes
South Yorkshire	(144,180)	(23,525)	(25,758)	(2,233)	(447)	No variance transacted
Nottinghamshire	(54,295)	(8,859)	(9,699)	(840)	(168)	
Lincolnshire	(408)	(67)	(92)	(26)	(5)	
Derbyshire	(3,020)	(493)	(419)	74	15	
West Yorkshire	(1,589)	(259)	(228)	31	6	
Humber & North Yorkshire	(4,552)	(743)	(741)	2	0	
Total	(208,044)	(33,945)	(36,936)	(759)	(152)	

Activity Against Plan 2025/26

Data as at 03/06/2026

Point of Delivery	Activity vs Plan (May 2026)
Outpatients New	97.5%
Outpatient Follow up	97.9%
Daycase, excluding MEOC	107.1%
Elective, excluding MEOC	115.3%

- OP PODs were below plan and IP PODs were above plan in month.
- OP (New) was -335 activity below plan in month and -1055 below plan YTD (96.2%).
- OP (FU) was -605 below plan in month and -410 below plan YTD (99.3%)
- Daycases were above plan by 269 cases in month and 210 cases above plan YTD (102.7%)
- Electives were above plan by 92 cases in month and 88 cases YTD (107.2%)



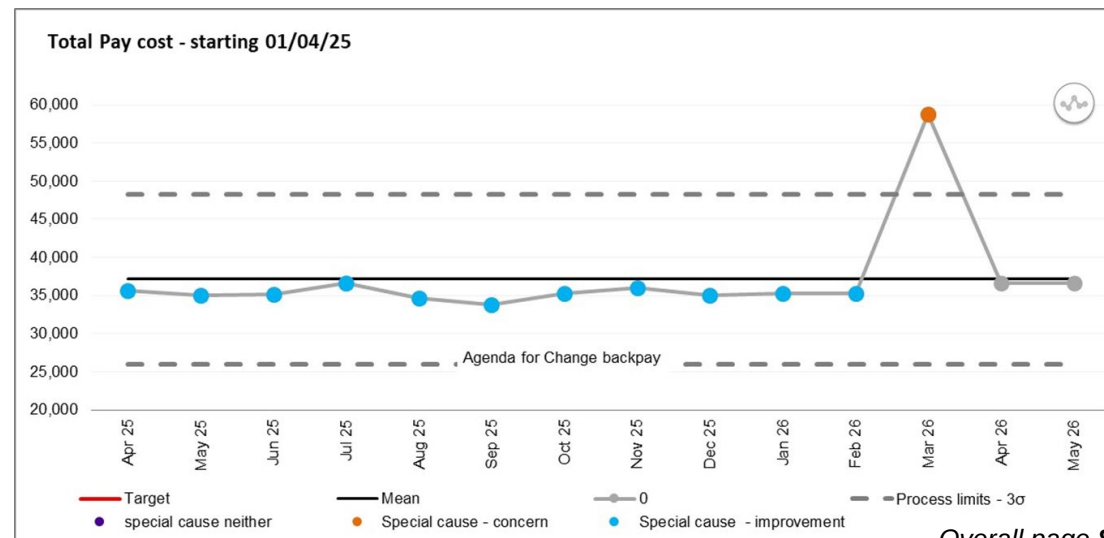
Please note that the performance is expected to improve as further clinics are reconciled after the data was extracted for this reporting period

Financial Performance - Pay

In Month - £0.3m favourable to budget and breakeven YTD.

- Pay is £0.3m favourable to plan in month mainly due to additional funding received for the pay award relating to prior month
- Pay is in line with plan year to date.
- Bank/agency and additional medical sessions spend in month is £4.0m (previous month: £3.7m) due to operational pressures, cover for vacant posts and sickness cover.
- Additional sessions remained in line with month 1, whereas agency and bank costs were both c£0.1m higher than month 1.
- Medics pay award has been accrued as it is due to be paid in future months.

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	6,776	6,181	-595 F	-1,001 F
Ambulance staff				
Apprenticeship Levy	135	132	-3 F	-11 F
Allied health professionals	3,108	3,074	-35 F	-141 F
Healthcare science staff	23	32	9 A	18 A
Medical and dental	10,945	11,818	873 A	1,809 A
Non Medical Non Clinical			A	A
Nursing & midwifery	13,823	13,932	110 A	-17 F
Comprising:				
Registered nursing	10,523	10,215	-309 F	-786 F
Unregistered nursing	3,299	3,707	408 A	748 A
Scientific, therapeutic and tech	882	871	-11 F	-35 F
Reserves & Technical Adjustments	1,335	619	-715 F	-661 F
Total Trust	37,026	36,660	-366 F	-39 F

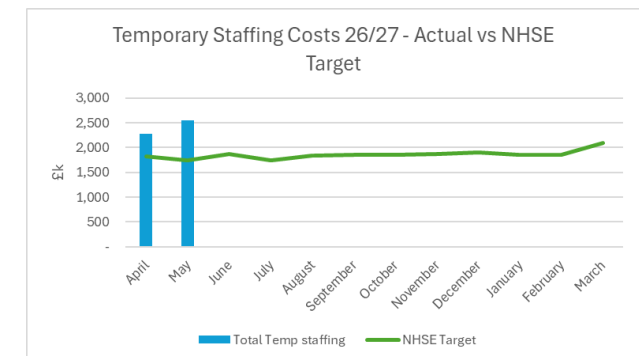
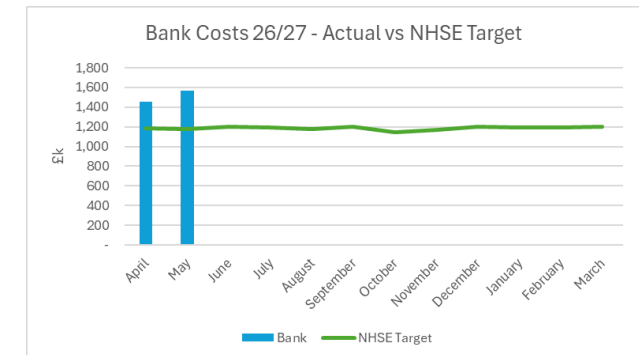
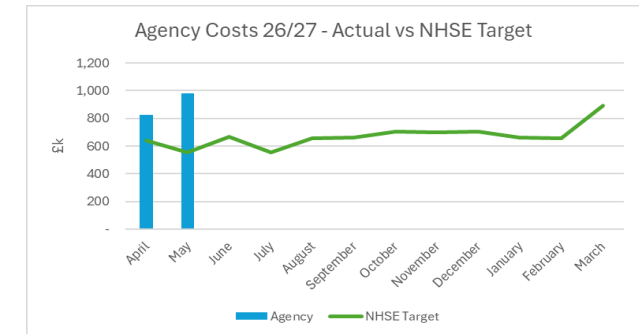


Financial Performance – Bank and Agency

In Month: Agency - £1.0m, Bank - £1.6m

- The NHSE target is based on the plan submission to NHSE and meets the cap limit.
- Agency costs in month are £1.0m, above plan and £0.2m higher than the previous month.
- Bank costs in month are £1.6m, above plan and £0.1m higher than the previous month.
- The majority of agency spend is within the Medical staff group covering premium costs for vacant posts, sickness and industrial action costs.
- Latest benchmarking data (M10 25/26) shows the Trust ranks poorly on agency spend, well on Bank spend and middling on Total Temporary Staff spend.

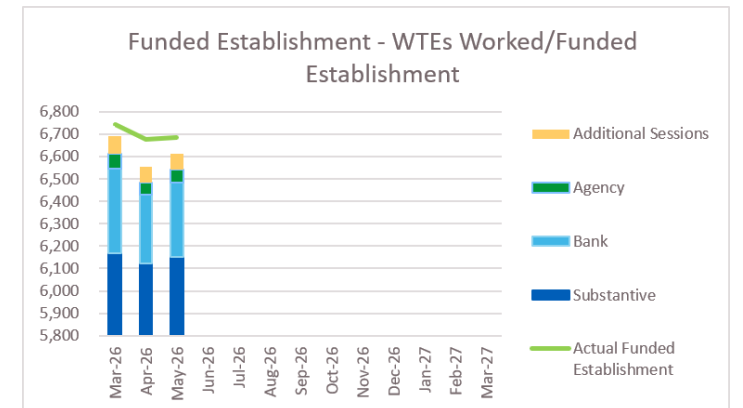
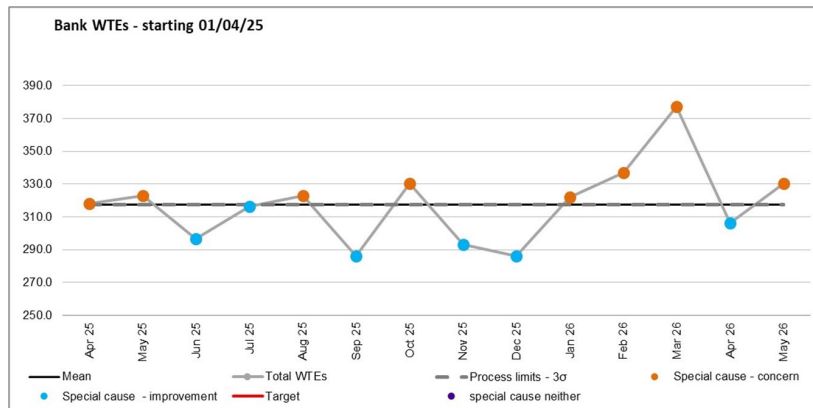
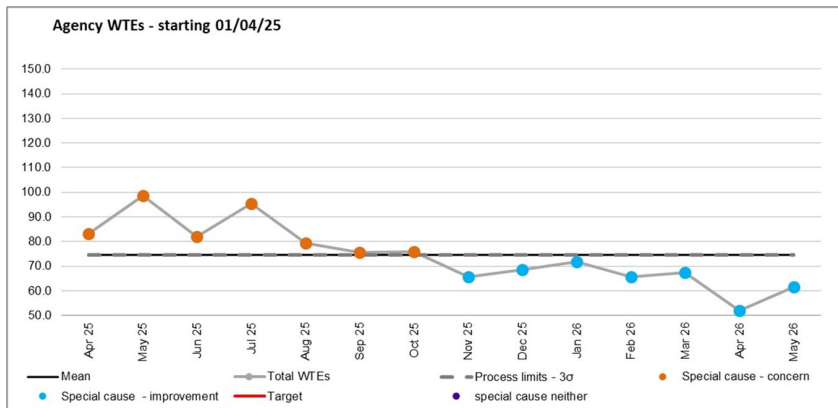
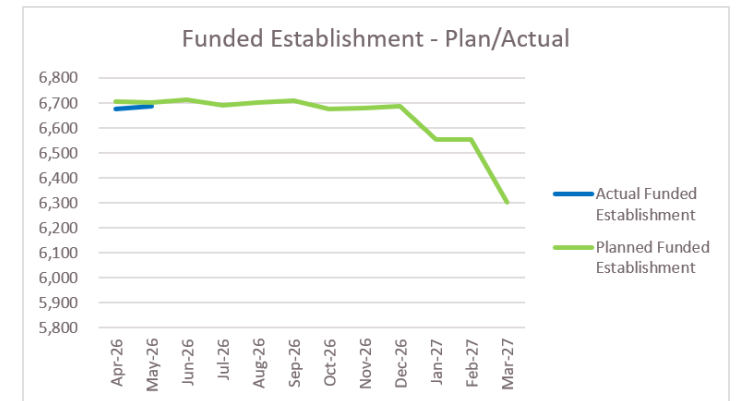
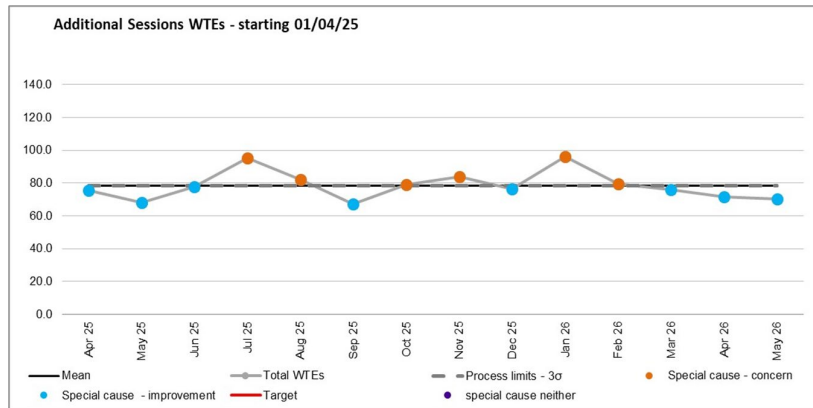
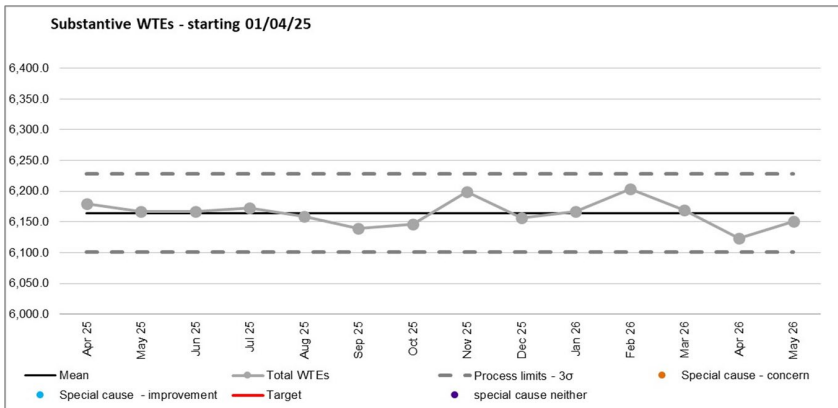
	YTD % of total pay	National Rank
Agency	2.5%	177/195
Bank	3.4%	26/195
Total	5.9%	65/195



Financial Performance – Worked WTE

Workforce								
	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Additional Sessions	Total Temporary WTE	Total Worked WTE	Variance
Current Month	6,686.2	6,151.5	330.4	61.5	70.46	462.3	6,613.8	-72.4
Previous Month	6,677.6	6,123.8	306.1	52.0	71.48	429.5	6,553.4	-124.2
Movement	8.6	27.6	24.3	9.5	-1.0	32.8	60.4	51.8

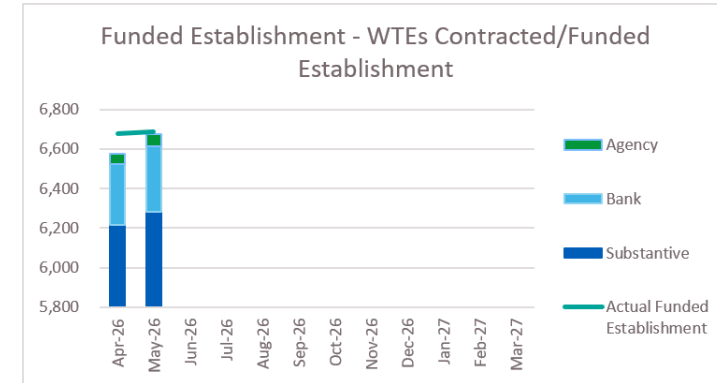
- The WTE's reported are worked WTE which are derived from the actual hours paid and worked.
- Funded Establishment – WTE Contracted and Plan Graph the WTEs for Additional Sessions, Bank and Agency are the worked WTE as we do not have any contracted wte for temporary staffing.
- Funded WTE have increased by 8.6 mainly in medicine due to alignment of medics spend.
- Substantive staff have increased in month mainly due to new starters in Medicine.
- Bank WTE increased mainly in Medicine due to the recruitment of new staff who are currently supernumerary and therefore unable to meet full roster requirements immediately.
- Additional sessions have remained stable.
- Agency has increased mainly in Surgery due to rota gaps.



Financial Performance – Contracted WTE

	2026/27 Budget WTE		
Total Pay WTE by Cost Type	Apr-26	May-26	Movement
2a. Substantive	6,739.8	6,768.7	28.9
2b. Bank	1.4	1.3	-0.1
2c. Agency	44.6	27.2	-17.4
2d. Reserves - Pay	-108.3	-111.0	-2.8
Total	6,677.6	6,686.2	8.6

Table 1 – Budget WTE Reserves – Relates to Reset Savings



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	6,686.2	6,282.4	403.8	6.0%	330.4	61.5	0.0	391.9	6,674.2	11.9	0.2%
Previous Month	6,677.6	6,215.3	462.3	6.9%	306.1	52.0	0.0	358.1	6,573.3	104.2	1.6%
Movement	8.6	67.1	-58.5	-0.9%	24.3	9.5	0.0	33.8	100.9	-92.3	-1.4%

Table 2 - Vacancies are calculated as per national guidance on Contracted WTE and are submitted by Workforce to NHSE on a monthly basis. The funded establishment has increased by 8.6 Whole Time Equivalents (WTE) in month 2. Based on the number of contracted staff, there is a 'vacancy' rate of 6.0% gross (6.9% last month) or 0.2% net of temporary staffing (1.6% last month).

Additional sessions WTE are excluded as they are not contracted WTEs.

Financial Performance – Non-Pay

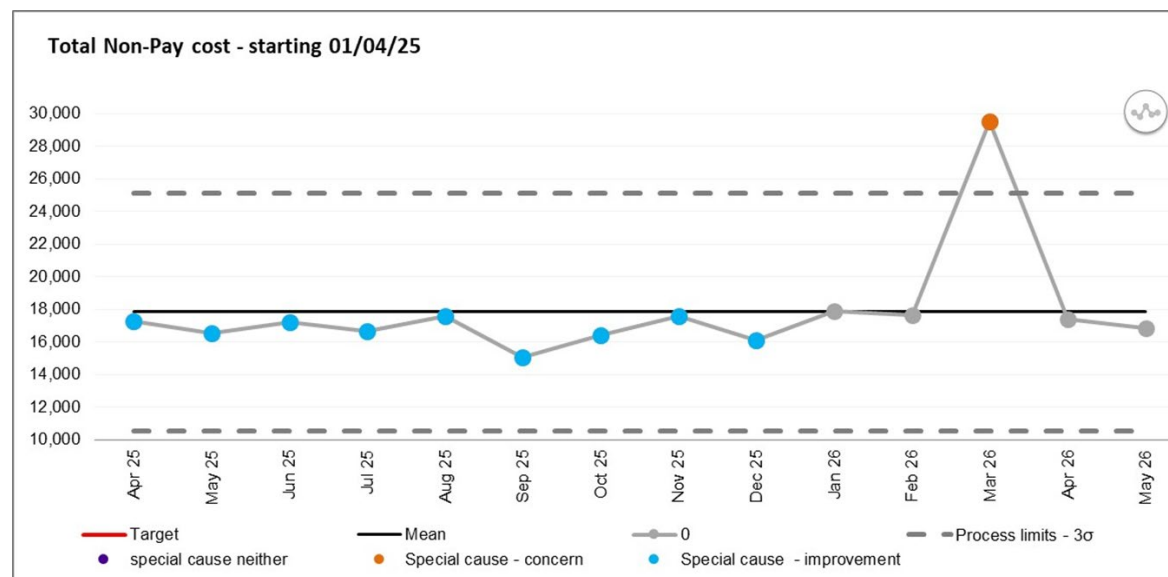
In Month - £0.3m adverse to budget

YTD - £0.3m adverse to budget

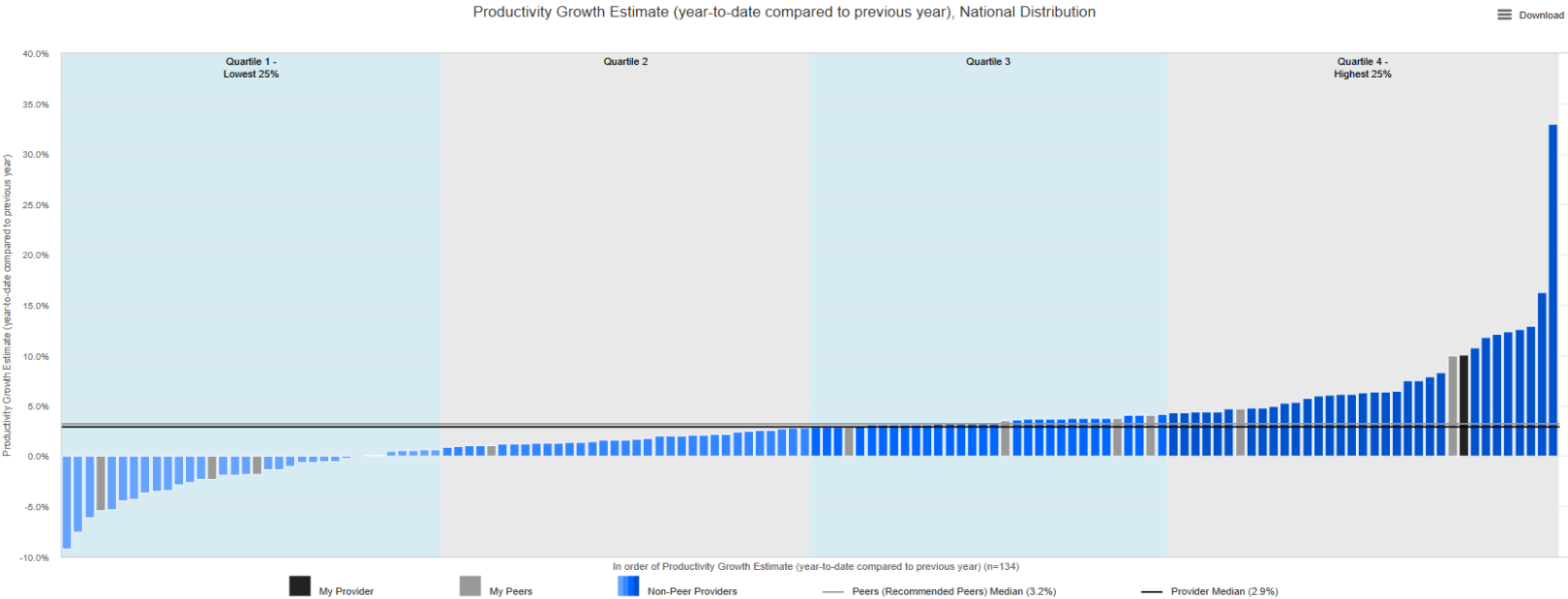
The main reasons for the adverse in month and YTD variance is due to:

- £0.2m Loan kits/prosthesis in the Division of Surgery.
- £0.1m X-ray equipment and contracts in the Division of CSS.
- Non pay reserves of £1.0m have been released in month to support the position.

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)	1,735	1,593	(142) F	52 A
Drugs (non PBR)	1,168	1,491	324 A	(43) F
Clinical Supplies and Services	3,246	3,652	406 A	323 A
Other costs	7,474	7,596	122 A	462 A
Non-Executive Directors	16	13	(3) F	(7) F
Depreciation	1,658	1,705	47 A	94 A
Reserves & Technical Adjustments	(486)	(956)	(470) F	(530) F
Recharges	1,718	1,718	- A	- A
Parkhill	39	37	(2) F	(19) F
Total Trust	16,567	16,848	282 A	333 A



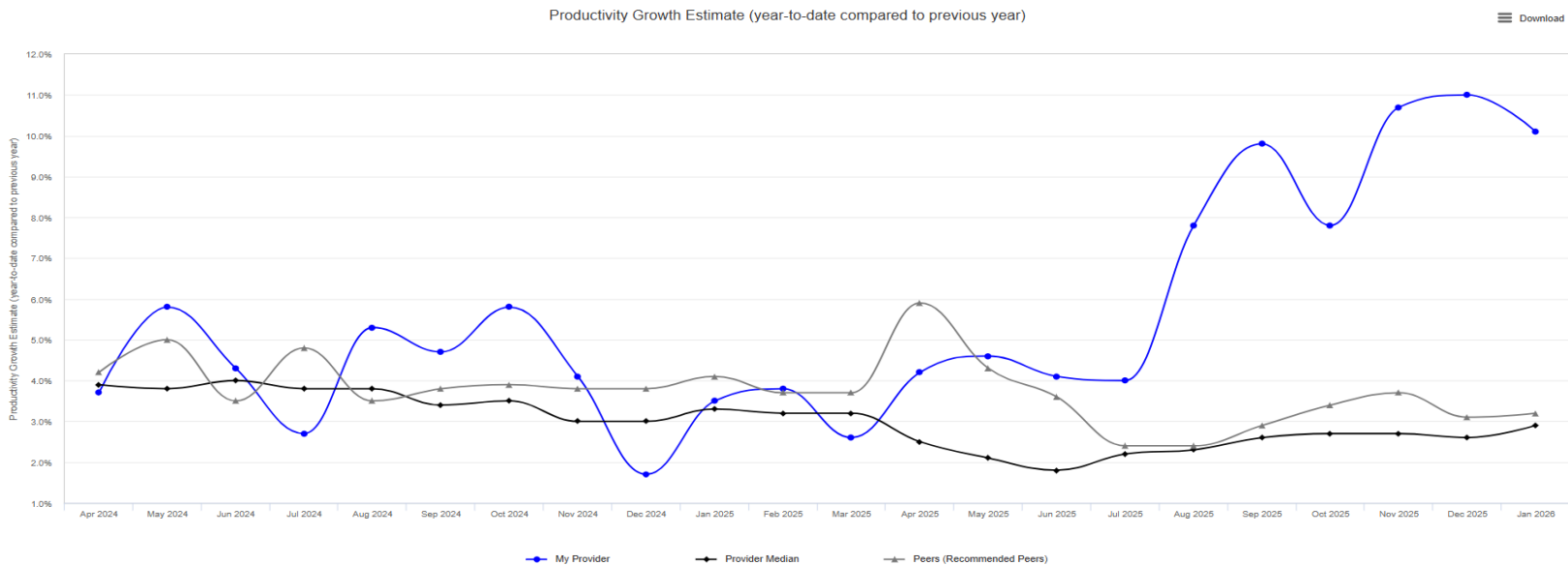
Implied Productivity (per £ compared to prior year)



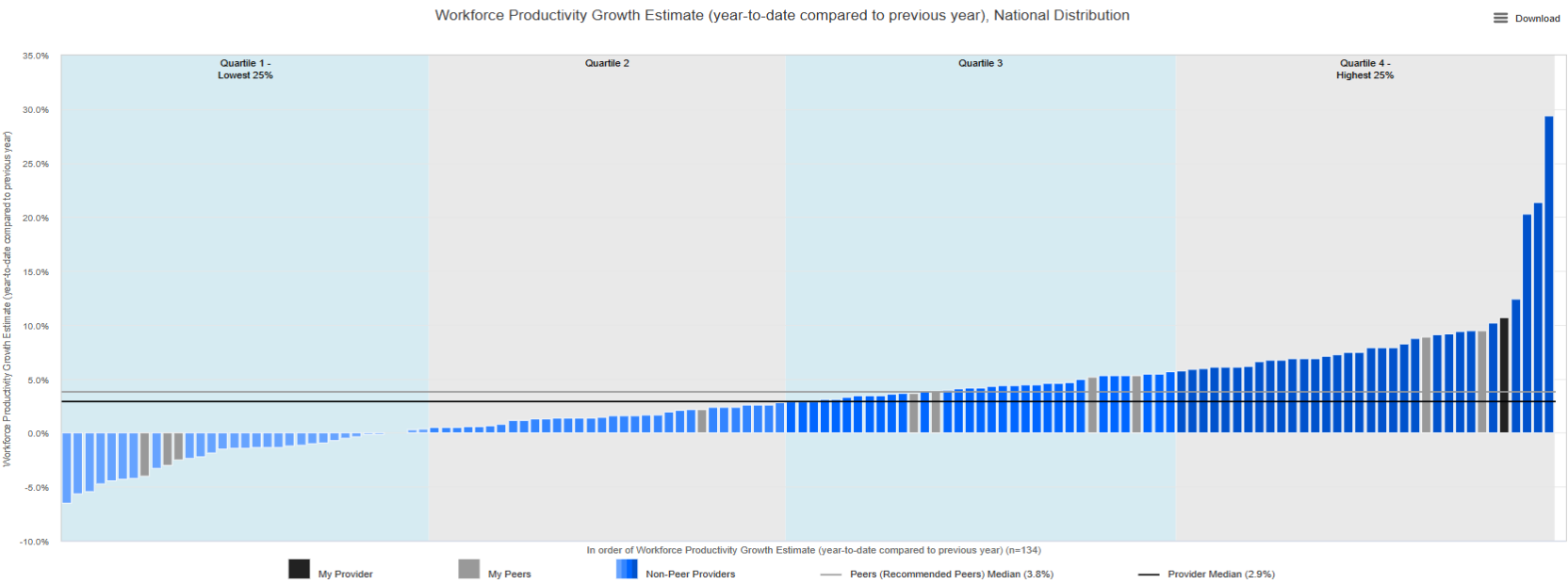
The most recently published data (year to M10 25/26) shows an 10.1% improvement in implied productivity for DBTH in comparison to the same period in the previous year (prior month: +11.0%). This places the Trust in the best quartile of performers nationally and is favourable against both the national median (2.9%) and the median of the group of peer Trusts selected by NHS England (3.2%).

The peer group is:

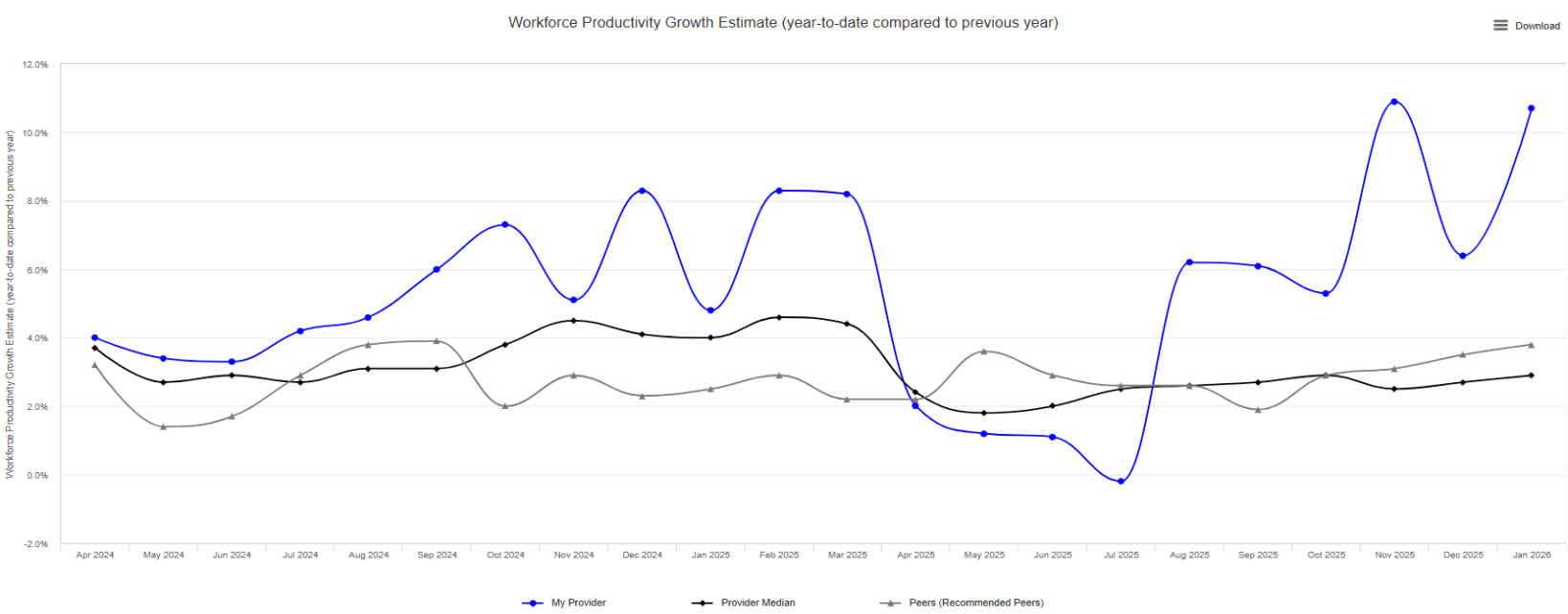
- Bradford Teaching Hospitals (-5.4%)
- Barnsley Hospital (-2.3%)
- Wirral University Hospital (-1.8%)
- County Durham & Darlington (+1.1%)
- Wrightington, Wigan and Leigh Hospitals (+2.9%)
- Northern Lincolnshire & Goole (+3.5%)
- North Tees and Hartlepool (+3.8%)
- Bolton Hospital (+4.1%)
- Sherwood Forest Hospitals (+4.7%)
- East Sussex (+10.0%)
- DBTH (10.1%)**



Implied Workforce Productivity (per WTE compared to prior year)



The most recently published data (year to M10 25/26) shows a 10.7% improvement in implied workforce productivity for DBTH in comparison to the same period in the previous year (prior month: +6.4%). This places the Trust in the top quartile of performers nationally and is better than both the national median (2.9% improvement) and the median of the group of peer Trusts selected by NHS England (3.8% improvement).



- The peer group is:
- Barnsley Hospital (-4.0%)
 - Bradford Teaching Hospitals (-3.0%)
 - Wirral University Hospital (-2.5%)
 - County Durham & Darlington (+2.2%)
 - North Tees and Hartlepool (+3.7%)
 - Sherwood Forest Hospitals (+3.9%)
 - Northern Lincolnshire & Goole (+5.2%)
 - Wrightington, Wigan and Leigh Hospitals (+5.3%)
 - East Sussex (+8.9%)
 - Bolton Hospital (+9.5%)
 - DBTH (+10.7%)**

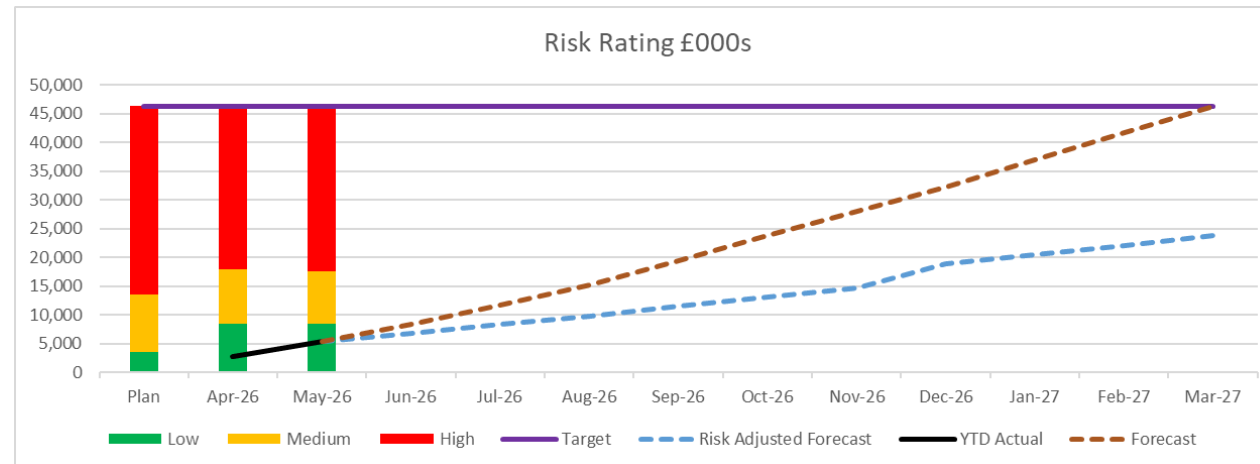
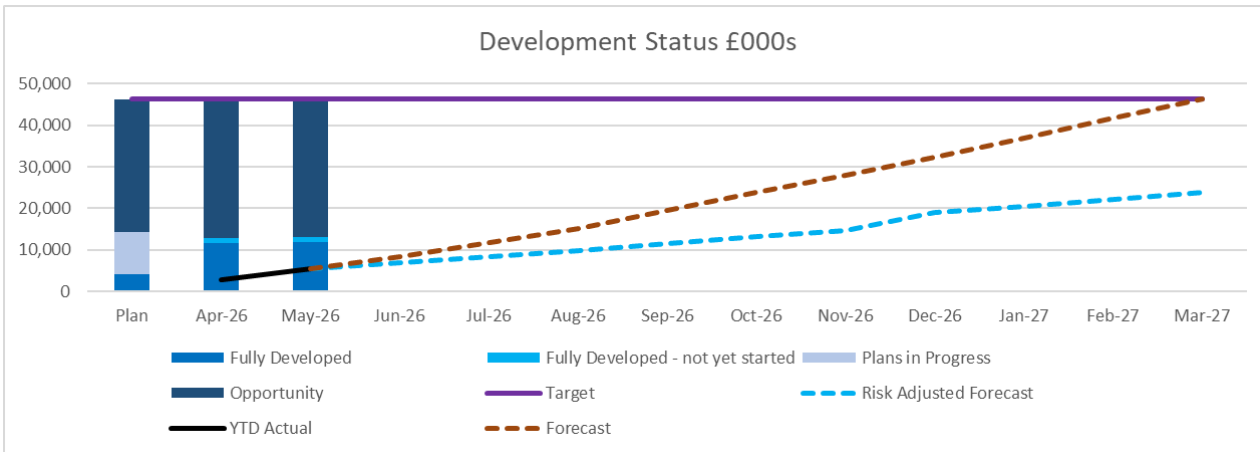
IDP Programme

NB Includes both the Reset Programme and Local Schemes

In terms of 2026/27 in-year impact:

- In month 2 the Trust delivered £2.7m of savings in line with plan. This includes non-recurrent savings of £1.08m.
- Forecast in-year savings are £46.3m in line with plan, with a risk adjusted forecast of £23.7m.
- The committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction in month 2 is 100.6 WTE, with an average of 76.6 WTE reduction year to date. There is forecast to be an average reduction of 395.3 WTE across the full year.

IDP Programme – 2026/27 In Year Savings (£)



Efficiency Plan Status £000's	April Plan Submission	Month 1	Month 2	Increase (Decrease)
Fully Developed - in delivery	4,077	11,702	11,840	138
Fully Developed - not yet started	0	1,258	1,222	(36)
Plans in Progress	10,311	0	0	0
Opportunity	31,902	33,330	33,229	(101)
Unidentified	0	0		0
Total	46,290	46,290	46,290	0

Efficiency Plan Risk £000's	April Plan Submission	Month 1	Month 2	Increase (Decrease)
High	32,657	28,444	28,687	243
Medium	10,072	9,301	9,097	(204)
Low	3,561	8,545	8,507	(38)
Total	46,290	46,290	46,290	0

Pillar	In Year - Year to Date £000s			In Year - Full Year £000s		
	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	250	-	(250)	3,416	3,416	0
Workforce & Organisational Design	977	-	(977)	11,980	11,980	0
Access & Flow	958	246	(711)	7,634	7,634	0
Productivity & Financial Reset	2,099	2,540	441	9,577	9,577	0
Sub Total	4,284	2,787	(1,497)	32,607	32,607	0
Local	1,169	2,666	1,497	13,683	13,683	(0)
Grand Total	5,452	5,452	(0)	46,290	46,290	0

The committed plan is to deliver £46.3m of in-year savings during 2026/27. As at month 2 we have delivered £5.5m of savings (12% of the full year plan). This is in line with plan and includes non-recurrent savings. Forecast delivery for the full year is £46.3m and the risk adjusted forecast is £23.7m.

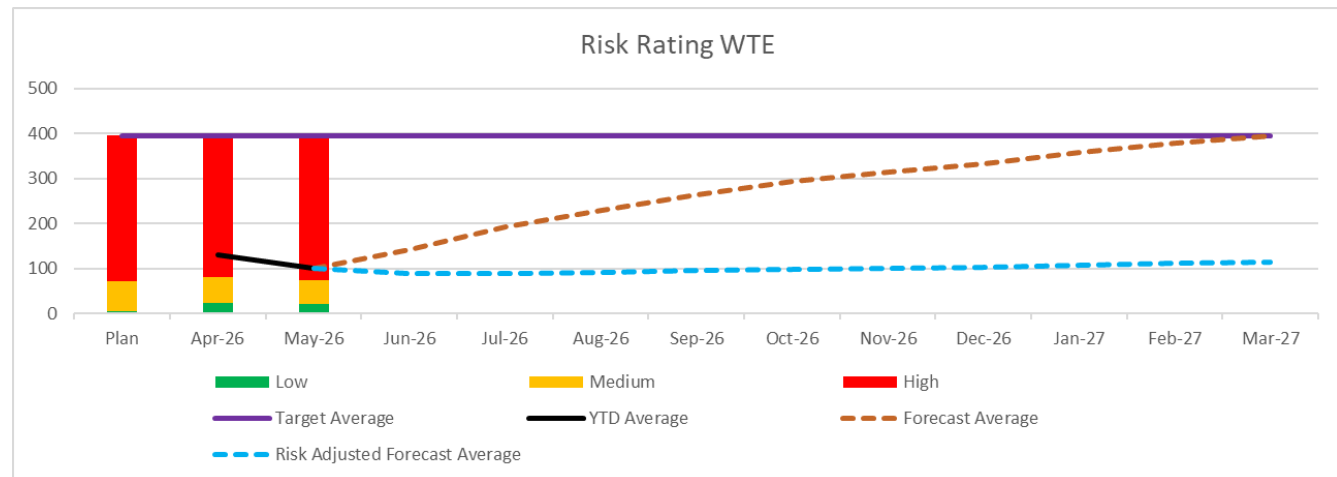
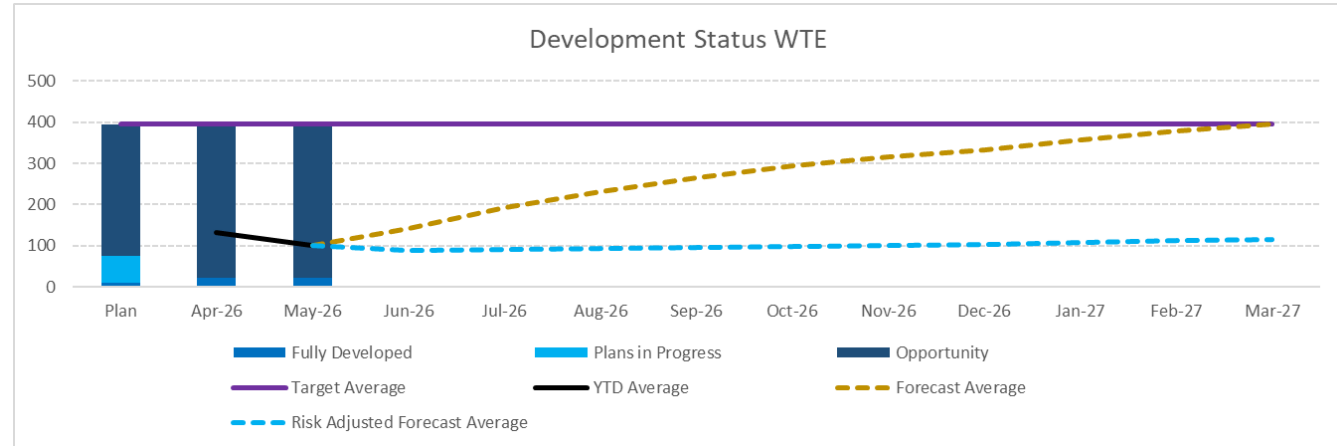
IDP Programme – 2026/27 In-Year (WTE reduction)

Our committed plan is to reduce by 395.1 WTE on average across the year. The average WTE reduction as at month 2 is 100.6 WTE and the forecast average reduction across the full year is currently 395.3 WTE.

WTE - in year	April Plan Submission	Month 1	Month 2	Increase (Decrease)
Fully Developed - in delivery	9.3	23.3	21.4	(1.9)
Fully Developed - not yet started	0.0	0.0	0.0	0.0
Plans in Progress	66.5	0.0	0.0	0.0
Opportunity	319.4	371.4	373.9	2.5
Unidentified	0.0	0.0	0.0	0.0
Total	395.1	394.6	395.3	0.6

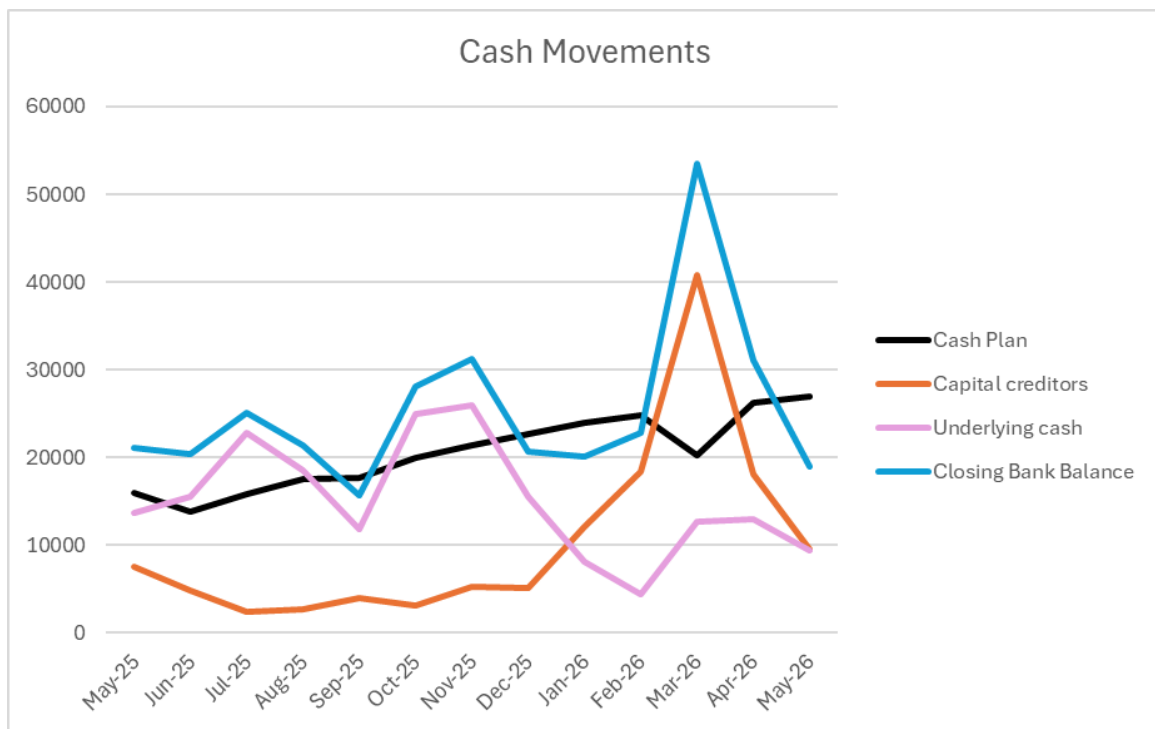
WTE - in year	April Plan Submission	Month 1	Month 2	Increase (Decrease)
High	323.9	313.3	321.0	7.7
Medium	64.9	58.1	52.9	(5.2)
Low	6.3	23.3	21.4	(1.9)
Total	395.1	394.6	395.3	0.6

Pillar	In Year - Year to Date WTE			In Year - Full Year WTE		
	Committed Plan	Actual	Better / (worse)	Committed Plan	Forecast	Better / (worse)
Shape of DBTH	0.0	0.0	0.0	32.0	32.0	0.0
Workforce & Organisational Design	95.1	0.0	(95.1)	253.0	253.0	0.0
Access & Flow	0.0	0.0	0.0	36.1	36.1	0.0
Productivity & Financial Reset	29.2	21.8	(7.5)	9.3	6.5	(2.8)
Sub Total	124.3	21.8	(102.5)	330.3	327.5	(2.8)
Local	64.9	78.8	14.0	64.9	67.8	2.9
Grand Total	189.2	100.6	(88.6)	395.1	395.3	0.1



Cash, Receivables and Payables

Cash reduced to £18.9m as a result of the Trust paying £8.9m of capital creditors in the month and is £8.1m below planned levels. Capital creditors currently total £9.5m and these will be paid during the next few months. The revenue cash balance is £9.4m. Better Payment Practice Code overall performance has remained steady in month.



Invoice Turnaround

Average days	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
Between date of invoice and date available on system	16.6	12.6	16.3	18	16.7	12.5	14.6
Between being available on system and approval	13.4	12.1	25.7	12.7	8	8.1	8.05
Between approved date and payment date	18.8	16.5	18.6	18.9	24.1	21.1	22.6
Total	48.8	41.2	60.6	49.6	48.8	41.7	45.25
Total that the Trust has control over	32.2	28.6	44.3	31.6	32.1	29.2	30.65
Number of invoices	10,728	7,054	7,474	9,726	8,981	7,645	8,313

Better Payment Practice Code (In month)

Average days	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD
NHS - %age based on invoice count	85.85%	59.09%	86.61%	90.34%	63.89%	86.96%	75.43%
NHS - %age based on invoice value	92.50%	50.37%	88.02%	86.94%	77.26%	84.89%	81.08%
Non NHS - %age based on invoice count	34.23%	40.95%	34.95%	39.08%	35.99%	31.80%	33.90%
Non NHS - %age based on invoice value	80.47%	65.41%	78.77%	79.04%	75.08%	69.76%	72.42%
Overall - %age based on invoice count	36.01%	41.18%	36.50%	40.15%	37.25%	32.87%	35.06%
Overall - %age based on invoice value	82.79%	64.97%	79.92%	79.63%	75.31%	70.69%	73.00%

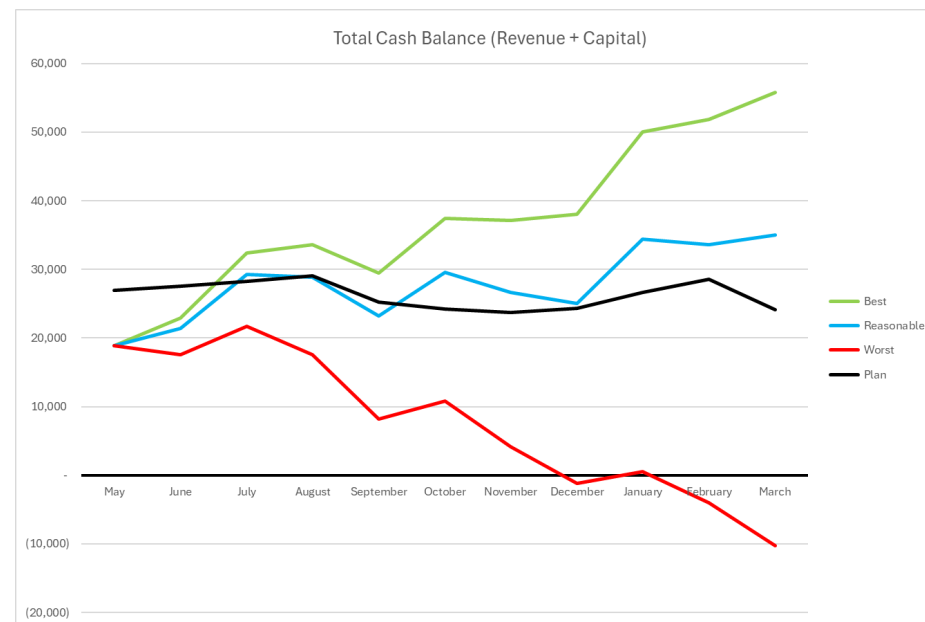
Cash Projections

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 planned to be 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.

Based on the worse case the Trust will require overall cash support in December 2026, although this position will be supported by capital creditors.

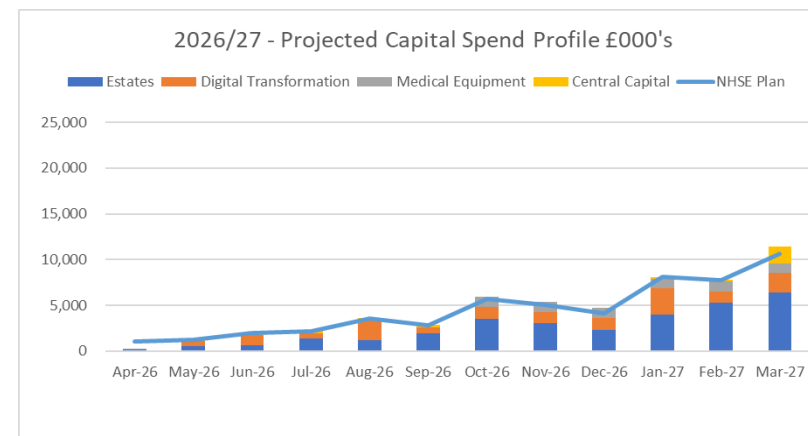
As the risks and mitigations become more pronounced during 2026/27, the cash projections will become more granular.



Key variations in models	Best	Reasonable	Worse
Risks/Mitigations (See Slide 14)	Total mitigations of £16.4m	Risks and mitigations offset to nil	Total risks of £38.1m
Deficit Support Funding	Trust to receive all funding	Trust to receive all funding	Trust not to achieve Q3 and Q4 funding Total risk £7.9m
Cash Management pressures	Extension of creditor payment terms by £5m	Nil	Nil

Capital spend in month is £0.3m, £0.9m variance to plan.

	In Month Plan (£'000)	In Month Spend (£'000)	In Month Variance (£'000)	YTD Plan (£'000)	YTD Spend (£'000)	YTD Variance (£'000)	Annual Plan (£'000)
Estates Projects	501	106	(395)	789	214	(575)	30,221
Medical Equipment	0	6	6	0	87	87	6,551
Digital Transformation Projects	566	187	(380)	1,293	263	(1,029)	14,978
Central Capital	117	10	(106)	184	(30)	(214)	2,292
IFRS16 Leases	0	0	0	0	0	0	0
Total Capital Spend	1,184	309	(875)	2,265	533	(1,732)	54,042
Charitable Funds/Donated Assets	0	0	0	0	0	0	295
Total Capital Spend inc Charitable Funds/Donated Assets	1,184	309	(875)	2,265	533	(1,732)	54,337



The capital plan for 2026/27 includes the following

- £25.4m CDEL (Capital Departmental Expenditure Limit)
- £10.6m Frontline Productivity PDC for the EPR Project
- £9.0m RTCS PDC allocation for DRI UEC Reconfiguration
- £6.0m Estates Safety Fund
- £3.0m High Value Estates Fund – supporting the EWB programme

The current spend YTD is driven by continuation of projects rolled over from 2025/26, work is progressing on the development of business cases for 2026/27 with 6 capital cases approved in May and further cases expected in June including the overarching Medical Equipment Replacement business case. The variance to plan is predominantly driven by EPR delays which are expected to be recovered. The Trust have received confirmation that the Estates Safety Fund £6.1m has been approved, awaiting the MOU to progress. Approval to proceed to business case for the RtCS DRI UEC Reconfiguration (£9m) proposal was confirmed by NHSE and work is now underway.

2607 - C1I Q3 2025/26 LEARNING FROM DEATHS REPORT

● Discussion Item

👤 Nick Mallaband, Chief Medical Officer

🕒 10:20

10 minute

REFERENCES

Only PDFs are attached

📄 C1i - Q3 2025-26 Learning from Deaths Report.pdf

📄 C1i - Appendix 1 - Q3 Learning from Deaths Report.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Learning from Deaths – Quarter 3 Report			
Sponsor:	Dr Nick Mallaband, Chief Medical Officer			
Authors:	Mandy Cumberbatch, Interim Learning from Deaths Manager			
Appendices:	Appendix 1 – Q32 2025/26 Learning from Deaths Report			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level	<i>Significant Assurance</i>			
Assurance Rationale	The Board is asked to take significant assurance that there are effective systems in place to monitor, review, and learn from patient deaths across the Trust. This is evidenced by 100% Medical Examiner scrutiny of in-hospital deaths, increased completion of Structured Judgement Reviews (now 11% of deaths), and clear identification and dissemination of learning themes, particularly in sepsis management and clinical documentation. Mortality surveillance through SHMI continues to show an improving position. Assurance is moderated by a 24% increase in deaths this quarter and capacity constraints impacting SJR completion rates and timeliness, alongside ongoing challenges with changing digital systems from SJR+ to an in-house developed data collection and reporting system.			
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				
Executive Summary – Learning from Deaths Q3 2025/26 This report outlines the effective systems in place to identify, review, and learn from patient deaths, and determine whether these arrangements are resulting in improved quality of care and patient safety. Assessment of Evidence and Assurance Level The evidence demonstrates significant assurance. Robust oversight is evidenced through 100% Medical Examiner scrutiny of all in-hospital deaths, providing a comprehensive baseline for mortality surveillance and family engagement. There is improving compliance with Structured Judgement Reviews (SJRs), increasing from 7% to 11% of deaths reviewed, indicating strengthening governance processes and increasing depth of case review. The SHMI of 113, alongside a downward trend, suggests improving mortality outcomes when benchmarked nationally, supported by internal predictive modelling tools enhancing early identification of variation. Learning outputs are clearly articulated, with recurrent themes identified (e.g. sepsis management, documentation and VTE assessment), demonstrating an embedded learning culture with mechanisms for dissemination across clinical teams.				

Key Risks and Issues

Notwithstanding this positive position, a number of known risks and areas for improvement remain:

- SJR completion rates (11%) remain below the 15% national expectation, with delays primarily attributable to the continued use of hybrid record systems.
- The quarter-on-quarter increase in deaths (570; +24%), although not associated with elective mortality and not currently reflected in adverse SHMI variation, requires ongoing scrutiny to ensure early identification of emerging trends.
- Clinical learning themes persist, particularly relating to:
- Sepsis management (timeliness of antibiotics, pathway compliance)
 - VTE reassessment
 - Fluid balance documentation
 - Timely microbiology input
- Digital system limitations (including SJR platform constraints and transition to EPR) continue to present a risk to:
 - Timeliness of review
 - Data quality
 - Consistency of learning capture

Actions, Impact and Oversight Arrangements

Actions are in place to strengthen review capacity and targeting, including:

- The Trust has established appropriate mitigating actions and controls to address these risks:
- Targeted mortality reviews are being undertaken in areas of higher-than-expected mortality (e.g. sepsis, anaemia, UTI, intestinal infection), with findings indicating that care is predominantly good, and concerns escalated appropriately.
- Structured learning processes are embedded, with themes identified, triangulated through governance routes, and shared at divisional and Trust level.
- Strengthened data intelligence capability via the DERICK dashboard enables earlier identification of variation and proactive clinical response.
- Divisional governance oversight is in place to monitor compliance with key care standards (e.g. sepsis pathway, VTE, documentation).
- These controls provide confidence that risks are recognised, actively managed, and subject to ongoing oversight.

Effectiveness of Controls

Controls are assessed as generally effective but not yet optimised. Core processes for mortality surveillance and review are embedded and functioning, but are constrained by capacity and system limitations, reducing overall efficiency and coverage against national benchmarks.

Organisational Impact

The increase in mortality activity and ongoing operational constraints present a sustained pressure on clinical and governance capacity, with potential implications for timely learning, staff workload, and delivery of consistent quality improvements across services.

Confidence in Data

The report provides good confidence in the underlying data, supported by comprehensive Medical Examiner scrutiny and use of national (SHMI) and internal modelling systems. However, confidence is moderately impacted by known delays in national datasets and limitations associated with fragmented data sources and systems, which may affect completeness and timeliness of analysis.

Overall Assurance

- The report provides significant assurance that effective mortality governance arrangements are in place across the Trust, with comprehensive oversight, appropriate escalation, and evidence of continuous learning and improvement.
- Robust processes are established and embedded, including 100% Medical Examiner scrutiny of in-hospital deaths and consistent utilisation of escalation pathways (coroner referral, PSIRF and SJR processes).
- Mortality indicators remain within expected range and demonstrating a developing downward trend, supported by strengthened internal surveillance via the DERICK dashboard.
- Family engagement remains strong, with communication achieved in 97% of cases, reinforcing transparency and compliance with national Learning from Deaths expectations.
- This provides assurance that statutory and regulatory requirements are being met, and that mortality review remains systematic, transparent and embedded within governance structures.

Recommendations

The Board is asked to take assurance from the report, note the contents and support the ongoing actions:

- **Continue targeted improvement on sepsis management**, with demonstrable action on timely antibiotics, blood culture compliance and IPOC completion, with divisional oversight and monitoring of impact.
- **Strengthen SJR completion rates towards the 15% national expectation**, addressing delays associated with hybrid records and ensuring consistency across specialties pending EPR implementation.
- **Ensure sustained focus on fundamental care standards**, particularly VTE reassessment and fluid balance documentation, through divisional governance and audit.
- **Maintain enhanced oversight of mortality outliers (e.g. anaemia, UTI, intestinal infection)**, ensuring learning is triangulated with SHMI trends and embedded into clinical practice.
- **Support digital transition arrangements** (SJR system replacement and EPR readiness) to mitigate risks to timely review, data quality and learning capture.

Healthier together – delivering exceptional care for all

Patients	Patients benefit from strengthened oversight and targeted improvements in care quality, particularly in sepsis management and fundamental clinical practices, which support safer, more timely, and consistent care.
People	Staff are supported to deliver safer care through clearer expectations, improved processes, and focused learning from reviews.
Partnerships	Partnerships with coronial services, families, and external systems are strengthened through improved communication, transparency, and collaborative learning from deaths.
Pounds	Improved mortality oversight and targeted interventions support more efficient use of resources and may reduce avoidable costs associated with complications, extended length of stay, and potential litigation.
Health Inequalities	The report highlights equitable oversight of all deaths, but identifies the need to maintain focused review of vulnerable groups (e.g. patients with learning disabilities and sepsis) to ensure any variation in outcomes is recognised and addressed promptly.
Legal/ Regulation:	The report provides assurance that the Trust is meeting its statutory and regulatory requirements for mortality review, including Learning from Deaths guidance, Medical Examiner scrutiny, coronial processes, and PSIRF compliance, with appropriate escalation and governance oversight.

Partner ICB strategies	Alignment with strategies is supported through strengthened mortality surveillance, data quality, and shared learning, enabling collaborative system-wide improvement and consistency in care standards across partner organisations.
Assurance Route	
Previously considered by - including date:	Mortality Governance Group 20 February 2026. Effective Assurance Group 6 May 2026. Quality Committee
Any outcomes/next steps / time scales	

**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust****LEARNING FROM DEATHS QUARTERLY REPORT 2025/26 - Quarter 3****1. Introduction**

This is the quarterly report to be received by the Mortality Governance Group and the Effective Committee. It reports on the deaths of patients under the care of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust as required by the Learning from Deaths Guidance dated March 2017. It covers **Q3 (1st October – 31st December 2025)** and includes the most recent data on crude mortality, Summary Hospital-level Mortality Indicator (SHMI) metrics and presents key metrics on the mortality case review process, namely Structured Judgement Reviews (SJRs) and provides insight into the learning from SJRs.

2. Key Points.

- There have been 491 in-patient deaths at the Trust during the quarter and 79 in the Emergency Department. Total = 570. This is a 24% increase from Q2
- No deaths occurred following an elective admission, and two deaths were of patients with a learning disability.
- 139 deaths were reported to HM Coroner
- 39 inquests have been opened.
- 13 Structured Judgement Reviews (SJRs) were requested by the Medical Examiner office
- 54 further SJR's have been requested for cases where either sepsis, anaemia, intestinal infection and UTI were the last coded diagnosis. In the case of anaemia, intestinal infection and UTI, these all appeared as the diagnosis groups where a higher-than-expected level of deaths has occurred.
- 8 cases were referred to the "Learn from patient safety events panel" (LFPSE).
- The Summary Hospital Level Mortality Indicator (SHMI) rolling 12-month figure is 113
- 100% of all in hospital deaths have been scrutinised by the Medical Examiner's office.

- Learning points from the completed SJRs are:
 - Re-assess VTE risk at either 24 or 72 hrs post admission or if change in clinical condition
 - Completion of fluid balance charts is essential in patients who have IV fluids and urinary catheters in situ
 - Sepsis IPOC completion is crucial
 - Blood culture sampling in “sepsis” needs improvement
 - Timely administration of first dose of appropriate antibiotics needs to improve with frequent involvement of microbiology

3. Deaths by month- Crude Mortality October 2025- December 2025

3.1 There were a total of 491 in-patient deaths in Doncaster & Bassetlaw Teaching Hospital Foundation Trust (DBHFT) in the 3 months between October 2025 and December 2025 and 79 in the Emergency department. Total deaths = 570 (Source: Information services) This is a 24% increase in numbers from last quarter. There were 459 total deaths in the same quarter last year (Jul – Sep 2024).

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

Figure 1

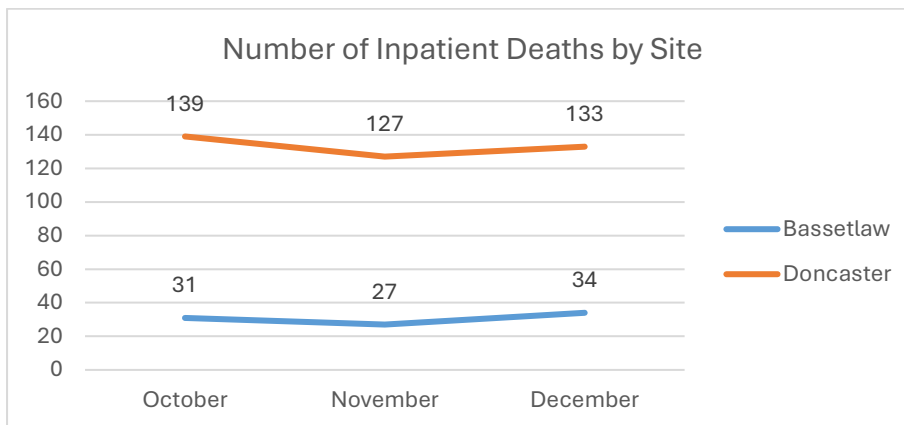


Figure 2.

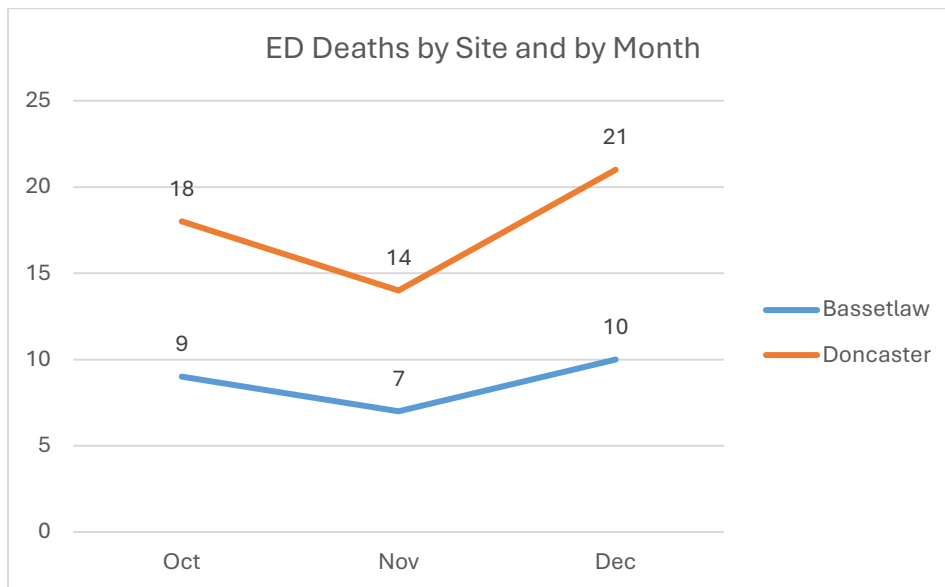
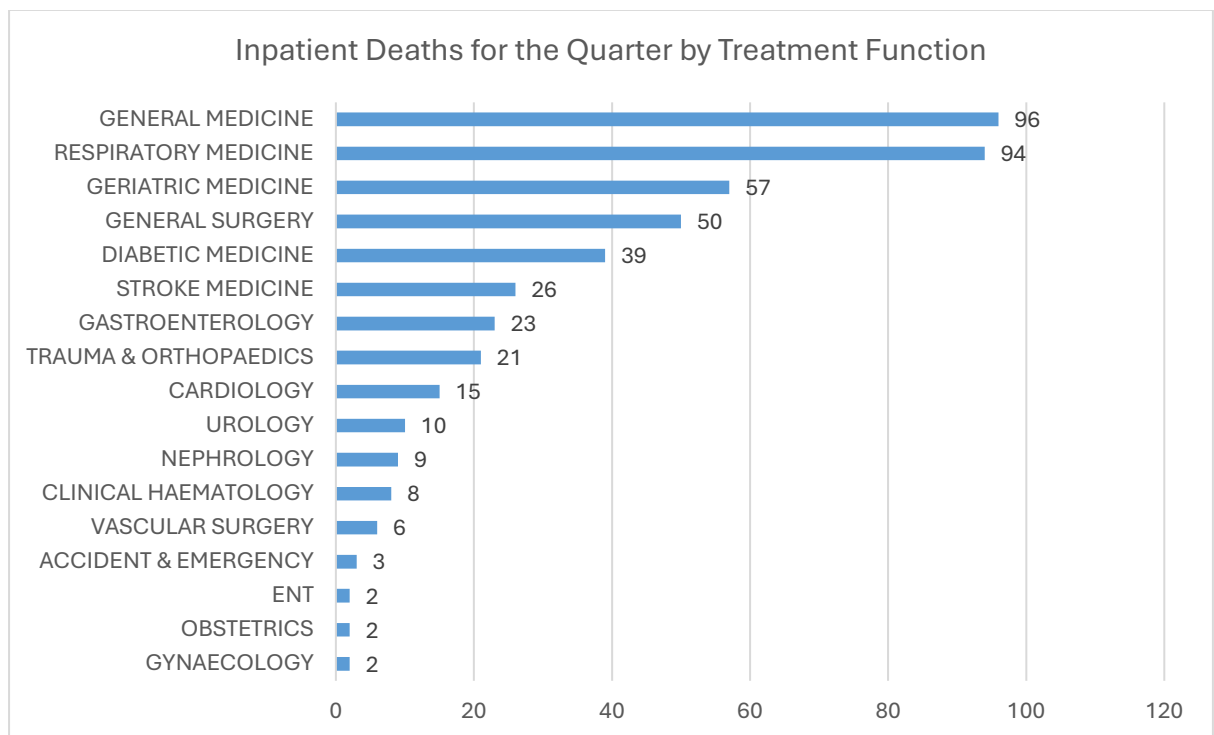


Figure 3.



3.3.

Two patients initially classed as elective admissions and died were reviewed within the Mortality Governance group. The conclusion was that neither of these cases were actual elective admissions. There continues to be issues with the correct classification of the type of admission in a small number of cases.

This has been discussed at Mortality Governance and escalated to the medical director for advice.

There were two patients recorded as having a Learning Disability. Both of these cases were referred to LeDeR. One of the cases is the subject of a coronial investigation and listed for inquest in April. LeDeR have been informed. The other case was subject to an SJR. The review identified good care with a particular mention of the early recognition of deterioration and the dying patient, enabling good end of life care and communication with the family.

4.Summary Hospital –Level Mortality Indicator (SHMI)

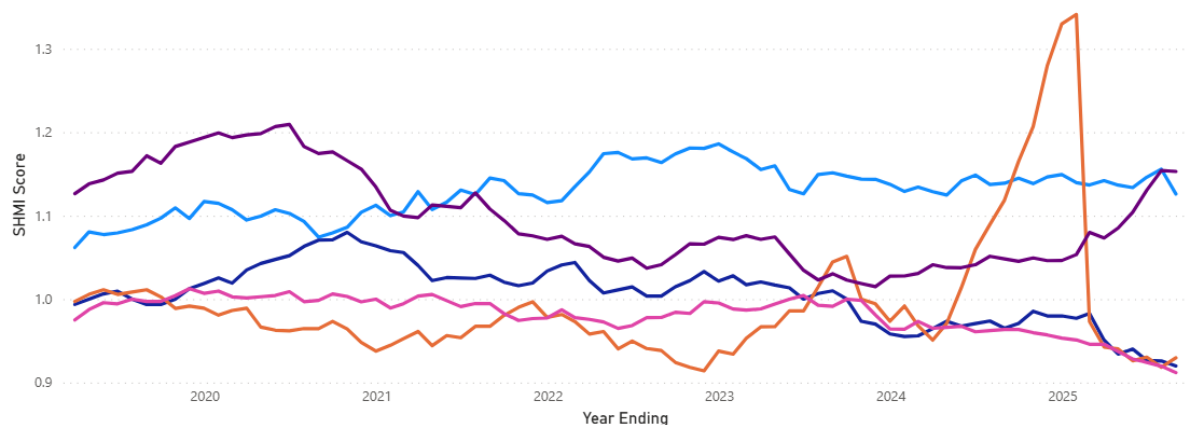
4.1 The Trust uses SHMI as the national metric to monitor mortality. This figure includes deaths of patients who have died within 30 days of discharge. In addition to this, internal data modelling is ongoing via the “DERICK” dashboard. This data modelling continues to provide good predictions relating to the number of deaths and remains within the data confidence intervals which will help ensure earlier conversations can happen should any unexpected anomalies occur prior to any national data being published.

Figure 4 shows the rolling SHMI score compared to our peers accurate as of end of July 2025. There is always a delay of at least 6 months in assessing the SHMI value. It is currently 113 and after a relatively stable period, now shows a promising downward curve.

Figure 4.

Rolling Yearly SHMI Score Comparison

● DBTH ● Barnsley ● Chesterfield ● Rotherham ● Sheffield



Latest 12 Months

ProviderCode	ProviderName	Expected	Observed	SHMI_Score
RFR	The Rotherham NHS FT	1,340.00	1545	1.15
RP5	Doncaster and Bassetlaw Teaching Hospitals NHS FT	2,420.00	2725	1.13
RFS	Chesterfield Royal Hospital NHS FT	2,065.00	1920	0.93
RFF	Barnsley Hospital NHS FT	1,750.00	1610	0.92
RHQ	Sheffield Teaching Hospitals NHS FT	3,805.00	3470	0.91

The table below, is ordered to show statistically, those diagnosis groups where a higher-than-expected level of deaths has occurred. It is a selection of these cases that are being reviewed to understand if any learning can be identified. Anaemia and urinary tract infections are the ones being further reviewed using SJR and Intestinal infection cases have also been reviewed as they appeared in this table last quarter.

Latest 12 Months

Group Description	Total Spells	Predicted Deaths	LowerLimit	UpperLimit	Actual Deaths	SHMI banding	SHMI Score	StdDevs from Expected
Fluid and electrolyte disorders	650	36.8	25.4	48.1	56	Higher than expected	1.52	3.3
Pleurisy; pneumothorax; pulmonary collapse	265	19.8	11.7	28.0	33	Higher than expected	1.66	3.2
Urinary tract infections	1690	71.5	55.6	87.3	97	Higher than expected	1.36	3.2
Acute bronchitis	1563	35.2	24.1	46.2	49	Higher than expected	1.39	2.5
Congestive heart failure; nonhypertensive	794	102.2	84.0	120.3	123	Higher than expected	1.20	2.2
Acute and unspecified renal failure	559	72.6	57.5	87.8	90	Higher than expected	1.24	2.2
Anaemia	641	18.6	10.4	26.9	27	Higher than expected	1.45	2.0
Neoplasms (unspecified), Nonmalignant breast conditions	151	4.3	0.6	8.1	8	As expected	1.84	1.9
Total	80245	2,445.9	2,357.7	2,534.1	2603	Higher than expected	1.06	3.5

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

5.1 A team of 20 trained senior medical and nursing staff undertake reviews on specific cases each month. There is a national guideline that around 15% of all hospital deaths should be reviewed using SJR methodology. Last quarter, 33 cases were reviewed which equates to 7% of deaths. This quarter 67 SJRs have been requested and at the time of reporting, 46 completed, which is a significant increase on last quarter. However, due to the increase in deaths generally, this still only equates to 11% of all hospital deaths, albeit a good increase.

It should be noted that the current situation of clinical records being maintained in several different electronic forms as well as the continued use of paper records, is resulting in SJR's taking much longer to complete. In addition, the situation within specialties differs across hospital sites. The eventual arrival of EPR should address all of this, however this may be yet another 18months. This situation is felt at a regional level also, as described at the last Regional Mortality meeting.

Cases are selected by various methods:

1. ME team referral:
 - if patient has a learning disability/ significant mental health issue and /or autism
 - If a patient is admitted electively and dies
 - If staff or bereaved family members have raised concerns
 - If ME/MEO has identified issues during their scrutiny which do NOT fit into the PSIRF process or coronial process.
2. Sepsis related deaths: These are captured by the ME team based on the cause of death under 1a or 1b of the MCCD
3. Diagnostic groups where a higher-than-expected number of deaths has occurred and as such, contribute to the SHMI. This quarter includes:
 - Anaemia
 - Intestinal Infection
 - UTI

See 6.3, 6.4, 6.5 for analysis of these.

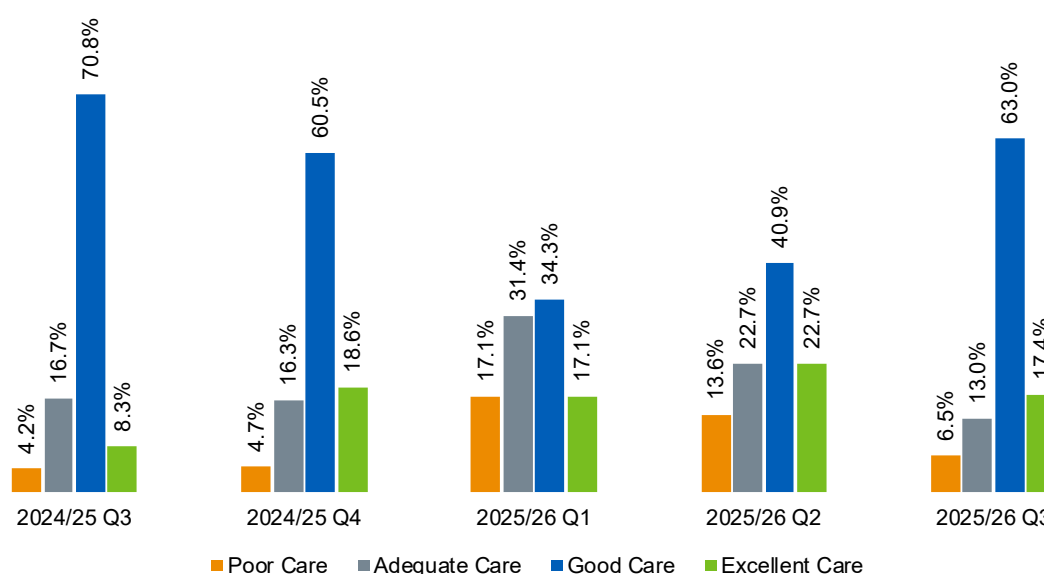
To note: The ME team also refer cases to individual clinical teams where clear learning is identified. Learning can then be shared with immediate effect amongst the team. They also attempt to communicate with every bereaved family. The numbers of those who they fail to communicate with are extremely low. This quarter there were only 19 families (3%) who they failed to communicate with. One could therefore conclude that as they communicate with the large majority, families are satisfied with the care provided.

The referral for SJR from the ME team is under debate at the moment with a meeting planned. Any changes to process will be captured in the Q4 report.

6. Learning from SJR.

6.1 An important aspect of the SJR process is that it highlights good care as well as poor care. Alongside judgement comments, the reviewer is asked to score each phase of care from “very poor” to “excellent” and then provide a score for the overall assessment of care. The following graphs illustrate the care score given for the overall assessment since we began gathering the data on the SJR plus app:

Overall assessment ratings as % per quarter



The majority of cases reviewed this quarter have recorded “good” and “excellent” in the overall assessment. Frequently seen examples of good or excellent care can be seen below:

- Good timely assessment and recognition of sepsis
- Exemplary documentation and communication
- Good recognition of the dying patient with supportive plan in place
- Early escalation and good team working
- Good early involvement of the Consultant at a critical stage

If the overall assessment of a case is “very poor” or “poor”, it is sent to the specialty governance lead/DQAC/Senior Nurse for further review and sharing within the governance meeting and to share any identified learning.

Examples of poor care judgement comments have been:

- Poor recognition of ceiling of care and agreement for palliation
- Significant delay in controlling pain.
- Lack of VTE assessment.
- “not my patient” mentality having a negative impact on patient care and onward management

General learning includes:

- Re-assess VTE risk at either 24 or 72 hrs post admission or if change in clinical condition
- Completion of fluid balance charts is essential in patients who have IV fluids and urinary catheters in situ
- Sepsis IPOC completion is crucial
- Blood culture sampling in “sepsis” needs improvement
- Timely administration of first dose of appropriate antibiotics needs to improve with frequent involvement of microbiology

6.2 Sepsis

Three recurring points for learning from the 24 sepsis cases reviewed and for which the reviewer concluded the care to be either “adequate” or “poor” are:

- Blood Culture sampling needs improvement
- Sepsis IPOC completion is crucial
- Timely administration of first dose of appropriate antibiotics and involvement of microbiology needs to improve.

6.3 Anaemia

12 reviews have been undertaken on cases where “anaemia” appears in the data, as a diagnosis group where a higher-than-expected number of deaths have occurred. Each of these reviews identified good care overall. One observation is that each case had multiple consultant episodes with a working diagnosis noted initially but which changed quite considerably further into the patient journey. Anaemia was primarily often a chronic condition.

6.4 Intestinal infection

Three cases have been reviewed. All cases were of patients with frequent admissions due to multiple comorbidities. Care was assessed as being “good” with no learning identified in any of the reviews

6.5 UTI

Five cases have been reviewed. Three of these died in the community and were very elderly patients, residing in care homes. All hospital care was judged as being good and fast track discharge arrangements excellent. The other two patients were also elderly, admitted with urinary retention and subsequently received good care for urosepsis.

6.6 SJR PLUS APP

The SJR plus application will be no longer available from 27th March 2026. This is due to the de-commissioning of the service by the current supplier. The digital team are currently working to build up the Trust's own data collection form and analysis tool. This situation may result in Q4 data being gathered in two separate ways though all data captured within the SJR Plus app will be exported and available to the Trust from the time of closure.

7 Referral to His Majesty's Coroner (HMC)

This quarter there have been **139** referrals to the coroner.

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

39 inquests have been opened this quarter and 36 concluded.

From 1st April 2025 the process for Cause of Death statement requests from HMC has changed. These now go through the inquest team, rather than the bereavement team, for oversight and awareness. There have been 12 such requests this quarter.

8. Regulation 28 Prevention of Future deaths reports (PFDR's)

There have been 0 PFDR's received this quarter.

9. Referral to PALS from the Medical Examiner (ME) office.

When the ME speak to bereaved family members, they enquire if they had any issues/concerns with their loved one's care. In the majority of cases, the response is very positive, offering praise to ward teams. If they raise concerns which they want to take

further, then the PALS contact details are provided. During this quarter, six families were given the PALS number and to date, one of these has been logged as a formal complaint. The subject of the complaint is: *delay in treatment and communication with relatives*.

10. Patient Safety Incident Response Framework (PSIRF) investigations

Eights cases were flagged by the ME team as potential PSII's, incidents. All were reviewed and discussed at divisional panel +/- brought to LFPSE. 1 case was escalated and discussed at LFPSE panel. 3 cases are still being reviewed by the division, as awaiting further information.

Of these cases, there was 1 open discussion

10 Conclusion

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

11 Recommendations

- All Divisions to share this report via their clinical governance groups and more widely with the ward and department staff. Clinical Governance groups to suggest, design and implement change to ensure improvements are made.

Reporting schedule

QUARTER 2025/26	Mortality Governance	Effective Assurance Group	Quality Committee	Clinical Quality Review Group
Q1 : April - June	August 2025	3/9/25	9/10/25	14/10/25
Q2: July - Sept	Nov 2025	7/1/26	5/2/26	10/02/26
Q3: Oct - Dec	Feb 2026	4/3/26	23/4/26	12/05/26
Q4: Jan - March	May 2026	1/7/26	6/8/26	11/08/26

Mandy Cumberbatch (nee Dalton)

Interim LFD Manager.

Received by Mortality Governance : 20th February 2026.

2607 - D1 RESEARCH & INNOVATION CASE STUDY

● Information Item

● Zoe Lintin, Chief People Officer

● 10:30

Professor Sam Debbage, Director of Education & Research
Dr Jane Fearnside, Head of Research

10 minutes

REFERENCES

Only PDFs are attached



D1 - Research & Innovation Case Study.pdf



D1 - Appendix 1 Presentation.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Research & Innovation Case Study			
Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Sam Debbage, Director of Education and Research Jane Fearnside, Head of Research			
Appendices:	Appendix 1 - Presentation			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (For assurance papers only)	N/A			
Assurance Rationale	N/A			
Impacts on Strategic Risks (BAF 1-7)	BAF 1 & 2			
Executive Summary – Key messages and Issues				
Research active organisations have better patient outcomes. DBTH continues to grow research capacity and capabilities to maximise research opportunities for all our patients and colleagues. We have continued to grow our commercial research portfolio in support of patients where there are limited treatment options available on the NHS. Patients with chronic, debilitating or terminal conditions, often describe limited treatment options or unavailable life-extending drugs on the NHS as the “end of the line” for them. Access to investigational therapies results in improved quality of life, hope and treatment options to not only empower patients but also support the NHS with cost savings, income generation for reinvestment and attraction of clinical talent to the organisation. Due to the drop in commercial trials in the UK over recent years as a result of delays in study set up, the government has implemented the 150-day clinical trial set up target and invested £1.6billion in infrastructure to attract the life sciences sector back to the UK. However, timely set up and delivery of clinical trials cannot be completed without the right infrastructure and resources within NHS organisations. A case study of a DBTH patient participating in a research study (Myopath) is presented to demonstrate the importance of having access to research study opportunities (as an alternative clinical pathway) at individual, organisation and system level. The presentation therefore also highlights: • The 150-day metric (value to patients and the organisation) • The impact of any delays in study set up • An overview of reasons for clinical trial set up delays • Mitigation and growth of research opportunities for our patients • Confirmation of oversight from the Executive Team and governance through the People Committee				
Recommendations				
To continue to support the delivery of the Research and Innovation strategic plan, complementing the ambition for DBTH to be recognised as a University Teaching Hospital.				
Healthier together – delivering exceptional care for all				
Patients	Increase access to research opportunities to complete or replace standard NHS treatments			
People	Support a research skilled workforce to champion, facilitate, lead and/ or participate in research			
Partnerships	Work in collaboration with the NIHR (National Institute for Health and Care Research) to expand research activity			

Pounds	Work with industry and academic partners to grow research funding opportunities
Health Inequalities	Consider the impact through a Health Inequalities lens all research activity and undertake purposive research into Health Inequalities
Legal/ Regulation:	Continue to comply with regulatory standard
Partner ICB strategies	Recognise DBTH's role in the regional research ecosystem to complement patient pathways and enhance our regional opportunities and impact
Assurance Route	
Previously considered by - including date:	-
Any outcomes/next steps / time scales	-



Research and Innovation Case Study

Professor Sam Debbage, Director of Education and Research
Dr Jane Fearnside, Head of Research



150 day clinical trial set up target

NHS CLINICAL TRIAL

SET-UP

150-DAY TARGET



Set and meet higher recruitment targets – reverse the trend of falling participant numbers in industry trials



Executive level accountability across the NHS – NHS Chief Executive and DHSC Chief Scientific Advisor are accountable for commercial clinical trials performance in the NHS



Accelerate set-up times – cut the delays in site opening and recruitment



Demonstrate impact of Investment Programme funding – deliver fast trials to increase the opportunities for patients to take part in globally leading research

What is the 150-day target?

Why it matters to our patients?

Why it matters to the organisation?



Rheumatology case study: Myositis

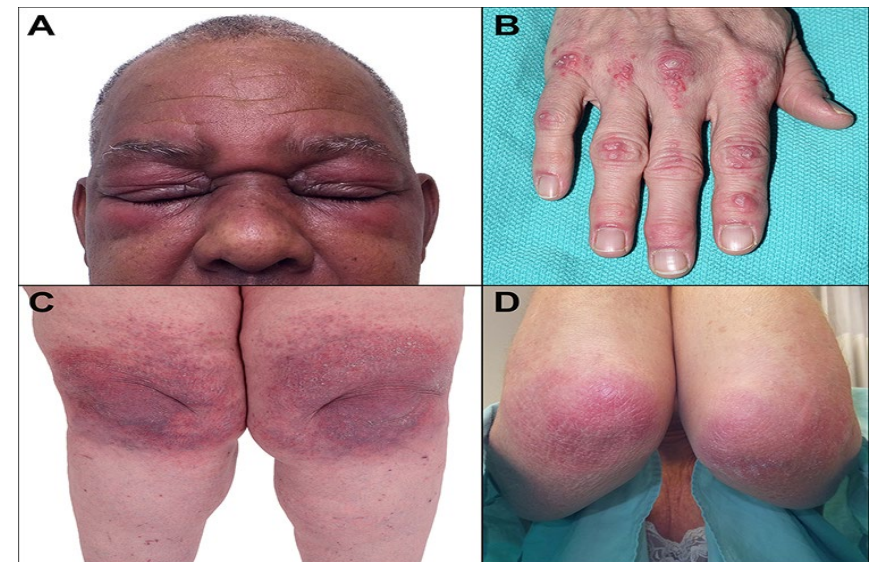
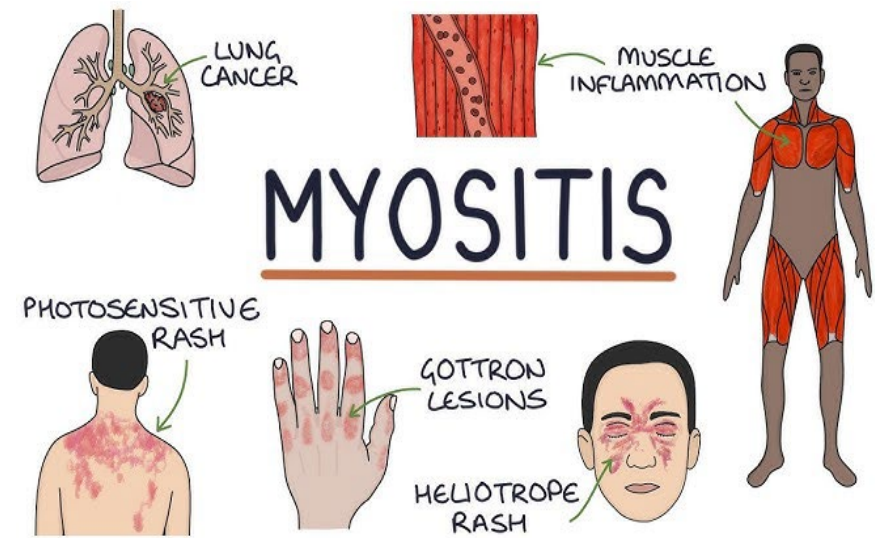
Dermatomyositis is a rare, systemic autoimmune disease characterised by chronic muscle inflammation (myositis) and distinctive skin rashes.

Polymyositis is a rare autoimmune disease where the immune system mistakenly attacks muscles, causing chronic inflammation and weakness.

Standard treatment: cost to the NHS £50K to £70K per patient annually

- First line therapy – corticosteroids
- Immunosuppressive drugs to reduce the long-term side effects of steroids
- Intravenous immunoglobulin for severe or refractory cases (an infusion of healthy antibodies from blood donors that helps block the immune system from attacking muscle tissue)
- Options of physiotherapy and Occupational Therapy

What happens when standard treatment doesn't work?



Research study options: Myopath research study

Patient Story:

Dr Yee identified a patient with lupus who had also developed myositis resulting in significantly limited treatment options. A suitable research trial was needed. Following an expression of interest for Myopath (commercial study) and a site selection visit, DBTH was accepted as a site for the study.



"Living with lupus is like being robbed, it has gradually eroded and erased nearly all of the person I used to be. I was an active, vibrant, sharp witted, intelligent woman, who worked in management juggling being a single mum to a neurodivergent child, with work and multiple hobbies. I was a healthy weight, never left the house without my hair styled and makeup on and happily helped family and friends out when needed. Once lupus took hold, I gradually had to reduce what I did. Pain, weakness, tremors, many other symptoms, but most of all the body and spirit crushing levels of fatigue made **living** impossible and eventually only **survival** possible. I can no longer work (it would be my single low level goal in life, to work again), I don't have the 'energy' or physical ability to cook, clean, bathe myself or do any activities, even quiet, home based ones now, apart from around once a year or so...and those can actually be some of the cruelest times, those small glimmers of the person I once was, the life that could have been, but the knowledge that by the next day I will be back to the 'useless' thing just killing time until the next possible glimpse of life, relying on help from people I should be helping instead, just to barely 'function' as a human.

Medication and regular blood tests mean that I'm less likely to die than previous generations, but I'd like to think that no one, in future, should have to take destructive medications just to 'not die', but that they might be able to take safer medications and actually be able to 'live' and never have to feel like a burden...on family or the H&C system"

The Myopath Study

Primary objective: evaluate the efficacy of Dazukibart in reducing muscle symptoms in adult participants with active Dermatomyositis (DM) and adult participants with active Polymyositis(PM) compared with placebo.

Provides an option for patients to go onto the extension study and have continued access to investigational therapy not available on the NHS.

After patient consent, the initial treatment requires the patient to undergo a 'washout period' of the patient's current treatment. 60 days in this instance.

Eligible participants receive either dazukibart or a placebo via intravenous (IV) infusion every 4 weeks

The treatment period and monitoring last for approximately 1 year



The Myopath Study – Lessons learnt

Individual level

- Identification of patient prior to submission of expression of interest for the study
- Optimal screening time for patients (condition markers)

Organisational level

- Working with Pharmacy to expand infrastructure (people and places) to prevent delays
- Reinvestment of commercial income*
- Reducing Health Inequalities by improving access to clinical trials

System level

- Making research available to everyone
- Maximising partnerships
- Support our ambition to grow clinical capabilities

*3 example studies for Rheumatology (8 patients) saved DBTH (NHS) £400k (cons



Questions and feedback



2607 - D2 QUALITY ACCOUNTS

● Information Item

● Simon Brown, Deputy Chief Nurse

● 10:40

5 minutes

REFERENCES

Only PDFs are attached

-  D2 - 2025-26 Quality Accounts.pdf
-  D2 - Appendix 1 - Quality Account 2025-26.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Quality Accounts 2025/2026			
Sponsor:	Karen Jessop, Chief Nurse			
Authors:	Simon Brown, Deputy Chief Nurse			
Appendices:	2025/26 Quality Accounts			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (For assurance papers only)	N/A			
Assurance Rationale	N/A			
Impacts on Strategic Risks (BAF 1-7)	BAF1			
Executive Summary – Key messages and Issues				
This paper presents the Trust's Quality Accounts 2025/26, setting out performance, achievements, assurance and future priorities across patient safety, clinical effectiveness and patient experience. The report evidences progress in reducing avoidable harm, strengthening antimicrobial stewardship, improving mortality review, embedding Patient Safety Incident Response Framework (PSIRF) and advancing work on health inequalities, research and service transformation. It also provides a balanced account of ongoing challenges relating to urgent and emergency care flow, elective recovery, workforce pressures and operational performance. Overall, the paper provides assurance that robust governance arrangements are in place to oversee quality, sustain improvement and address areas requiring continued focus in 2026/27.				
Recommendations				
The Board is asked to note the Quality Accounts.				
Healthier together – delivering exceptional care for all				
Patients	Safe and effective care			
People	Keeping our people safe			
Partnerships	n/a			
Pounds	n/a			
Health Inequalities	n/a			
Legal/ Regulation:	n/a			
Partner ICB strategies	n/a			
Assurance Route				
Previously considered by - including date:	Approved by the Quality Committee on 4 June 2026			
Any outcomes/next steps / time scales	Approved			



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



Quality Accounts

Financial year 2025/26

Doncaster and Bassetlaw Teaching Hospitals



Doncaster and Bassetlaw Teaching
Hospitals NHS Foundation Trust
Quality Accounts 2025/26

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Overall performance overview and analysis in 2025/26	15
Quality achievements in 2025/26	17
Looking ahead: Priorities for 2025/26	25
Conclusion	37

Chief Nurse's Statement

As Chief Nurse at Doncaster and Bassetlaw Teaching Hospitals (DBTH), I am proud to introduce our Quality Account for 2025/26, reflecting another year of determined progress, honest reflection and continued commitment to delivering safe, exceptional and person-centred care for the communities we serve.

This year has once again brought significant challenges across the NHS, with rising demand, increasing clinical complexity, workforce pressures and continued operational strain across urgent, planned and community services. Despite this, colleagues across DBTH have continued to respond with professionalism, resilience and compassion, delivering high-quality care under sustained pressure.

During 2025/26, we cared for more than 235,000 emergency patients, delivered over 634,000 outpatient appointments, cared for almost 140,000 inpatients and welcomed 4,549 babies into our services. Demand across urgent and emergency care remained particularly high throughout the year, with Emergency Department attendances increasing by more than 25,000 compared with the previous year.

Against this backdrop, there are many areas of meaningful progress reflected throughout this report.

We continued embedding the Patient Safety Incident Response Framework (PSIRF) across the organisation, further strengthening our culture of openness, learning and continuous improvement. This included more mature approaches to patient safety investigations, greater focus on system learning, and strengthened governance around safety alerts, mortality review and clinical audit activity.

I am particularly pleased with the progress made in reducing avoidable harm. During 2025/26, there has been sustained reductions in hospital-acquired pneumonia and strengthened antimicrobial stewardship arrangements. We also continued to improve the quality of care planning and assessment for vulnerable patients through enhanced Mental Capacity Act training, safeguarding oversight and improvements within Nervecentre documentation and audit processes.

This year also marked an important period of transition for our Nursing, Midwifery and Allied Health Professionals (NMAHP) Strategy, with key priorities now embedded into business-as-usual delivery and governance arrangements. Workstreams focused on mouth care, antimicrobial prescribing, mental capacity and patient safety have all demonstrated measurable improvement and strengthened assurance around quality and clinical effectiveness.

Alongside our safety and quality work, we have continued to strengthen how we listen and respond to the voices of patients, carers and communities. This includes targeted engagement work with underserved groups, improvements to interpretation and accessibility services, continued investment in patient feedback mechanisms and the expansion of volunteer and patient involvement initiatives across our sites.

A major focus throughout the year has also been tackling health inequalities. In 2025/26, this became formally embedded as one of the Trust's core strategic ambitions within our refreshed strategy, *Healthier Together*. Through dedicated training programmes, new governance structures and innovative data tools such as the Equity Index, we are increasingly ensuring that quality improvement and service redesign are informed by the needs of the populations we serve.

This report also reflects an organisation continuing to evolve and modernise. Whether through Virtual Wards, Community Diagnostic Centres, digital transformation programmes, research and innovation partnerships, or the expansion of community-based care, we are increasingly redesigning services around patient need whilst supporting long-term sustainability.

At the same time, we remain honest about the challenges that continue to face us. Pressures across urgent and emergency care, elective recovery, workforce wellbeing and operational performance remain significant. Some areas require further improvement and this report outlines clearly where our focus must continue over the coming year.

Looking ahead to 2026/27, our priorities are clear. We will continue strengthening the fundamentals of safe and compassionate care, improving access and patient flow, reducing inequalities, supporting colleagues through change and embedding the cultural expectations set out through the DBTH Way. We will also continue progressing our ambition to become a leading University Teaching Hospital, where excellence in care, education, research and innovation are fully integrated.

On behalf of the Nursing, Midwifery and Allied Health Professional leadership teams, I would like to thank every colleague across DBTH for their continued commitment, professionalism and compassion. The progress reflected within this Quality Account belongs to all of Team DBTH.

I hope this report provides a meaningful and transparent reflection of our work throughout 2025/26, alongside a clear sense of the direction we are taking as an organisation in the years ahead.

Karen Jessop
Chief Nurse

Who we are and what we do

We are Doncaster and Bassetlaw Teaching Hospitals (DBTH), an acute NHS Foundation Trust serving over 440,000 people across South Yorkshire and North Nottinghamshire.

We are one of the region's busiest emergency care providers, delivering a wide range of hospital and community services. As a teaching hospital, we work with the University of Sheffield and Sheffield Hallam University to support education and research. We also work closely with our Integrated Care Boards and system partners.

We became a Foundation Trust in 2004, giving us greater financial and operational autonomy while maintaining national standards and regulation.

We are licensed by NHS England and registered with the Care Quality Commission to provide a full range of regulated healthcare services:

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

We deliver district general hospital services, community services such as audiology and family planning and specialist services including vascular surgery.

Our main sites are:

- **Doncaster Royal Infirmary (DRI):** A large acute hospital with over 450 beds, a 24-hour Emergency Department and trauma unit, providing inpatient, outpatient and day case care.
- **Bassetlaw Hospital (BH), Worksop:** A medium-sized hospital with over 170 beds, a 24-hour Emergency Department and obstetrics unit, offering a full range of general services.
- **Montagu Hospital (MH), Mexborough:** A smaller site focused on rehabilitation, with inpatient beds, an Urgent Treatment Centre, day surgery, dialysis, pain services and outpatient clinics. It is also home to the Rehabilitation Centre, Clinical Simulation Centre, MEOC and Community Diagnostic Centre.

We also provide services at Retford Hospital and other community locations in Doncaster. Our headquarters are based at Doncaster Royal Infirmary:

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

Our strategy, vision, mission, values and objectives

In early 2025/26 we refreshed our organisational strategy with input from colleagues, patients, communities and partners. The result is Healthier Together – Delivering exceptional care for all - a clear, shared direction for Doncaster and Bassetlaw Teaching Hospitals that aligns with national NHS priorities while responding to local needs.

The strategy sets out how we will deliver safe, high-quality and innovative care through a structured framework built on four Strategic Priorities:

- **Patients:** Delivering safe, exceptional, person-centred care, improving access, outcomes and experience.
- **People:** Creating a supportive, inclusive and positive workplace where colleagues can thrive.
- **Partnerships:** Working collaboratively across health, care and community systems to improve population health.
- **Pounds:** Using resources efficiently and responsibly to ensure long-term sustainability.

These priorities are constant and shape how we work every day.

Supporting them are our Strategic Ambitions, which describe the long-term changes needed to achieve our vision:

- Providing the best care environments through modern, sustainable facilities.
- Tackling health inequalities by improving access, prevention and outcomes.
- Becoming a leading centre for research and education.
- Becoming a digitally enabled and mature organisation.

Together, the priorities and ambitions are delivered through a set of enabling plans covering areas such as people, estates, quality, digital, research and procurement. These ensure a coordinated approach to service improvement, workforce development and infrastructure investment.

Overall, the strategy provides a cohesive roadmap for the organisation, linking day-to-day delivery with long-term transformation, so that patients receive outstanding care, colleagues feel supported and communities are healthier, together.

Our values and the DBTH Way

‘We Care’ sets out the way we work together at DBTH. It defines how we treat our patients, visitors and one another, and shapes the culture we continue to build.

This stands for:

- We always put the patient first.
- Everyone counts – we treat each other with courtesy, honesty, respect and dignity.
- Committed to quality and continuously improving patient experience.
- Always caring and compassionate.
- Responsible and accountable for our actions - taking pride in our work.
- Encouraging and valuing our diverse colleagues and rewarding ability and innovation.

The DBTH Way builds on the We Care values, bringing them to life in how we work together across wards, departments and services.

It sets out what good looks like at DBTH, from supporting one another, to leading by example, to continually improving what we do. It defines what colleagues can expect of one another and what patients should experience from Team DBTH:

We are:

- Kind
- Inclusive
- Person-centred
- Empowering
- Accountable
- Collaborative

We show:

- Attentive listening
- Integrity and honesty
- Courage and positivity

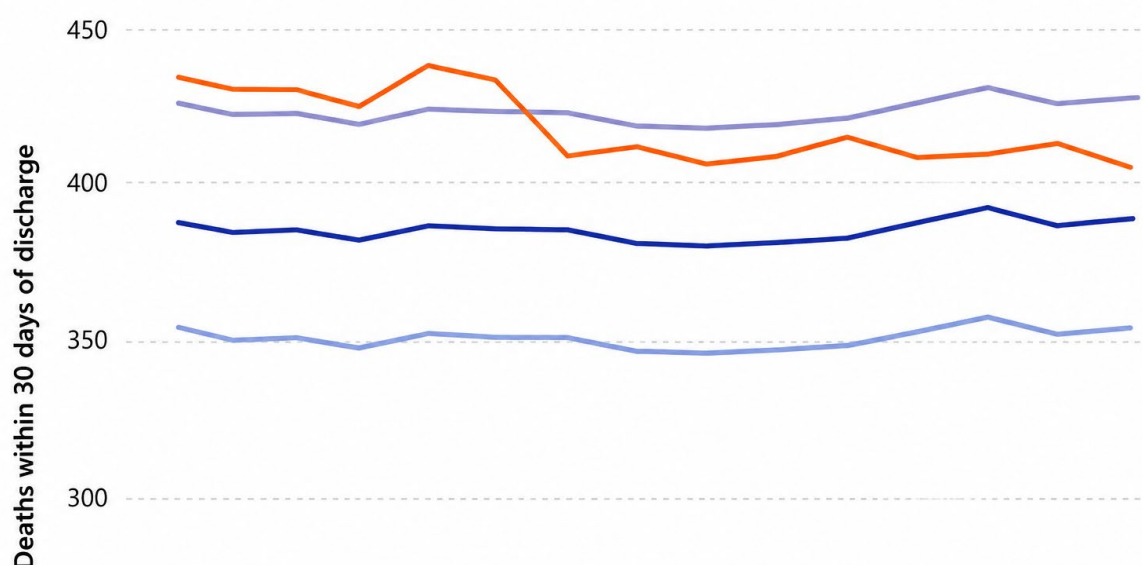
Together, our vision, values and behaviours create a shared culture that supports our colleagues and helps ensure patients receive safe, high-quality and compassionate care.

Quality Priorities

Following the transition of our Nursing, Midwifery and Allied Health Professionals (NMAHP) Strategy to a business-as-usual workplan model, four key quality priorities were identified for 2025/26.

Reduction of Hospital Acquired Pneumonia (HAP)

Pneumonia is now below the upper limit for predicted deaths associated with the condition and continues to show a downward trend.



Pneumonia has not appeared in the top five causes of death in the past 12 months, indicating a sustained improvement compared with previous years and providing clear assurance that clinical outcomes and preventative measures are being maintained and embedded.

Deliver effective mouth care training to colleagues involved in assessing and providing mouth care

Pneumonia has not appeared in the top five causes of death over the past 12 months, indicating sustained improvement compared with previous years and providing clear assurance that clinical outcomes and preventative measures are being maintained and embedded.

Deliver effective mouth care training to colleagues involved in assessing and providing mouth care.

Consistent utilisation of the mouth-care assessment tool within Nervecentre reached 80.09% in February 2026, providing assurance of sustained adoption and enabling timely identification of need and targeted clinical intervention.

Ongoing mouth-care training continues to be delivered to all relevant colleagues, ensuring practice remains aligned with evidence-based standards and that colleagues maintain the competence required to provide safe, high-quality care.

Specialist programmes covering oral health assessment and mouth-care delivery have trained 99 colleagues over the past 12 months, strengthening capability and sustaining key competencies.

Between January 2024 and March 2026, 214 new HCAs completed the Foundations of Care training programme, demonstrating effective induction processes and robust preparation of the support workforce.

A new audit process assessing the availability and correct use of oral-care equipment - triangulated with mouth-care assessment compliance - has been established, with early pilot findings showing good compliance and a Trust-wide rollout planned.

Taken together, these measures provide strong assurance that the Trust has effective training, monitoring and governance arrangements in place to maintain high standards of oral care and ensure sustained compliance with evidence-based practice.

Pilot Ward

Date	Month	% patients with mouthcare documentation	% patients with the correct RAG rating	% actual mouthcare products present
17/07/2025	Jul 25	100%	0%	88%
31/07/2025	Jul 25	38%	0%	69%
15/08/2025	Aug 25	100%	0%	94%
19/08/2025	Aug 25	100%	0%	76%
27/08/2025	Aug 25	100%	0%	100%
01/09/2025	Sep 25	100%	0%	100%
10/09/2025	Sep 25	100%	0%	65%
19/09/2025	Sep 25	100%	0%	88%
23/09/2025	Sep 25	100%	0%	88%
02/10/2025	Oct 25	89%	0%	88%
07/10/2025	Oct 25	100%	0%	86%
15/10/2025	Oct 25	100%	94%	100%
07/11/2025	Nov 25	100%	88%	82%
21/11/2025	Nov 25	100%	100%	88%
25/11/2025	Nov 25	100%	94%	88%
05/12/2025	Dec 25	100%	88%	88%
Average		95%	93%	87%

Antimicrobial Prescribing

The IPC and Antimicrobial Stewardship (AMS) team undertook quarterly audits at random intervals to evaluate antibiotic prescribing against key AMS indicators. In some instances, the frequency of these audits was increased in areas where compliance did not meet local policy requirements. The composite audit score assessed a range of key AMS indicators across 41 wards, with a total of 905 patients included in the audit programme.

Fig. 1 - Documentation of a clear indication for antibiotic therapy results

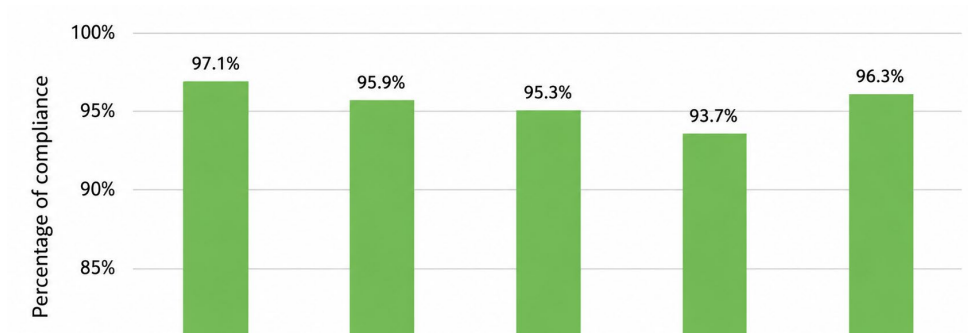


Fig. 2 - Documentation of a review

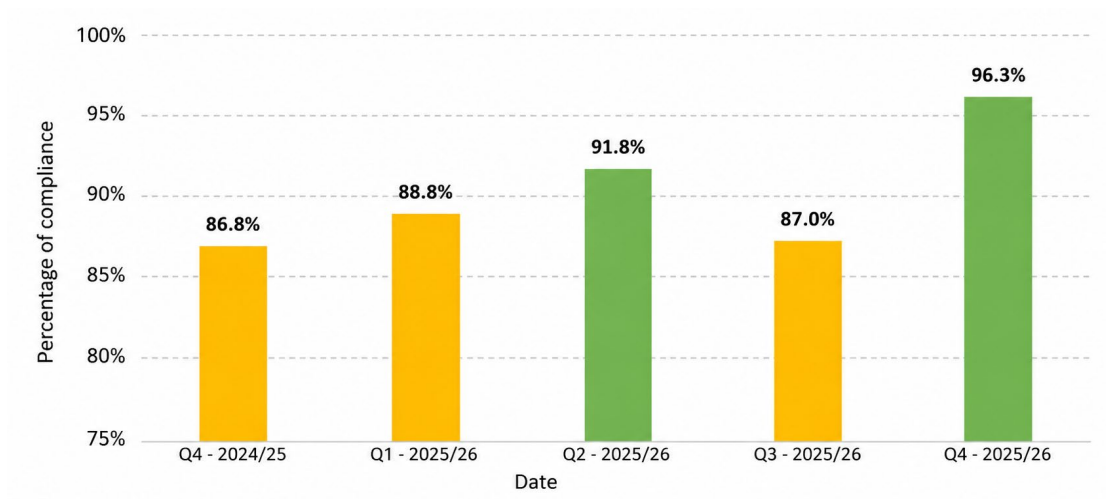


Fig. 3 - Evidence of a 48 to 72-hour antibiotic review

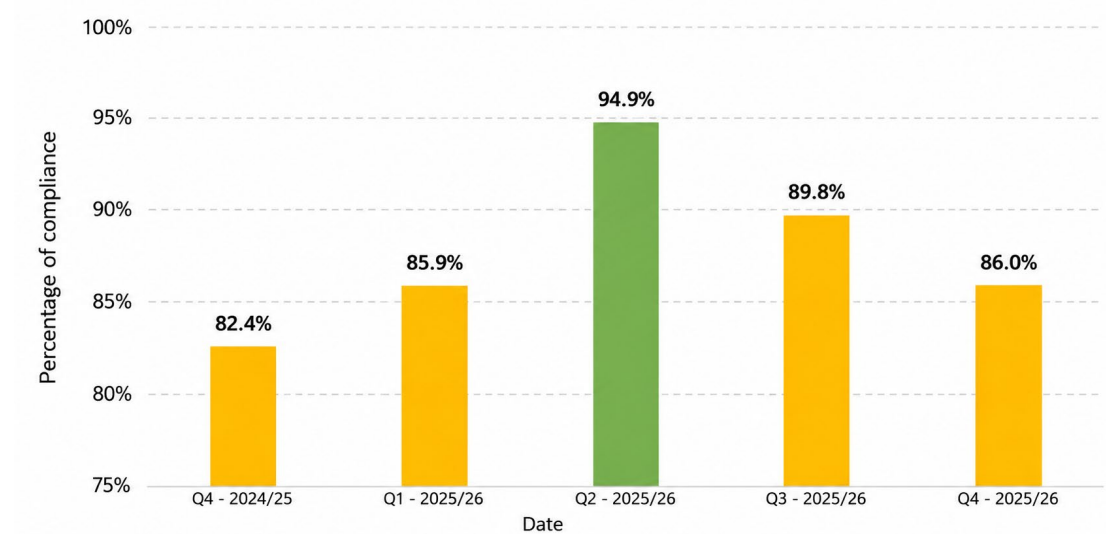
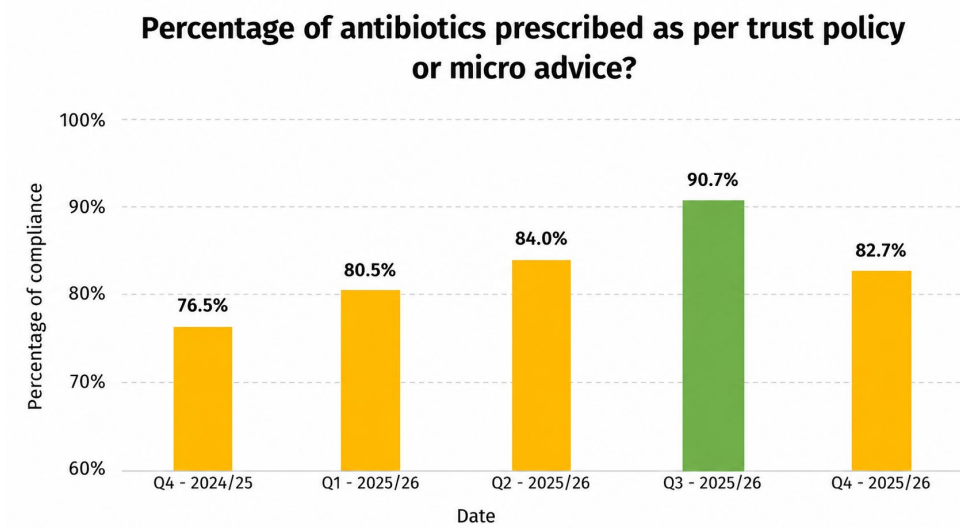


Fig. 4 - Antibiotic choice in accordance with local guidelines or microbiology advice



A pilot multidisciplinary team (MDT) meeting was established every Tuesday lunchtime in the Acute Medical Unit (AMU) to review all patients receiving antibiotics.

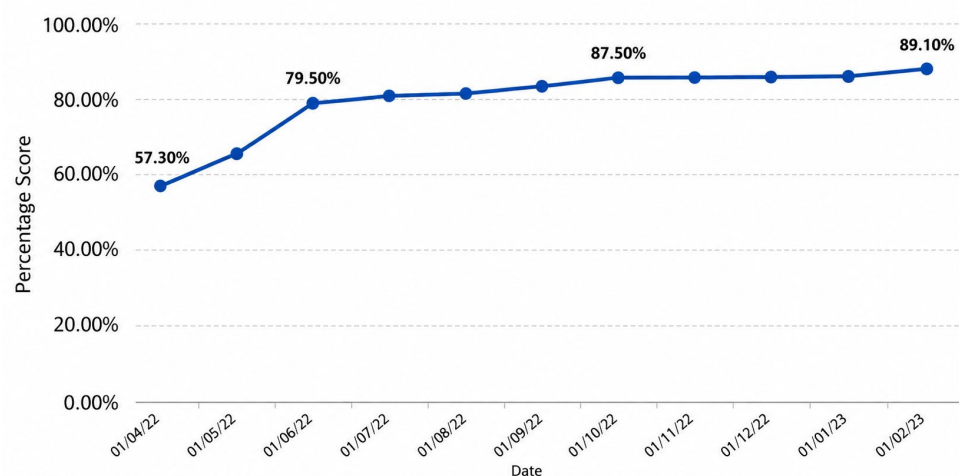
The MDT included Consultants in Infectious Diseases and Microbiology, AMU doctors, the AMU nursing team, the Antimicrobial Stewardship Nurse, Sepsis Nurse and Pharmacists.

Recommendations were made regarding indication for use, dosage, course length, antibiotic choice, IV-to-oral switch and antibiotic cessation.

Quarterly audits were undertaken on four random dates to evaluate the impact of the regular MDT meetings on antibiotic prescribing practices.

Results

A total of 79 patients were included in the audits.



Overall compliance with Trust antimicrobial prescribing standards improved significantly from 57.3% to 89.1%, providing assurance that the strengthened MDT approach and targeted feedback are driving measurable and sustained improvement across key stewardship indicators.

Plans for sustainability

Maintain quarterly antibiotic audits by the IPC and AMS team across all ward areas, with performance reviewed through governance forums and actions tracked through to completion.

Ward areas will complete their own quarterly antibiotic audits across medical and nursing teams, with results submitted for review and supported improvement implemented where compliance falls below the required standard.

Continue ongoing education and feedback, including ward-level training days and formal governance reporting, to provide assurance that learning is embedded and sustained.

Explore updates to the e-learning package to strengthen standardisation and provide accessible refresher training for all prescribers.

Weekly AMU infection rounds are now embedded, providing routine specialist oversight and real-time challenge to prescribing decisions.

Quarterly AMS audits and feedback will continue to provide assurance of ongoing compliance and enable early identification and mitigation of any regression.

Ongoing education updates will maintain stewardship capability and ensure colleagues remain sighted on current risks, emerging resistance patterns and required controls.

The AMU model can be replicated across other departments, providing a scalable approach to strengthen hospital-wide antimicrobial stewardship and support sustained reduction in avoidable variation and resistance risk.

Compliance with Mental Capacity Act (MCA)

Ensure Trust colleagues across all disciplines have a clear understanding of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) responsibilities, achieve the required SET training competencies, and apply this knowledge to provide care for patients with mental capacity deficits within a lawful framework that meets their needs.

1. Colleagues will be clear on when to formally assess decision-specific mental capacity.
2. Colleagues will undertake mental capacity assessments that are robust and able to withstand scrutiny.
3. Colleagues will follow the MCA Code of Practice guidance when making decisions on behalf of patients who lack mental capacity.

SET training compliance for MCA training increased by 8.94%. The target of 90% is now within reach, with a current compliance rate of 86.45% achieved.

A total of 443 colleagues have received bespoke training on the MCA, Best Interests processes and Deprivation of Liberty Safeguards.

Daily Mental Capacity Assessments within Nervecentre are being completed consistently, with 100% of audited records containing a documented daily assessment. Quarterly audits of MCA documentation also demonstrate strong improvement.

	April 2025	July 2025	October 2025	Jan 2026
Use of MCA proforma	49%	33%	47%	55%
Evidence of Best interest process considered	68%	63%	82%	85%
Evidence of advocate consideration	51%	33%	85%	75%

The MCA questions included within the weekly audit continue to achieve scores above 90%, with the current average score standing at 96.98% across the two MCA audit questions.

A new standard narrative for the MCA element has been incorporated into relevant policies.

Regular Safeguarding Liaison meetings continue to take place across ward and departmental areas.

Trust approved proformas have been updated and made available within Nervecentre.

Updates have also been made to the daily Nervecentre assessment to support high-quality assessments relating to accommodation decisions and the fundamentals of care.

All workstreams for 2025/26 will continue as business-as-usual activity and will be monitored through the relevant governance forums on an exception basis, providing ongoing assurance that controls remain effective and improvements are sustained.

Overall Performance Overview and Analysis in 2025/26

As an organisation it is our goal to provide timely access to care for all our patients.

In this section, you can find a brief summary of our operational performance against a number of national standards, highlighting some of our achievements from the past 12 months.

Urgent and Emergency Care

During 2025/26, average daily attendances to our Emergency Departments were 589, a 3.2% increase compared to the previous year.

In March 2026, 77.5% of our patients were admitted, transferred or discharged from our Emergency Departments within 4 hours from arrival.

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

We have continued to work in collaboration with partners across Doncaster Place during 2025/26 to deliver the Urgent and Emergency Care Improvement Plan, recognising that timely access to urgent and emergency care requires a co-ordinated approach across the health and social care system.

Elective Care

Our focus in 2025/26 has been to continue to reduce the number of patients experiencing long waiting times, following the COVID-19 pandemic and backlog created as a result.

By March 2026 we had virtually eliminated the longest waiting times in all but two specialties. In total we had 52 patients at the end of March 2026 waiting over 65 weeks.

By the end of 2025/26, 61.85% of our patients were treated within 18 weeks from referral, compared to 62.6% nationally:

- Diagnostics Waiting Times and Activity - 73.8% (March 2026 Performance)
- Cancer Faster Diagnosis Standard (FDS) - 83.3% (February 2026 Performance)

Diagnostics

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

Cancer

The number of urgent suspected cancer referrals has remained high throughout 2025/26 yet we achieved our plan to reduce the number of people waiting over 62 days on a cancer pathway by the end of the year.

We have consistently delivered the 28-day faster diagnosis standard, ensuring the majority of patients are diagnosed, or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. In February 2025/26, we achieved the faster diagnosis standard for 83.3% of our patients.

2025/26 Activity

During 2025/26 we continued to see high levels of demand across urgent, planned and maternity services:

- We cared for 235,192 emergency patients.
- We cared for 634,251 outpatients.
- We cared for 139,469 inpatients.
- We delivered 4,549 babies.

Compared to the previous year:

- Emergency attendances increased by 25,370, reflecting continued pressure on urgent and emergency care services.
- Outpatient activity increased by 83,210 appointments, demonstrating growing demand across a wide range of specialties and services.
- Inpatient activity reduced slightly by 1,157 patients compared to the previous year.
- The number of babies delivered reduced by 269 compared to 2024/25.

Quality Achievements in 2025/26

In 2025/26, Doncaster and Bassetlaw Teaching Hospitals (DBTH) made meaningful progress in delivering safe, exceptional and person-centred care. Against a backdrop of rising demand, workforce pressures and increasingly complex patient needs, we continued to strengthen the quality, safety and responsiveness of services across the organisation.

This year's Quality Account highlights the impact of targeted improvement work across urgent and emergency care, elective recovery, cancer, diagnostics, outpatient transformation and care for our most vulnerable patients.

Urgent and Emergency Care

One of the most significant achievements was the improvement in Emergency Department (ED) performance, with 77% of patients admitted, transferred or discharged within four hours, despite a rise of more than 7,000 attendances. This reflects the continued efforts of frontline teams and investment in flow and urgent care redesign.

Cancer and diagnostics

Cancer care continued to evolve through redesigned pathways, faster diagnostics and wraparound support.

We also continued to strengthen diagnostic capacity across the Trust. Our Community Diagnostic Centre at Montagu and expanded imaging services at Bassetlaw have reduced delays and helped manage elective pressures.

Elective recovery and orthopaedic excellence

The Mexborough Elective Orthopaedic Centre of Excellence (MEOC) achieved national accreditation for high-quality surgical care. Awarded by NHS England's GIRFT programme, the accreditation recognises the centre's exceptional clinical standards, patient safety and efficiency.

Winter resilience and Virtual Wards

Through an expanded Virtual Ward model and strengthened community partnerships, we supported more patients to receive high-quality care at home during the winter months. This helped alleviate pressure on inpatient services, reduce avoidable admissions and ensure a safe response to seasonal demand.

Embedding health equity

In 2025/26, tackling health inequalities became formally embedded as one of four strategic ambitions within our new Trust Strategy, Healthier Together, reflecting our commitment to ensuring that factors such as deprivation, ethnicity or place of birth do not determine a person's access to, or experience of, care. Our dedicated Health Inequalities team has continued to drive this agenda at pace.

A new governance structure was established this year, with a Health Inequalities Oversight Group providing a clear escalation route to the Executive Team and formal six-monthly reporting to the Board. All Board members have made personal Health Inequalities pledges, health inequalities impacts are now a required consideration within all Trust coversheets and business cases, and a Citizens' Panel has been established to bring lived experience voices into Trust decision-making.

Building colleague capability has been a major focus, with more than 7,200 colleagues completing Health Inequalities training through the Trust's Statutory and Essential Training programme, and more than 220 colleagues completing the more intensive Change Initiator Training. This training pyramid has been recognised as best practice by South Yorkshire Integrated Care Board, with plans to roll it out across all South Yorkshire acute trusts.

Alongside this, we developed an Equity Index, a data tool which scores equity across services by deprivation and ethnicity and a dedicated Did Not Attend (DNA) and Was Not Brought (WNB) dashboard, both designed to support targeted, evidence-based quality improvement interventions.

Key workstreams now underway include a fair waiting list pilot using the BEACON equity scoring tool, developed by Barnsley Hospital NHS Foundation Trust, targeted action to reduce DNA rates amongst underserved groups and an equity-focused programme to improve access to Women's and Children's services. Research and innovation also remain integral to our approach, with active NIHR-funded projects addressing perinatal mental health inequalities and maternity disparities.

Looking ahead to 2026/27, our focus will be on embedding these initiatives further, expanding the Change Initiator programme and implementing Equity Index tools across the Trust.

Enhancing patient experience

We continued to invest in the experience of those using our services, recognising that quality is about more than outcomes alone.

Seeking out patient voices

During 2025/26, we continued to focus on four specific community engagement campaigns relating to carer involvement, the Deaf community, partially sighted people and Special Educational Needs and Disabilities (SEND). This work was carried out alongside Healthwatch, local community partners and the South Yorkshire interpretation and translation services provider.

Patient experience and involvement project feedback

Accessible: Following funding support from DBTH Charity, we have continued our work with [AccessAble](#) to provide service users and visitors with improved accessibility information.

Fieldwork began in early 2026 across public and clinical areas, with resources due to become available via both the AccessAble and Trust websites. In addition to these resources, the Trust will receive an evaluation report setting out recommendations to further improve accessibility across our sites.

Interpretation and translation services: Following feedback from colleagues and patients, extensive work has been undertaken to improve interpretation and translation services across the Trust. The [CardMedic](#) translation solution has now been launched Trust-wide.

Alongside face-to-face, telephone and video interpretation services, CardMedic supports colleagues in overcoming communication barriers through access to a wide range of clinically interpreted interactions available in more than 200 languages, with the additional ability to switch content into easy-read formats.

The solution also enables easier access to on-demand telephone interpreters through direct links to the South Yorkshire interpretation provider. Twenty digital devices and portable stands, funded

through DBTH Charity, will be distributed across all three sites to support colleagues in making effective use of current interpretation solutions and CardMedic.

Improved access to British Sign Language (BSL) interpretation services has also been enabled through the availability of these devices, alongside partnership working with the South Yorkshire language provider and Convo Now. This extended provision builds on the existing BSL translation support already used by DBTH.

The move to Convo provides patients, visitors and colleagues with instant access to BSL interpreters whilst accessing Trust services, simply by scanning a QR code. The service launched in February 2026, with interim web-link access already available for colleagues.

Friends and Family Test

The Friends and Family Test inpatient response rate did not consistently reach the key performance target of 20%, achieving an overall average of 17.1%. However, quarter four saw significant and sustained improvement across several areas over the three-month period, demonstrating an increased focus on obtaining patient feedback.

The A&E overall response rate also remained below the national best practice target of 10%. However, there was significant improvement at Bassetlaw Hospital, alongside month-on-month improvement throughout quarter four within Doncaster ED.

The number of outpatient responses continued to increase compared with previous years, supported by the ongoing use of text messaging, alongside paper and QR code-initiated surveys. Maternity response rates remained below both local and national averages, with development of a divisional improvement plan currently underway to strengthen engagement.

The contract with [I Want Great Care](#) was extended for a further 12-month period. There remains a continued focus and commitment to embedding a range of approaches to increase patient feedback response rates, enabling both service improvement and recognition of positive changes in care delivery.

Complaints

During the 2025/26 financial year, 639 complaints were reported to the Trust. This represented a 3% increase compared with 2024/25, when 620 complaints were reported. However, this still reflects a 14% reduction when compared with the year prior.

Volunteers

Volunteers remain integral to enhancing the quality of care provided to patients at DBTH and we continue to recognise and value the commitment and hard work of all volunteers across the organisation.

Recruitment of Patient Experience and Chaplaincy volunteers will continue throughout 2026/27, supporting improved accessibility for patients and visitors, alongside enhanced collection of valuable patient experience feedback.

Pressure ulcer prevention

Preventing avoidable harm remains a core focus of our quality improvement work and, during 2025/26, we saw the culmination of a multi-year programme to reduce hospital-acquired pressure ulcers (HAPUs) across DBTH.

The Pressure Ulcer Reduction Quality Improvement Work Plan, launched in 2021, was designed to strengthen early identification, prevention and organisational learning relating to pressure damage. Now in its final year, the programme has delivered substantial and measurable improvements in both clinical outcomes and patient safety culture.

Most notably, the Trust achieved a 64% reduction in Category 2 and above HAPUs compared with the 2020/21 baseline. This represents the most significant improvement recorded to date and reflects the sustained efforts of clinical teams across inpatient wards, theatres and community settings.

The Trust-wide HAPU rate now stands at 1.05 per 1,000 bed days, the lowest level since consistent monitoring began. This achievement demonstrates not only improved care practices, but also the successful embedding of preventative approaches into everyday clinical decision-making.

Several targeted interventions supported this improvement, including:

- Implementing the national recommends published from the National Wound Care Strategy Programme recommendations and categorisation tool for pressure ulcers.
 - Operational Policy for pressure ulcer prevention linked to Moisture Associated Skin Damage to meet the national requirements.
 - Implementing at risk care plans and intervention updated to meet the national requirements.
- Verification of suspected Category 2 and above hospital acquired pressure ulcer by the Skin Integrity Team, enabling timely and appropriate PSIRF process to be commenced.
- Focus on pressure redistributing equipment provisions being available in line with the average percentage of patients that are at risk of pressure ulcers, including mattress, heel offloading devices, and medical fixations devices.

Alongside these physical improvements, we also strengthened our learning and review processes. By applying the Patient Safety Incident Response Framework (PSIRF) to pressure ulcer investigations, we moved away from blame-focused analysis and adopted a more system-based and compassionate approach.

A Trust-wide education programme was delivered to support awareness and clinical practice, including training for nurses, allied health professionals and students. Pre- and post-training assessments demonstrated a 12% improvement in knowledge scores, indicating increased clinical confidence and understanding in this area of care.

This work has been delivered through close collaboration between the Skin Integrity Service, nursing leadership teams, clinical educators and ward colleagues. While we are proud of the progress made, we remain committed to sustaining these improvements and ensuring the prevention of pressure ulcers continues to be recognised as a key marker of safe, compassionate and effective care across all services.

Patient Safety Alerts and Notices

A responsive and reliable system for managing national safety alerts remains a cornerstone of strong clinical governance. At Doncaster and Bassetlaw Teaching Hospitals (DBTH), we remain committed to responding promptly to national guidance, safety notices and medical device alerts to reduce risk and support continuous organisational learning.

During 2025/26, we maintained high levels of responsiveness and compliance across all categories of safety alert, ensuring timely action, audit and assurance processes were consistently delivered. This work is overseen by the Clinical Governance team in partnership with divisional safety leads and subject matter experts, forming a key part of the Trust-wide approach to risk management, patient safety and continuous improvement.

Safety Alert Performance Overview (2025/26)

- Nine National Patient Safety Alerts (NPSAs) issued by NHS England:
 - Seven fully actioned and closed with one exceeding expected timescales.
 - Two in progress and not due for reporting until 2026.
- 63 additional national alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA), UK Health Security Agency (UKHSA) and others:
 - 100% closed within required timeframes.
- 91 Field Safety Action Notices (FSANs) related to medical devices and equipment:
 - 100% completed.

Each alert is tracked through a centralised system that ensures visibility at both executive and divisional level, with documented evidence of action plans, training and, where appropriate, changes to clinical practice or procurement.

During the year, teams across the Trust continued to demonstrate strong vigilance and coordination across specialties, ensuring alerts were not only actioned in a timely manner, but also used as opportunities to strengthen systems and reduce future risk. Examples included rapid responses to alerts relating to infusion devices, surgical safety and infection prevention measures, which led to policy updates, equipment checks and targeted communication campaigns.

Importantly, this work does not take place in isolation. The Trust's alert management process is now closely aligned with the wider Patient Safety Incident Response Framework (PSIRF) and complements the organisation's focus on proactive risk identification and system learning.

Together, this performance reflects a mature safety culture and robust governance processes that are agile, transparent and responsive to national priorities, ensuring we continue to meet our duty of care to every patient, every time.

Clinical Audit and National Confidential Enquiries

Clinical audit remains fundamental to assuring the quality, safety and effectiveness of care for patients across Doncaster and Bassetlaw Teaching Hospitals (DBTH). By systematically reviewing clinical practice against nationally recognised standards, clinical audit enables the Trust to identify

variation, highlight areas of good practice and drive targeted quality improvement initiatives. It is a core component of our commitment to continuous improvement, organisational learning and clinical accountability, and continues to underpin the delivery of our Trust-wide Quality Strategy.

During 2025/26, the Trust sustained strong engagement with national clinical audit programmes and the National Confidential Enquiries into Patient Outcome and Death (NCEPOD). Participation in these programmes ensures that our services are benchmarked against national standards and best practice, while also contributing to wider system learning and the ongoing improvement of patient care nationally.

Performance on National Audits and Enquiries

- 43 national clinical audits.
- Eight National Confidential Enquiry into Patient Outcome and Death (NCEPOD) enquiry reviews.
- 100% participation in all eligible national projects.

Participation in national clinical audits demonstrates the commitment of clinical teams across the Trust to improving quality and maintaining high standards of care. Where data submissions were incomplete, this was primarily due to project timing and changes to national reporting schedules. However, local measures were implemented to ensure improvement activity and oversight continued throughout the reporting period.

Key National Audits and Enquiries

The audits and reviews we engaged with during 2025/26 covered a wide range of specialties and high-impact areas of care, including:

- National Hip Fracture Database (NHFD) – assessing standards of care for older adults following hip fracture, including surgical timeliness, delirium screening and multidisciplinary rehabilitation.
- National Emergency Laparotomy Audit (NELA) – focusing on timeliness of intervention and perioperative care for patients undergoing high-risk emergency abdominal surgery.
- National Maternal, Newborn and Infant Clinical Outcome Review Programme – surveillance of maternal deaths.
- National Cardiac Arrest Audit (NCAA) – examining in-hospital cardiac arrest responses, escalation pathways and survival outcomes.
- National Heart Failure Audit.
- Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR).

All local and national clinical audit results for 2025/26 were reviewed through the Trust's divisional governance processes, with DBTH committed to taking appropriate action to support continuous improvement in the quality of healthcare provided.

These audits supported local quality improvement activity, helping guide action plans, service discussions and targeted interventions. Some resulted in changes to documentation, training or service redesign, whilst others prompted further audit activity to assess compliance and address identified gaps.

Looking ahead, we will continue to strengthen internal audit governance arrangements, further integrate findings into quality improvement planning and ensure learning is shared openly across divisions. Clinical audit remains a vital tool in measuring performance and supporting our ambition to deliver outstanding care every time.

Learning from Deaths

As a Trust, we are committed to learning from every patient's death to improve safety, reduce avoidable harm and ensure compassionate, high-quality care for all.

During 2025/26, a total of 2,033 patients died across our hospital sites, including within the Emergency Department. All deaths were scrutinised by the Medical Examiner (ME) team.

Structured Judgement Reviews (SJRs) were requested for 225 cases, representing 11% of all deaths, a significant improvement from 6.8% in the previous year. Cases selected for SJR included:

- Referrals from the ME Team where concerns relating to care had been raised by colleagues or bereaved families.
- Cases where sepsis was identified as the cause of, or contributor to, death.
- SHMI outlier cases showing variation over time, including pneumonia, urinary tract infection, anaemia, and fluid and electrolyte disorders.

By the end of April 2026, 195 reviews had been completed. This improvement reflects an increase in the number of trained reviewers across the organisation. Going forward, it is expected that more reviews will be undertaken by divisions as part of wider mortality and morbidity activity. The introduction of an online SJR form in April 2026, linked directly to the Trust's clinical portal system, will further support this process.

However, it should also be recognised that SJRs are increasingly complex and time-consuming to complete, as they often require access to multiple electronic clinical systems and paper records.

Two deaths reviewed during the year were judged to be more likely than not attributable to problems in care. These cases were investigated through the Trust's patient safety processes, with all findings contributing to organisational learning and improvement.

Themes identified through SJRs this year highlighted a number of key learning opportunities, including:

- The need for more timely involvement of microbiology teams in cases of sepsis.
- Timely blood culture sampling, alongside prompt prescribing and administration of antibiotics in suspected sepsis.
- Ensuring timely referral to the Learning Disability Team for all patients with a learning disability.

- Ensuring escalation status is clearly documented for all patients.

Alongside areas for improvement, SJRs also identified examples of high-quality care, including:

- Excellent nursing documentation and effective use of assessment tools.
- Strong escalation of treatment and senior clinical involvement.
- Excellent communication with relatives, supported by clear documentation.
- Early recognition of ceilings of care, with timely initiation of end-of-life care measures.

Looking ahead: Priorities for 2025/26

As we move into 2026/27, our focus is firmly on building upon the progress made this year whilst continuing to respond to the evolving needs of our patients, colleagues and communities.

Informed by our refreshed Trust Strategy, *Healthier Together*, our new Three-Year Plan, and the learning identified throughout this Quality Account, we have identified a set of key priorities that will guide improvement and delivery over the year ahead.

These priorities are designed to strengthen quality, safety, equity and sustainability across all areas of our services, whilst supporting our long-term ambition to become a leading University Teaching Hospital recognised for delivering safe, exceptional and person-centred care every time.

Our key priorities for 2026/27 are:

Improving elective access and reducing long waits

We will continue to focus on recovering elective activity and reducing waiting times, particularly for patients who have waited the longest for treatment. This includes increasing theatre productivity and day-case activity, optimising outpatient pathways, reducing unnecessary follow-up appointments and expanding the use of Community Diagnostic Centres and community-based services to provide earlier, more convenient access to care. Over the next three years, we also aim to eliminate 52-week waits and restore Referral to Treatment performance in line with national standards.

Strengthening urgent and emergency care

Building on the improvements made during 2025/26, we will continue to improve Emergency Department flow, reduce ambulance handover delays and strengthen patient flow across all hospital sites. This will include further expansion of Same Day Emergency Care, Virtual Wards and discharge improvement initiatives to help patients receive the right care, in the right place, at the right time. We will also continue work to improve four-hour performance and reduce the longest waits within urgent and emergency care services.

Expanding cancer and diagnostic services

We remain committed to improving cancer performance standards, including the 62-day and Faster Diagnosis standards. This will be supported through continued investment in diagnostic capacity, pathway redesign and stronger partnership working to ensure patients are diagnosed and treated as quickly as possible. Expanded imaging, diagnostics and community-based testing services will continue to play a key role in supporting earlier diagnosis and reducing delays.

Delivering more care closer to home

Over the coming year, we will continue developing community and town-centre services to improve convenience and accessibility for patients. By providing more outpatient, diagnostic and pre-operative services closer to where people live, we aim to reduce unnecessary travel, improve patient experience and allow our acute hospital sites to focus on more specialist and urgent care activity.

Improving productivity and financial sustainability

Ensuring long-term financial sustainability remains essential to protecting patient care and investing in our future services. During 2026/27, we will continue delivering productivity and efficiency

improvements across theatres, diagnostics, outpatient services, procurement and workforce management, ensuring all improvements are supported through robust quality impact assessment and governance processes.

Supporting colleagues and strengthening culture

We will continue to invest in leadership, colleague development and organisational culture through the DBTH Way and wider cultural improvement programmes. This includes strengthening visible leadership, supporting colleagues through change, promoting civility and continuous improvement and ensuring teams feel valued, supported and equipped to deliver high-quality care.

Reducing health inequalities

Addressing health inequalities will remain a core strategic priority throughout 2026/27. We will continue embedding equity into decision-making, service design and quality improvement activity through the expansion of our Equity Index tools, targeted interventions for underserved groups and continued development of our Health Inequalities training and Change Initiator programmes.

Strengthening digital transformation and innovation

We will continue to expand digitally enabled services and improve access to patient information across clinical pathways. This includes supporting digital-first models of care, improving data visibility and using innovation, research and technology to support safer, more efficient and more personalised care delivery.

Our 2026/2027 Quality Priorities

A Trust-wide survey was launched in early 2026 (open for two months) giving opportunities for our people to shape the quality priorities for 2026/2027.

Following a review of the feedback and triangulation of complaint and incident themes by the senior nursing team in conjunction with the Chief Nurse and Acting Executive Medical Director the following quality priorities have been agreed for 2026/2027.

1. Pain Assessment, Management and Monitoring (Ensure pain is assessed consistently and managed effectively for all patients).
2. Anti-Microbial Resistance/Stewardship priorities (Reduce Total Antibiotic Consumption, Diagnostic Quality & Blood Culture Compliance and Strengthen AMS Workforce & Clinical Capability).
3. Recognition of the Dying Patient (Improve early identification, clear communication and holistic support for patients approaching end of life).
4. Controlled Drugs Management (Strengthen the safe handling, administration, storage, documentation, and governance of controlled drugs to minimise risk and ensure full regulatory compliance).

Statements of Assurance

Participation in clinical audits

During 2025/26, 42 national clinical audits and eight national confidential enquiries covered services provided by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. During this period, the Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries for which it was eligible to participate.

The national clinical audits and national confidential enquiries in which Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust participated, and for which data collection was completed during 2025/26, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the total number of registered cases required.

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2025/26 are as follows:

Trust participation	Data collection completed during 2024/25	% of eligible cases submitted
BAUS Data and Audit Programme	Yes	100
Breast and Cosmetic Implant Registry	Yes	100
British Spine Registry	Yes	100
Case Mix Programme (CMP)	Yes	100
Child Health Clinical Outcome Review Programme	Yes	100
Emergency Medicine QIPs	Yes	100
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young people	Yes	100
National Falls & Fragility Fracture Audit Programme	Yes	100
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Yes	100
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100
Medical and Surgical Clinical Outcome Review Programme	Yes	100

Trust participation	Data collection completed during 2024/25	% of eligible cases submitted
Myocardial ischaemia National Audit Programme (MINAP)	Yes	100
National Audit Diabetes	Yes	100
National Audit of Cardiac Rehabilitation (NACR)	Yes	100
National Audit of Cardiac Rhythm Management (NACRM)	Yes	100
National Audit of Care at the End of Life	Yes	100
National Audit of Dementia	Yes	100
National Bariatric Surgery Registry (NBSR)	Yes	100
National Cancer Audit Collaborating Centre (NATCAN):	Yes	100
National Cardiac Arrest Audit (NCAA)	Yes	100
National Hip Fracture Database	Yes	100
National Early Inflammatory Arthritis Audit	Yes	100
National Emergency Laparotomy Audit (NELA)	No	Not 100%. Exact figures available when report published
National Gestational Diabetes Audit 2025	Yes	100
National Heart Failure Audit (NHFA)	Yes	100
National Joint Registry	Yes	100
National Kidney Cancer Audit (NKCA) NATCAN	Yes	100
National Major Trauma Registry Network	Yes	100

Trust participation	Data collection completed during 2024/25	% of eligible cases submitted
National Lung Cancer Audit (NLCA)	Yes	100
National Maternal, Newborn and Infant Clinical Outcome Programme: Surveillance of maternal deaths	Yes	100
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100
National Obesity Audit	No	On
National Pregnancy in Diabetes Audit	Yes	100
National Respiratory Audit Programme ((NRAP)	Yes	Not 100%. Exact figures available when report published
National Vascular Registry	Yes	100
Perioperative Quality Improvement Programme (PQIP)	Yes	100
Sentinel Stroke National Audit Programme	Yes	100
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100
UK Parkinson's Audit	Yes	100
UK Renal Registry Chronic Kidney Disease Audit	Yes	100
UK Renal Registry National Acute Kidney Injury Audit	Yes	100

Participation in Clinical Research

We remain committed to becoming a leading centre of research excellence, enhancing both patient care and workforce development. In 2025/26, we successfully delivered against Year 2 of our strategic Research and Innovation delivery plan (2023-2028), which integrates seamlessly with our broader organisational goals, including the Clinical Quality, People and Health Inequalities strategic delivery plans. This alignment has reinforced our objectives, fostering the growth of research talent and innovation leadership across our organisation.

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

Commercial research has grown by 10% in 2025/26 (eight new studies opened with three due to open) following strategic funding of almost £80K through the National Institute for Health and Care Research (NIHR) Regional Research Delivery Network (RRDN). The benefits of commercial research are significant; clinical trials of novel treatments allow patients access to treatment options not available on the NHS, bring income generation opportunities and support cost savings to NHS organisations and patients through the cost of expensive drugs and patient visits being covered by Pharma.

In the area of maternal and child health, we continue to make significant strides. The Born and Bred in Doncaster (BaBiD) research study has reached 5,249 recruits, with 1,871 new participants (mothers and babies) annually. Our ongoing collaboration with Sheffield Hallam University continues to strengthen in this area, identifying inequalities in maternity care with a view to developing potential interventions. We are also supporting two NIHR-funded projects tackling maternal health disparities, in collaboration with the University of Sheffield, City of Doncaster Council and Bournemouth University.

We again met our annual contract requirements with the NIHR RRDN, receiving commendations for patient recruitment across a wide range of studies, demonstrating our inclusive approach.

Among our notable achievements is the expansion of Rheumatology research, with clinical trials evaluating new treatments for patients with systemic lupus erythematosus (SLE). To support the growth of our clinical capabilities and improve access to research opportunities for our communities, the Clinical Research Hub opened in September 2025 and has offered dedicated clinical space for patients on Rheumatology, Gastroenterology, and Dermatology research studies. We are in the process of implementing Vascular research clinics and exploring opportunities for Paediatric research. Funding from the NIHR has been awarded to deliver Phase 2 of the Clinical Research Hub, which will further enhance our ability to deliver different types of clinical trials.

Our research portfolio continues to grow, with us expanding partnerships with local academic and innovation institutions. Notably, our membership with INSIGNEO (University of Sheffield) has enabled research into surgical innovations, while the South Yorkshire Digital Health Hub is exploring pump-prime funding for research stemming from the BaBiD study. We are a collaborator, alongside Manchester and Sheffield NHS Trusts, on the NIHR/EPSRC £6 million award to redesign healthcare for patients with multimorbidities. The programme aims to use innovative approaches such as systems engineering and digital twins to improve the health and wellbeing of people living with multiple long-term conditions.

We have also engaged in the development of South Yorkshire Health Partners (formerly the South Yorkshire Academic Health Partnership). An Academic Health Partnership is a collaboration between academic, health, and care organisations aimed at collaborating in research, attracting investment, and transforming the health and wellbeing of our population. Additionally, we remain a key partner within the South Yorkshire and North Nottinghamshire Integrated Care Boards, contributing to regional research and innovation strategies.

Our work with the Public Involvement and Community Engagement (PICE) group, hosted by the Doncaster Health Determinants Research Collaborative, is a key part of our public involvement approach and helps shape and prioritise our research and innovation activities. For example, as we develop and deliver programmes aligned to the three key shifts, the voice of our communities has shaped our approach to research and innovation involving AI, machine learning, and digital technologies.

Furthermore, we have engaged with The Carr Fenton Foundation (formerly the Doncaster Deaf Trust) to develop initiatives to increase access to research for the Deaf community. We continue to work closely with Ethnic Minority Research Inclusion (EMRI) to reduce inequalities relating to access to research.

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

Statements from the Care Quality Commission (CQC)

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is FULL Registration compliance with no conditions on registration.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has actively engaged with the Care Quality Commission during the reporting periods as part of routine engagement activity. The Care Quality Commission were invited into our Maternity, Emergency and Urgent Care Services and Children and Young People services to carry out a number of colleagues' listening events.

In December 2025, the Care Quality Commission undertook an inspection of our Urgent and Emergency Care services at Doncaster Royal Infirmary. The report was published in May 2026 The inspection report identifies some areas for improvement and a programme of work is in place to address these. Progress against this programme is reported to the Trust's board in-line with the governance and control processes.

The Care Quality Commission issued a section 29a warning notice following this inspection.

The Care Quality Commission action plan from the inspection in across Trust sites in August and September 2023 has been completed

The Trust overall is rated good in the 'caring' domain, whilst safe, effective, responsive and well-led remain as requires improvement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Bassetlaw District General Hospital	Requires Improvement ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Good ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Doncaster Royal Infirmary	Requires Improvement ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Good ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Montagu Hospital, Mexborough	Requires Improvement ↓ Mar 2024	Good ↔ Mar 2024	Good ↔ Mar 2024	Good ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024
Retford Hospital	Requires Improvement ↓ Mar 2024	Not rated	Good ↔ Mar 2024	Good ↔ Mar 2024	Good ↔ Mar 2024	Good ↔ Mar 2024
Overall trust	Requires Improvement ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Good ↔ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024	Requires Improvement ↓ Mar 2024

Clinical Coding Error Rate

In line with the DS&P requirements the Trust has undertaken clinical coding audits (diagnoses and procedure coding) during 2024/2025 which resulted in the Trust achieving the Expectations Exceeded level (the highest level attainable). The combined results of the audits were:

Table 1: Overall results for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust:

Criterion	DS&P Advisory Level	DS&P Mandatory Level	Doncaster and Bassetlaw Teaching Hospitals
Primary diagnosis correct	>=90.0%	>=90.0%	98.0%
Secondary diagnosis correct	>=90.0%	>=80.0%	98.83%
Primary procedure correct	>=95.0%	>=90.0%	100%
Secondary procedure correct	>=90.0%	>=80.0%	99.55%

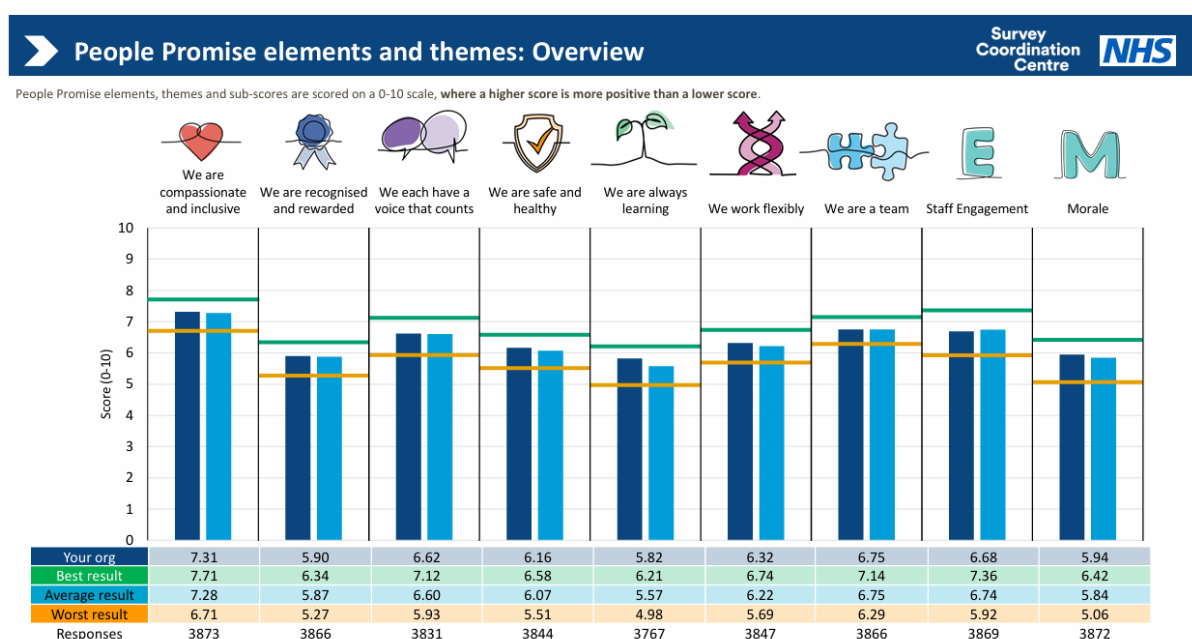
NHS Staff Survey

The NHS colleagues Survey is conducted annually and aligns with the NHS People Promise, focusing on the experiences of colleagues across seven themes, alongside the areas of colleagues Engagement and Morale. All indicators are scored out of 10, based on the average responses to a series of related questions.

The response rate to the 2025 survey among colleagues at DBTH was 54%, with 3,879 completed questionnaires. This remained above the national median response rate for comparable organisations, which was 47%.

On behalf of the Board of Directors, we would like to thank every colleague who took the time to complete this year's NHS colleagues Survey. Your feedback continues to play a vital role in helping us understand where we are performing well and where we need to improve.

The survey results continue to shape our People priority within the Trust Strategy and support the ongoing development of the DBTH Way. They help ensure we continue building a culture where colleagues feel valued, supported and empowered to deliver exceptional care.



What we're doing well

This year's results highlighted several areas of strength across the organisation:

Compassionate and inclusive culture: DBTH scored above the national average in the People Promise theme 'We are compassionate and inclusive', with particularly strong results around diversity, equality and compassionate leadership. Colleagues continued to report that they feel their role makes a difference to patients and service users.

Supportive leadership and line management: Results relating to immediate managers remained positive, particularly around listening, understanding challenges and supporting colleagues with problems at work. Line management scores improved again this year and remain above the national average.

Flexible working and work-life balance: The Trust continued to see improvements in flexible working and support for work-life balance, with scores improving year-on-year since 2021 and remaining above the sector average.

Learning and development: Opportunities for development and appraisal discussions continue to improve, with appraisal scores increasing for the fifth consecutive year. Colleagues increasingly feel supported to develop their skills and careers at DBTH.

Teamworking and engagement: Teamworking and colleagues engagement remained strong overall, with colleagues continuing to report positive working relationships within teams and a strong sense of motivation in their roles.

Where we need to improve

Alongside the positives, the survey also highlighted areas where further work is needed:

Recognition and reward: While scores improved slightly this year, recognition and reward remains one of the lower-scoring themes. We recognise the importance of ensuring colleagues feel appreciated and acknowledged for the work they do every day.

Speaking up and involvement: Although results around autonomy and involvement remain broadly positive, scores linked to raising concerns declined slightly this year. We want all colleagues to feel confident that their voice matters and that concerns will be listened to and acted upon.

Workload, burnout and wellbeing: Pressures across the NHS continue to impact colleague wellbeing. Burnout and work pressure scores remain areas of challenge both locally and nationally and we will continue strengthening our wellbeing support and promoting healthy working environments.

Advocacy and morale: While overall morale remained slightly above the national average, some indicators relating to advocacy and recommending the organisation as a place to work declined compared to previous years. This remains an important focus as we continue improving colleague experience.

Inclusion and respect

Although DBTH continues to perform well in diversity and equality measures overall, some indicators relating to feeling valued, respected and included within teams showed small declines this year. Strengthening inclusive cultures across all teams remains a key priority.

Conclusion

The 2025/26 year has been one of meaningful progress, continued challenge and enduring commitment across Doncaster and Bassetlaw Teaching Hospitals. In a healthcare landscape shaped by rising demand, workforce pressures, increasing clinical complexity and continued operational strain, colleagues across Team DBTH have continued to rise to the challenge, delivering safe, person-centred care whilst also driving forward long-term transformation and improvement.

This Quality Account reflects a year in which we not only sustained high standards of safety, effectiveness and compassionate care, but also strengthened the foundations needed to support the future sustainability and resilience of our services. From reducing hospital-acquired pressure ulcers and embedding the Patient Safety Incident Response Framework (PSIRF), to strengthening antimicrobial stewardship, improving mortality review processes and expanding Virtual Wards and Community Diagnostic Centres, we have continued to make measurable progress across a wide range of priorities.

We are proud of the advances made in clinical effectiveness, patient safety, audit participation, health inequalities, digital transformation and patient engagement, all of which reflect a maturing culture of continuous improvement, accountability and learning. During the year, we also continued embedding our Nursing, Midwifery and Allied Health Professionals (NMAHP) Strategy into business-as-usual practice, whilst strengthening how we listen and respond to the voices of patients, carers and communities.

This year also marked a significant step forward in our approach to tackling health inequalities. Through the introduction of new governance arrangements, colleague training programmes and innovative tools such as the Equity Index and BEACON waiting list work, we are increasingly ensuring that service improvement is informed by the needs of the diverse communities we serve.

At the same time, we recognise there remain areas where further improvement is needed. Pressures across urgent and emergency care, elective recovery, colleague wellbeing and operational performance continue to present significant challenges. However, these are not areas we shy away from. They are recognised priorities, supported by clear plans, strong governance and a continued commitment to openness, learning and improvement.

Looking ahead to 2026/27, our strategic direction remains clear. We will continue focusing on improving access to urgent and planned care, reducing inequalities, strengthening productivity and sustainability, supporting colleagues through change and further embedding the DBTH Way across our organisation. Alongside this, we remain committed to progressing our ambition to become a leading University Teaching Hospital, where excellence in care, education, research and innovation are fully integrated.

None of this would be possible without the extraordinary commitment of our colleagues, the patients and carers who continue to shape and challenge our services, and the communities whose trust we work every day to earn and uphold.

Together, we are continuing to build a stronger, more responsive and more inclusive healthcare service, one that reflects the very best of our people, partnerships and shared ambition to deliver safe, exceptional and person-centred care every time.

2607 - E1 GUARDIAN OF SAFE WORKING HOURS REPORT

● Discussion Item

👤 Zoe Lintin, Chief People Officer

🕒 10:45

Dr Mohammad, Guardian of Safe Working Hours

10 minutes

REFERENCES

Only PDFs are attached



E1 - Guardian of Safe Working Hours Report.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Guardian of Safe Working Hours Report			
Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Mohammad I Khan, Guardian of Safe Working Hours			
Appendices:	N/A			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (	Significant Assurance			
Assurance Rationale	The Board is asked to take significant assurance that there are appropriate controls and processes in place regarding exception reporting, which ensures that the vast majority of resident doctors can work safely and within the defined contractual hours with any issues being identified and actions taken.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2			
Executive Summary – Key messages and Issues				
This report includes data for a two-month period between 1 February 2026 and 31 March 2026. All the data has been collected using Healthrota which is the software used to exception report by the resident doctors. The total number of exception reports (ERs) submitted from 1 February 2026 until 31 March 2026 is 190. The vast majority of ERs were filed by foundation year (FY) doctors or residents in their earlier journey in training (182 vs 8 by ST4 or above) indicating the pressure the doctors early in their careers are faced with especially in the major busy specialties. The highest number of ERs have been submitted by trainees working in General Surgery followed by Obstetrics/Gynaecology during this period. The majority of ERs are submitted in relation to additional hours worked, reflecting the high workload of resident doctors, often compounded by rota gaps, vacancies, seasonal pressures, leave, inadequate locum provision/cover and the need for extra cover. There have been few reports in relation to missed educational opportunities. The Board of Directors can be assured that the vast majority of resident doctors are able to work safely and that there are appropriate controls and processes in place for monitoring, with any issues being highlighted and actions taken. Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps/sickness absence preclude attendance at planned teaching sessions and specialty clinics. Departments have been requested to identify where this remains a challenge and to support resident doctors to maximise their training opportunities. Departments explore all possible options in supporting resident doctors to maximise their training opportunities. Medical Education team members engage with specialities to safeguard training opportunities for doctors.				
Recommendations				
The Board is asked to take significant assurance that there are appropriate controls and processes in place regarding exception reporting, which ensures that the vast majority of resident doctors can work safely and within the defined contractual hours.				
Healthier together – delivering exceptional care for all				
Patients	Resident doctors support the delivery of safe and effective patient care.			
People	The Guardian of Safe Working Hours role supports the resident doctors workforce.			

Partnerships	The Guardian of Safe Working Hours is part of regional and national networks to share learning and knowledge.
Pounds	The report describes the use of medical bank/agency usage and the application of fines.
Health Inequalities	None identified.
Legal/ Regulation:	-
Partner ICB strategies	-
Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING, DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Author: Mohammad I Khan, Guardian of Safe Working Hours

Report date: 07 July 2026

Introduction

This report sets out the information from the Guardian of Safe Working Hours (GOSWH) with regards to the 2016 Terms and Conditions for resident doctors to assure the Board of the safe working of resident doctors. This report is for the period 01 February 2026 to 31 March 2026. The Board should receive a report from the Guardian as per the 2016 contract, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade
- Details of fines levied against departments with safety issues
- Data on rota gaps, vacancies and locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

Table 1. Number of exception reports by month, February to March 2026.

Month	Approved	Draft	Rejected	Withdrawn	Under review	Pending Clarification	Review Requested	Total
February 2026	63	1	1	20				85
March 2026	89		1	15				105

The withdrawn ERs are mainly due to lack of response from the resident doctors when clarifications are needed to look into the ER. The reasons include requesting consent, time date evidence for late finish etc.

Table 2. Number of exception reports by specialty, 1 February 2026 to 31 March 2026.

Specialty	FEB	MAR	Total
Acute	9	9	18
BDGH Cardio		1	1
BDGH Diabetes & Endocrine	2		2
BDGH Elderly/Stroke		3	3
BDGH Gastro	5		5
Breast	1		1
Cardio	1		1
Diabetes & Endocrine	4	1	5
Elderly		2	2

Gastro	1		1
General Surgery	35	39	74
MMH Elderly/Stroke	1		1
Non-restored Dept		5	5
Obs and Gynaecology	13	15	28
Otolaryngology		1	1
Paediatrics	4	2	6
Renal	6	9	15
Respiratory		3	3
U & E	1		1
Urology	2	14	16
Vascular		1	1
Grand Total	85	105	190

Over this two month period, the majority of ERs have been submitted by trainees working in General Surgery, various branches of medicine, Obstetrics / Gynaecology and Urology.

Table 3. Reasons for submission of Exception Reports, February 2026 to March 2026

Difference in total hours of work (including opportunities for rest breaks)	88%
Min daily working rest reduced/ Maximum weekly hours breached	5%
Unable to attend scheduled teaching/training attendance	6%
Inadequate supervision	1%
Total	100%

During this two-month period, the vast majority (88%) of ERs were submitted in relation to additional hours worked with or without missed breaks, reflecting the high workload of resident doctors requiring them to stay late in order to ensure patient safety. Six percent of reports were made in relation to missed educational opportunities, and the most common reason was work pressures (sick patients, busy shift etc) or being understaffed (including sickness, rota gaps, vacancies and inadequate locum cover). There were also 1% ERs for inadequate supervision/support during the shift mostly from the foundation year doctors on a very busy shift or being responsible for quite a few patients in various locations.

Table 4. Number of exception reports by doctors' grade, February 2026 to March 2026.

FY1/2	CT1/2	ST1-3	ST4-8	Total
73%	3%	23%	1%	100%

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

Table 5. Comparison for Time off in Lieu vs Payment where applicable, 1 February 2026 to 31 March 2026

Exception Reports with TOIL granted	12%
Exception Reports with payment	88%

a) Work schedule reviews

No work schedule reviews were requested or conducted during this period.

b) Locum bookings

The data below details bank and agency shifts filled by training grade doctors along with gaps that remained unfilled.

Table 6. Gaps in respective specialities covered by internal bank along with the cost

Specialty	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Acute Medicine	86	815	£45,291
Anaesthetics and Critical Care	39	460	£27,085
Anaesthetics and Theatres	5	62	£4,145
Care of the Elderly	122	1108	£73,303
Emergency Medicine	414	3761	£232,742
General Medicine	134	1374	£72,573
General Surgery	28	238	£10,683
Obstetrics and Gynaecology	76	739	£45,843
Orthopaedic and Trauma Surgery	262	2616	£163,030
Paediatrics and Neonates	113	1273	£93,900
Renal Medicine	15	166	£8,470
Respiratory Medicine	16	156	£9,100
Stroke Medicine	7	73	£4,939
Urology	5	44	£2,113
Endocrinology and Diabetes	19	186	£9,144
Gastroenterology	40	428	£29,606
Vascular Surgery	1	13	£688
Cardiology (Medical)	24	238	£17,516
Rheumatology	13	144	£8,170
Infectious Diseases	3	28	£1,468
Haematology	2	17	£1,108
ENT	27	286	£15,654
Grand Total	1451	14221	£876,567

Table 7. Gaps in respective specialities covered by agency along with the cost

Specialty	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Acute Medicine	20	179	£7,932
Anaesthetics and Critical Care	4	47	£5,433
Anaesthetics and Theatres	1	13	£978
Care of the Elderly	78	695	£33,196
Emergency Medicine	718	6380	£526,869
General Medicine	99	857	£38,203
General Surgery	82	942	£70,949
Obstetrics and Gynaecology	43	475	£41,277
Orthopaedic and Trauma Surgery	256	2364	£165,791
Paediatrics and Neonates	62	755	£65,316
Renal Medicine	4	51	£2,319
Respiratory Medicine	6	50	£2,109
Stroke Medicine	1	9	£372
Urology	54	432	£36,168
Endocrinology and Diabetes	9	78	£3,427
Gastroenterology	3	25	£1,092
Vascular Surgery	3	38	£1,856
Rheumatology	8	68	£3,131
Infectious Diseases	1	9	£343
ENT	42	336	£27,209
Grand Total	1494	13798	£1,033,970

As expected, most of the hours covered by bank usage is for busy specialties like Acute & Emergency Medicine, Orthopaedics & Trauma.

Table 8. Gaps in respective specialities that could not be filled

Specialty	Data	
	Count of Job No	Sum of Estimated Quantity
Acute Medicine	7	71
Anaesthetics and Critical Care	1	10
Care of the Elderly	5	57
Emergency Medicine	53	509
General Medicine	4	45
General Surgery	3	35
Orthopaedic and Trauma Surgery	1	10
Respiratory Medicine	6	52
Stroke Medicine	3	23
Endocrinology and Diabetes	2	15
Gastroenterology	3	37
Vascular Surgery	1	13
Rheumatology	2	25
Grand Total	91	901

Table 9. Reasons for internal bank usage, 1 February 2026 to 31 March 2026

Reason	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Annual Leave	86	720	£47,820
Compassionate/Special leave	8	80	£5,713
Extra Cover	64	637	£33,126
Restricted Duties	21	232	£13,419
Sick	94	876	£52,814
Study Leave	3	25	£1,375
Vacancy	653	6347	£398,042
Maternity/Paternity leave	4	42	£2,480
Exempt from on calls for health reasons	29	338	£17,806
Induction/Rotation	43	397	£22,134
Additional session	10	83	£6,408
Seasonal Pressures	141	1401	£73,095
Vacancy - Less Than FT Trainee Gap	121	1271	£84,559
Vacancy – Deanary Gap	169	1730	£114,970
Less Than FT Trainee Gap	5	45	£2,808
Grand Total	1451	14221	£876,567

Table 10. Reasons for agency usage, 1 February 2026 to 31 March 2026

Reason	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
Annual Leave	65	565	£43,901
Compassionate/Special leave	12	121	£7,039
Extra Cover	102	960	£59,465
Restricted Duties	3	35	£3,797
Sick	25	286	£20,217
Study Leave	10	84	£5,403
Vacancy	935	8489	£698,449
Maternity/Paternity leave	74	667	£37,257
Exempt from on calls for health reasons	1	12	£606
Induction/Rotation	26	235	£10,980
Additional session	2	21	£1,111
Seasonal Pressures	133	1245	£71,149
Vacancy - Less Than FT Trainee Gap	33	388	£27,897
Vacancy – Deanary Gap	69	654	£44,042
Less Than FT Trainee Gap	4	37	£2,657
Grand Total	1494	13798	£1,033,970

The majority of locum cover was to provide staffing for vacancies, seasonal pressures, extra cover, sickness and leave.

Table 11. Reasons for shifts that remained unfilled, 1 February 2026 to 31 March 2026

Reason	Data	
	Count of Job No	Sum of Estimated Quantity
Annual Leave	1	10
Compassionate/Special leave	3	32
Extra Cover	1	8
Restricted Duties	4	50
Sick	20	185
Vacancy	57	559
Exempt from on calls for health reasons	1	13
Seasonal Pressures	2	25
Vacancy - Less Than FT Trainee Gap	2	20
Grand Total	91	901

Table 12. Breakdown by grade covered by internal bank

Grade	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
SpR 3+	568	5527	£412,068
FY2	10	106	£4,675
Core Trainee	855	8448	£453,759
FY1	18	140	£6,065
Grand Total	1451	14221	£876,567

Table 13. Breakdown by grade covered by agency

Grade	Data		
	Count of Job No	Sum of Estimated Quantity	Sum of Estimated Cost
SpR 3+	1026	9440	£824,984
FY2	19	213	£10,203
Core Trainee	448	4133	£198,292
FY1	1	13	£491
Grand Total	1494	13798	£1,033,970

Table 14. Breakdown of jobs that remained unfilled along with grades:

Grade	Data	
	Count of Job No	Sum of Estimated Quantity
SpR 3+	51	522
FY2	2	23
Core Trainee	38	357
Grand Total	91	901

c) Vacancies

In this period, monthly rota vacancies have decreased and were at 45 WTE in March 2026.

Table 15. Trainee vacancies by specialty, February 2026 to March 2026

	VACANCIES (WTE)	Posts	Feb-26	Mar-26
Medicine	Specialty Medicine	69	8.2	8.4
	FY1	18	0	0.2
	FY2	6	2.5	2.5
	CT/ST GPST 1-3	19	2.4	2.4
	ST3+	26	3.3	3.3
	Elderly Medicine	22	4	3.2
	FY1	3	0	0
	FY2 (No FY2 placements)	0	0	0
	CT/ST GPST 1-3	15	2.4	1.6
	ST3+	4	1.6	1.6
	Renal	7	2.2	2.2
	FY1 (No FY1 placements)	0	0	0
	FY2	6	1.2	1.2
	CT/ST GPST 1-3	0	0	0
	ST3+	1	1	1
U&EC	Urgent & Emergency Care	37	8.8	7
	FY1	5	0	0
	FY2	5	0	0
	CT/ST GPST 1-3	25	7.8	7
	ST3+	2	1	0
Women's & Children's	Obstetrics & Gynaecology	29	2.4	2.4
	FY1	3	0	0
	FY2	3	0	0
	CT/ST GPST 1-3	12	1.4	1.4
	ST3+	11	1	1
	Paediatrics	35	5.3	1.8
	FY1	4	1.2	0.6
	FY2	3	0.2	0.2
	CT/ST GPST 1-3	20	1.4	1
	ST3+	8	2.5	0
Surgery & Cancer	ENT	8	1.8	1.8
	FY1	0	0	0
	FY2	2	0	0
	CT/ST GPST 1-3	3	0.2	0.2
	ST3+	3	1.6	1.6
	General Surgery	27	3.8	3.8
	FY1	10	0	0
	FY2	2	0	0
	CT/ST GPST 1-3	7	3	3
	ST3+	8	0.8	0.8
	Ophthalmology	14	0.2	0.2
	ST3+	2	0.2	0.2
	Urology	7	7.4	7.4
	FY1	2	0.2	0.2
	FY2	3	0	0
	CT/ST GPST 1-3	0	0	0
	ST3+	2	0	0
	Trauma & Orthopaedics	6	3.6	3.6
	FY1	0	0	0
	FY2	1	0	0
	CT/ST GPST 1-3	5	2	2
	ST3+	5	1.6	1.6
	Vascular	8	2	2
	FY1	3	0	0
	FY2	1	0	0
	ST3+	4	2	2
Clinical Specialties	Anaesthetics	16	0.9	0.9
	FY1 (No FY1 placements)	0	0	0
	FY2	0	0	0
	CT/ST GPST 1-3	11	0.2	0.2
	ST3+	5	0.7	0.7
	ICT	12	0.4	0.4
	FY1 (No FY1 placements)	0	0	0
	FY2	6	0.2	0.2
	CT/ST GPST 1-3	4	0	0
	ST3+	2	0.2	0.2
Total		332	51	45.1

d) Fines

Six fines were issued during this two-month period as follows:

- 5 fines for breaching maximum 13 hours shift length
- 1 fine was levied for missed breaks (25% of times over a 4-week period)

e) Experiences of actual or threatened detriment

No such instances have been reported.

Qualitative information

An initiative named “Medical Education Engagement Group” facilitated by the Chief People Officer was started last year to bring the relevant stakeholders together on a quarterly basis and work together to improve connectivity between different workstreams.

The last Resident Doctors’ Forum (RDF) meeting took place on 21 May 2026 which was very poorly attended following a very successful RDF meeting in February 2026. This was again a hybrid meeting with the Guardian and HR representative present in the Education Centre and pizzas were ordered using the fine payments after reaching out to residents. There was only one trainee who joined on the Teams call despite several resident doctors confirming attendance for the food. This meeting also had a special talk on understanding payslips which we thought would benefit resident doctors’ understanding of reading their payslips.

There is progressive work being carried out on the 10-point NHS plan for improving resident doctors’ working lives and the meeting takes place monthly with all relevant stakeholders and led by the Chief Medical Officer. There is also progressive work going on from the Freedom to Speak Up team members to spread awareness and to engage with resident doctors.

NHS Employers have released a template for the GOSWH reports recently which was delayed as NHS trusts were expected to follow the template from April 2026. Although most of the requirements are covered by this report; it does not cover all aspects required and we have requested Healthrota to make the changes in data collection to become fully compliant. We anticipate we should have the ability to collect all required data as per national guidance for the next Board report.

Summary and Recommendation

Ongoing exception reports highlight high workloads for resident doctors, especially in the busy specialities despite significant improvements. High workload and understaffing are the usual causes for resident doctors being unable to undertake educational opportunities.

The Board of Directors can be assured that a clear majority of trainee doctors are able to work safely. Trainees are used to the system of reporting through Healthrota and there is positive feedback on the ease of using the app. Monthly regular meetings run between GOSWH and HR colleagues to action any outstanding ERs and make timely decisions. Supervisors have now been removed from the system and ERs with all the data are actioned in a timely fashion. Supervisors, tutors or departmental leads are only contacted after receiving the trainee’s consent for issues raised or to improve services.

Resident doctors are broadly able to access educational opportunities as envisaged in the 2016 contract, although this remains a challenge where high workload and rota gaps preclude attendance at educational sessions. This requires local resolution within those affected specialties and resident doctors are encouraged to discuss this issue with their Educational Supervisors /Education team for additional support.

2607 - E2 SPEAKING UP 2025/26 ANNUAL REPORT

● Discussion Item

👤 Zoe Lintin, Chief People Officer

🕒 10:55

Paula Hill, Freedom to Speak Up Guardian?

10 minutes

REFERENCES

Only PDFs are attached

📄 E2 - Speaking Up 2025-26 Annual Report.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Speaking Up (FTSU) 2025-2026 Annual Report			
Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Paula Hill, Lead Freedom to Speak Up Guardian			
Appendices:	A - FTSU Data Infographic 2025-2026			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level	Significant Assurance			
Assurance Rationale	The Board is asked to take significant assurance that FTSU Guardian systems and processes are in place and working effectively based on feedback and external peer review, in line with national guidance and best practice. Mitigations and actions are in place in areas of identified risk or issues. A significant assurance level is consistent with the conclusion of the People Committee at their meeting on 16 June 2026.			
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2			
Executive Summary – Key messages and Issues				
Freedom to Speak Up (FTSU), referred to locally as Speaking Up, underpins the Trust’s commitment to a culture in which colleagues feel safe, supported and confident to raise concerns, with assurance that these will be listened to and acted upon. A strong speaking up culture is fundamental to the delivery of safe, high-quality care and to supporting colleague wellbeing, and is aligned to the Trust’s strategic objectives and Reset programme notably the Culture and Leadership programme. In addition, strong Speaking Up cultures are delivered in line with CQC regulatory requirements (17(2)e – (learning from feedback) and wider Well-Led regulations, National Guidance and the Board’s Risk Framework. In line with the above, this report provides insight into areas of strength, where significant assurance can be given and some areas of challenge, where moderate assurance is provided alongside mitigating actions. In line with People Committee discussion and feedback (16 June 2026) this report is also reflective of the outcome of robust reflection on future Speaking Up assurance reporting and the Significant Assurance taken by the Committee at this time. The key points from this annual report and the ongoing strategic work in relation to Speaking Up, as part of our wider cultural workstreams, are summarised below. <u>Key areas of effective and/or best practice</u> ➤ Existing best practice and strong accountability enabling easy transition of NHSE responsibilities ➤ Consistent number of people accessing services and reporting good experiences, when comparing data year-on-year ➤ High feedback response rates and confidence in speaking up again ➤ Demonstrable impact of turning learning into action, Case studies from Guardian services and wider partners				

<u>Areas where additional consideration is required</u>	
➤ Training access, timescales and potential impact on delayed learning. Training completion rates are improving and a new blended model is being introduced. ➤ FTSU Guardian shared access to cases – using the impact of recent absence to inform the need for revised systems to enable early consent to share information in cases of emergency, to improve timeliness of response.	
<u>Areas of low risk with mitigating actions</u>	
➤ Non-compliance with the national guidance in relation to the provision of stand-alone “Detriment Guidance” due to delays in development of the local guidance - mitigated through the continued use of robust existing escalation processes, ensuring consistency, objectivity and timely action. ➤ Identification of those reporting perceived unfair treatment through feedback. This area requires ongoing monitoring and review to ensure all cases can be followed up and supported in a timely manner.	
Recommendations	
The Board is asked to take significant assurance that FTSU Guardian service systems and processes are in place and working effectively based on feedback and external peer review, in line with national guidance and best practice. Equally, it is recognised that there are variable perceptions in relation to the outcomes arising from speaking up depending on personal experiences and other factors. It is also acknowledged that where low and moderate level risks have been identified in relation to training, service cover, and perceived unfair treatment, appropriate mitigations are in place to prevent negative undue impact on colleague experience, the achievement of the wider objectives of the FTSU Strategic Enabling Plan and organisational culture.	
Healthier together – delivering exceptional care for all	
Patients	Speaking up supports patient safety through improved speaking up cultures that enable near miss and incident reporting, data analysis to encourage learning.
People	Speaking up supports colleague experience through improved speaking up cultures that enable near miss and incident reporting, data analysis to encourage learning.
Partnerships	Collaborative partnership working across DBTH and wider working with other trusts on FTSU activity and regionally on a Deanery Training Programme.
Pounds	Improved colleague experience positively impacts on wellbeing and retention, thereby reducing the need for temporary workforce and associated costs.
Health Inequalities	Barriers to speaking up are explored as part of the strategy development work and this considers inequalities.
Legal/ Regulation:	No legal implications.
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	The content featured in this report has been considered and explored by the People Committee on 16 June 2026.
Any outcomes/next steps / time scales	Presentation to Board on 7 July 2026.

1. Introduction

Freedom to Speak Up (FTSU), referred to locally as Speaking Up, underpins the Trust's commitment to a culture in which colleagues feel safe, supported and confident to raise concerns, with assurance that these will be listened to and acted upon. A strong speaking up culture is fundamental to the delivery of safe, high-quality care and to supporting colleague wellbeing, and is aligned to the Trust's strategic objectives and Reset programme notably the Culture and Leadership programme.

In addition, Strong Speaking Up cultures are delivered in line with CQC regulatory requirements (17(2)e – (learning from feedback) and wider Well-Led regulations, National Guidance and the Board's Risk Framework.

In line with the above, this report provides insight into:

- Areas of strength, where significant assurance can be given
- Areas of challenge, where moderate assurance is provided alongside mitigating actions

The report reviews progress against the DBTH Speaking Up Strategic Plan (2024–2028) and presents activity from 1 April 2025 to 31 March 2026, including:

- Trends and themes in reporting
- Feedback from the FTSU Guardian service
- Barriers to speaking up, including psychological safety and perceived inaction.

This is informed by triangulation of National Guardian's Office (NGO) data, local FTSU activity, and performance against the DBTH Reflection and Planning Tool, providing a comprehensive view of organisational performance and assurance overall.

In line with People Committee discussion and feedback at the meeting on 16 June 2026, this report is also reflective of the outcome of robust reflection on future Speaking Up assurance reporting.

In addition to the discussions in the Committee on this matter, the FTSU Guardian, the Chair of the People Committee, the Chief People Officer and the Chief Nurse met after the meeting to conclude and agree the reporting approach. This confirmed that the broad structure of the FTSU reporting framework to People Committee and Board would remain, to ensure consistency with national guidance and CQC requirements, with more focused reports for Board and further detail for People Committee. Examples were also discussed to strengthen clarity and demonstration of outcomes and impact within the reports.

2. Transition from National Guardian's Office to NHS England

Confirmation was received in May 2026 that, from 1 July 2026, FTSU responsibilities will transfer from the National Guardian's Office (NGO) to NHS England (NHSE). The standalone National Guardian role will cease, with functions integrated within NHSE structures.

NHSE responsibilities will include:

- Guardian registration, training, mentorship and data management
- Publication of quarterly and annual FTSU data
- Delivery of national training via the NHS learning platforms

Oversight of compliance with FTSU requirements will sit with the Care Quality Commission (CQC) through Well-led inspections, with a key focus on Regulation.

Trust responsibilities will include:

- Ensuring compliance with national standards, including appropriate Guardian resourcing
- Supporting Guardian training, development and registration
- Providing appropriate psychological support for Guardians
- Maintaining visibility and accessibility of FTSU services
- Submission of required data returns

Whilst most requirements align with existing arrangements, the provision of psychological support for Guardians requires further consideration.

3. Local Speaking Up Activity

During 2025–2026 117 colleagues raised concerns across 112 cases, reflecting stability in reporting numbers year on year, although a notable increase in individual cases (78 to 112).

2025-2026 annual activity remained broadly consistent with national benchmarks; however, it does not reflect the reduction in psychological safety indicated in:

- The 2025 Staff Survey
- FTSU Peer Review
- DBTH Way in Action review

Workforce profile of local speaking up activity:

- Nurses and Midwives: 33%
- Admin and Clerical: 22% (increase from previous year)
- Medical: 9%
- Other professional groups: more evenly represented

Key observation:

- Anonymous reporting has increased to 15%, rising above the national average.
 - This may indicate reduced psychological safety.
 - It may also reflect the introduction of new anonymous reporting mechanisms, and that people are making use of the options available to them. The anonymous reporting tool is aligned with the work of the Trust's Sexual Safety working group, in line with the national guidance.

Key themes:

- Worker Safety and Wellbeing: 44% (continuing downward trend)
- Leadership: 43%
- Systems and Processes: 36% (unchanged despite targeted investment)

Data also shows a reduction in Inappropriate Behaviour (18%) and Bullying and Harassment (11%). However, this contrasts with wider organisational feedback from reports and is currently subject to further analysis through the planned Bullying & Harassment Deep Dive review with feedback due in Quarter 3 - 2026-2027, as part of the Culture and Leadership programme.

Patient Safety:

- Reduced from 31% to 13%, consistent with national trends.
- Likely reflects strengthened reporting systems and improved confidence in PSIRF reporting processes as these have become further embedded.

Feedback and case management:

- Delays in case closure continue to impact feedback rates and confidence in Speaking Up.
- Delays in case closure are also reported to negatively impact colleague wellbeing impacting on wider performance against the NHS Avoiding Employee Harm workstream.
- Revised feedback processes are improving accessibility, though overall uptake remains limited

Overall, triangulated data supports the trends identified, except for behavioural themes where the data is not entirely consistent with feedback received through commissioned reports.

4. Learning and Impact

4.1 Peer Review Learning

Delivery of the Speaking Up Peer Review findings has included Trust-wide engagement sessions across sites and targeted or focused engagement across key staff groups. While attendance was lower than anticipated at these sessions, the quality of feedback provided valuable insight into colleague experience and expectations.

Further engagement activity, including targeted outreach and “crowdsourcing”, is underway to:

- Capture underrepresented voices
- Inform the next phase of the strategic plan
- Strengthen the partnership model

Notably, medical colleagues have not engaged in general sessions to date, potentially indicating:

- Reduced psychological safety
- Wider disengagement
- Other factors such as accessibility to the sessions

Due to the concerns highlighted in the peer review about some medical colleagues not feeling safe to speak up, this may support this claim or be evidence of wider senior medical disengagement. This will require further monitoring and review to inform future actions.

4.2 Case Access and Continuity

A period of Guardian absence highlighted potential risks in case continuity and, therefore, an impact on colleague experience and timeliness of response. A revised, consent-based case-sharing approach is being developed to maintain confidentiality and ensure timely support to colleagues.

Whilst outside existing guidance, this approach is considered proportionate in mitigating greater risk to colleague experience.

4.3 Sharing Impact and Outcomes

Although it is well acknowledged that sharing experiences of Speaking Up can improve both culture and confidence, some reluctance to share personal experiences remains. However, progress has been made in identifying and disseminating some positive Speaking Up case studies, demonstrating:

- Enhanced patient outcomes
- Improved patient experience
- Improved cross team collaboration
- Service improvement and performance

Notably, one case contributed to a clinical team going on to receive the DBTH Star of the Year Award (2025).

Sexual Safety

Following the introduction of NHSE guidance relating to Sexual Safety in NHS organisations, this has been a key focus for the Safeguarding Team and wider DBTH Sexual Safety Group. Their collaborative working and innovation have seen:

- The introduction of the DBTH Report & Support Process, including an option for anonymous reporting
- Increased reporting
- Improved access to support
- Strengthened confidence in reporting processes

This work has been recognised nationally as an example of good practice with a HPMA webinar held earlier in the year hosted by DBTH colleagues.

5. Performance Against Strategy

The 2024–2028 Speaking Up Strategic Plan is directly linked to the FTSU Reflection and Planning Tool and together they continue to drive measurable progress, with the majority of actions completed or on track for completion within timescale. The People Committee receive updates on progress and any issues as part of the bi-annual reports.

Identified exceptions and risks with mitigations

- Non-compliance with the national guidance in relation to the provision of stand-alone “Detriment Guidance” due to delays in development of the local guidance
- Delayed recruitment of additional FTSU Guardian capacity

Appropriate mitigations are in place through the continued use of the FTSU escalation process in relation to concerns about unfair treatment and through the extension of fixed term arrangements for additional FTSU Guardian cover whilst the recruitment processes take place.

Training compliance

Although the Trust has seen a significant increase in engagement with Speaking Up training, timely completion is impacted by the resource of FTSU Guardian services and colleague availability.

- Level 1 (Speak Up): 82%
- Level 2 (Listen Up): 39%

- Level 3 (Follow Up): 37%

The key risks related to training delivery are the capacity constraints impacting training completion, resulting in delays to learning and associated improvement in practice. By way of mitigation, it has been decided to introduce a blended learning model to improve accessibility and completion rates and to maximise the use of Guardian/colleague time.

6. Summary and Recommendation

This report demonstrates that the FTSU Guardian service is established and functioning effectively, with evidence of positive impact for colleagues, learning being taken and alignment with national standards and best practice. The majority of actions within the strategic plan and Reflection and Planning tool remain on track or have been completed.

Whilst some areas of issues and risk have been identified, including:

- Training access and capacity
- Guardian capacity and resilience
- Bespoke guidance on unfair treatment after Speaking Up

These are actively managed with appropriate mitigations in place, with no evidence of undue impact on colleague experience, delivery of strategic objectives or organisational culture

Recommendation

The Board is asked to:

- Take significant assurance regarding the effectiveness of FTSU systems and processes based on feedback and external peer review, and in line with national guidance and best practice.
- Note variation in colleague perception based on individual experience and wider factors.
- Recognise that the identified low and moderate level risks are under active management, with clear actions and oversight mechanisms in place

Further reading:

Transition of NGO Responsibilities to NHS England and NHS Providers

<https://www.england.nhs.uk/ourwork/freedom-to-speak-up/resources-to-help-you-develop-your-freedom-to-speak-up-arrangements/>

Appendices:

a) FTSU Data Infographic 2025-2026

PDF Version available as part of the additional information provided

DBTH Speaking Up

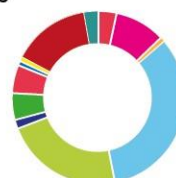
A summary of data from 2025-26

Number of cases brought to FTSU guardians in 2025-2026:

117
individuals
(112 cases)

Cases grouped by professions:

Allied Health Professionals	4	Additional Clinical Services	6
Medical and Dental	11	Estates & Ancillary	6
Commissioning	1	Healthcare Scientists	1
Registered Nurses & Midwives	39	Students	1
Administration, Clerical	26	Not known	17
Additional Professional Scientific and Technical	2	Other	3



Themes of concerns Number of people who raised concerns about...

Raised their concerns anonymously	19
Patient safety/quality	25
Worker safety or wellbeing	88
Bullying or harassment	21
Inappropriate behaviour	36
Disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment')	2

Internal data capture identified the following additional themes:

Fairness	12
Relationships	7
Systems and processes	33
Leadership	40



Summary of learning

- Less people speaking up in groups/teams
- Bullying & Harassment cases and inappropriate behaviours remain high
- Worker wellbeing remains a key impact, with many individuals and teams needing additional support from both internal and external sources.
- Q3 saw an increase in cases overall although there are less people speaking up in groups/teams.
- Considerable increase in anonymous reporting.

Consideration needs to be given to the ease of reporting due to new process and the indication of impaired psychological safety.

- Increase in concerns relating to staffing and safety and the potential this has to impact patient safety and experience.
- Increased concerns relating to the leadership of change and the impact of revised systems and processes.
- Colleagues feel more confident to speak up about impact on patient not each other.

Receiving feedback Of those asked: 'Given your experience, would you speak up again?'

93% response rate for initial feedback

84.6% said 'Yes'

11.5% said 'Maybe'

3.8% said 'No'

Common themes from feedback

Ongoing support for both colleagues who speak up and their managers/leaders was reassuring and has helped to build and strengthen relationships. It made a difference to be supported/enabled to have open conversations with the team and senior managers.

The advice, patience, and understanding helps colleagues to feel heard and supported during stressful and uncertain times, feeling heard made a big difference. The support provided helped colleagues have confidence to have more open conversations and to feel empowered to continue this going forward.

A small number of colleagues report feeling treated unfairly after speaking up but there are difficulties with identification/anonymous reporting.

Service was easy to access and the Guardians were very supportive.

Positive reports of sustainable change in some areas but this can be inconsistent.

2607 - E3 2025/26 WORKFORCE RACE & DISABILITY EQUALITY STANDARDS

● Information Item

👤 Zoe Lintin, Chief People Officer

🕒 11:05

10 minutes

REFERENCES

Only PDFs are attached



E3 - Workforce Race & Disability Equality Standards Report.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Workforce Race Equality Standards (WRES) & Workforce Disability Equality Standards (WDES) 2025-2026			
Sponsor:	Zoe Lintin, Chief People Officer			
Authors:	Gavin Portier, Head of OD, EDI & Wellbeing			
Appendices:	Appendix 1: DBTH 2025 NHS Staff Survey WRES and WDES graphs			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Impacts on Strategic Risks (BAF 1-7)	BAF 2			
Executive Summary – Key messages and Issues				
Introduction This report presents Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust’s Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data for the 2025–2026 reporting period. It provides insight into workforce representation, recruitment outcomes, employee relations activity and colleague experience, enabling benchmarking against national NHS standards and informing targeted organisational action. It is being presented to the Board for information and has previously been presented at People Committee and has been submitted in line with the national deadline. Workforce Analysis The data demonstrates progress in workforce diversity, with increased representation of Black and Minority Ethnic (BME) colleagues across most non-clinical and clinical bands, including senior roles. Similarly, there are improvements in the representation of disabled colleagues across several workforce groups, reflecting positive movement in inclusivity and workforce profiling. However, key inequalities persist. Recruitment data highlights a significant disparity in appointment rates, with White applicants more likely than BME applicants to be appointed from shortlisting, representing a marked deterioration from the previous year. Likewise, non-disabled applicants are now more likely to be appointed than disabled applicants, reversing prior progress. These findings indicate a need for continued action and governance, and to build on recent work on inclusive recruitment practices. In late 2025, the Trust introduced Inclusive recruitment training and this is being shared with recruiting managers in 2026 and onwards. Employee relations data shows disproportionate experiences. BME colleagues remain more likely to enter formal disciplinary processes compared to White colleagues. More significantly, disabled employees are almost four times more likely to enter formal capability processes than non-disabled colleagues, signalling a priority risk area which is being reviewed. Separate casework analysis undertaken by the People & OD team shows a higher proportion of colleagues who identify as living with a disability experienced the formal absence management process in the preceding 12 months than colleagues who do not identify as being disabled or chose not to disclose their status. Staff survey findings also indicate these disparities, with both ethnically diverse colleagues and those with long-term conditions reporting poorer workplace experiences, including higher levels of bullying and less favourable perceptions of career progression. This is reflective of the national picture. Conclusion While improvements are noted in areas such as reasonable adjustments, overall lived experience gaps remain. The absence of both BME and disabled representation at Board level in the reporting year highlights a critical leadership gap and limits visible inclusivity. This report underscores the need for continued evidence-based action aligned to the Trust’s Equality, Diversity and Inclusion (EDI) priorities, focusing on inclusive leadership, equitable				

processes, and cultural improvement to improve outcomes and experience for all colleagues. In addition, it requires each of us to demonstrate our We Care values and act in line with the DBTH Way as all colleagues have a responsibility and capacity to influence in making DBTH a more inclusive place to work. This work aligns with the wider Culture and Leadership programme and is monitored through the EDI improvement plan.

The Equality, Diversity and Inclusion Annual Report was presented at People Committee at the June 2026 meeting, setting out actions being taken to continue to address these disparities, the governance in place to monitor progress and outcomes, and the external accreditation and audit processes utilised during the last year. The People Committee took significant assurance from the EDI Annual Report.

Recommendations

The Board is asked to note the information provided in the report and that the data was submitted in line with the national deadline of 31 May 2026 as part of mandated EDI reporting. The report was presented at People Committee on 17 June 2026 and the information will be published on the Trust's webpage.

Healthier together – delivering exceptional care for all

Patients	Our workforce needs to be diverse and inclusive to ensure our delivery of care meets the needs and connects with people in the communities we serve.
People	Workforce processes, culture and the lived working experience must be in alignment with the DBTH Way.
Partnerships	The Trust works in partnership with our employees through Networks and works in partnership with other anchor institutions across South Yorkshire & Bassetlaw.
Pounds	Our EDI improvement plan uses DBTH resources for education, training and innovation in the first instance in driving the delivery of the plan.
Health Inequalities	Health Inequalities is one of the high impact actions of the DBTH EDI Improvement plan.
Legal/ Regulation:	The Equality Act 2010. NHS Mandated regulations
Partner ICB strategies	The EDI Improvement Plan has collaboration in some workstreams with partner ICB organisations and their strategies.

Assurance Route

Previously considered by - including date:	People Committee 17 June 2026
Any outcomes/next steps / time scales	Present to Board on 7 July 2026, to note

1. Introduction

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are mandatory NHS reporting frameworks used to compare the workplace experiences and career opportunities of minority ethnic and disabled colleagues with White and non-disabled colleagues. This report summarises DBTH's 2025/26 WRES and WDES submissions, covering the period 1 April 2025 to 31 March 2026, with a workforce snapshot date of 31 March 2026. The report will be published on the Trust website.

Data has been drawn from ESR, the recruitment system - TRAC and the Employee Relations case database. The validity of the analysis is dependent on colleague disclosure of ethnicity and/or disability within these systems. Improving disclosure requires a culture in which colleagues feel safe, included and valued, consistent with our We Care values and the DBTH Way.

2. Workforce Race Equality Standard (WRES)

The WRES assesses race and ethnicity-related inequalities using ESR, TRAC, Employee Relations data and the 2025 NHS Staff Survey.

The required WRES fields are:

- Workforce composition (BME and White)
- Leadership representation - VSM and Board
- Recruitment – likelihood of appointments (BME and White)
- Employee relations – likelihood of entering formal disciplinary process (BME and White)

The report also references relevant 2025 NHS Staff Survey findings.

Indicator 1 Non-clinical job roles

Indicators 1a and 1b show changes in BME headcount. Increases are rated as improved, reflecting greater workforce diversity.

AfC Band /VSM	BME head count total	BME head count from last year	2025 v 2024 status
AfC Bands 1 & under to 4	87	69	Improved
AfC 5 to 7	25	20	Improved
AfC 8a to 8b	7	5	Improved
AfC 8c to 9 & VSM	4	1	Improved

Indicator 1b Clinical job roles

AfC Band / VSM	BME head count total	BME head count from last year	2025 v 2024 status
AfC Bands 1 & under to 4	103	104	Declined
AfC 5 to 7	611	566	Improved
AfC 8a to 8b	4	6	Declined
AfC 8c to 9 & VSM	2	2	Same
Medical Dental Consultants	200	195	Improved
Non Consultant career grade	103	96	Improved
Staff & trainee grade	271	232	Improved

Indicator 2 - Relative likelihood of BME employees being appointed from shortlisting across all posts

This indicator compares the likelihood of BME and White applicants being appointed from shortlisting, using TRAC recruitment data for 1 April 2025 to 31 March 2026.

	BME	White	Ethnicity Unknown
Number Shortlisted	1238	1948	87
Number Appointed	100	460	50
Likelihood of shortlisting / appointed	8.1	23.6	57.5

The relative likelihood of White applicants being appointed from shortlisting compared to BME applicants is 2.92, indicating White applicants were more likely to be appointed.

Indicator 3 - Relative likelihood of employees entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator uses a two-year rolling average to compare the likelihood of BME and White colleagues entering the formal disciplinary process, based on employee relations case data.

	BME	White
Average number of employees on formal disciplinary process over 2 years	17	111
Likelihood of entering the formal disciplinary process	1.2%	1.9%

The relative likelihood of BME colleagues entering the formal disciplinary process compared to White colleagues is 1.26.

Metric 10 Board voting membership

The data showed that there are no Board members with BME ethnicity as at 31 March 2026. This is unchanged from the previous year.

3. DBTH 2025 Staff Survey WRES results

The 2025 NHS Staff Survey indicates that colleagues from “All other ethnic groups” continue to report a different lived experience from White colleagues. The relevant WRES Staff Survey graphs are provided in Appendix 1. The Trust achieved Bronze Accreditation from the North West BAME Assembly in December 2025 and continues to participate in the Doncaster Anti-Racism Partnership; further work is required to embed progress and reduce disparity.

4. Workforce Disability Equality Standard (WDES)

The WDES assesses disability-related inequalities using ESR, TRAC, Employee Relations data and the 2025 NHS Staff Survey. Metric 1 below shows changes in colleagues declaring a disability across clinical and non-clinical roles; increases are rated as improved, reflecting greater workforce diversity.

Metric 1 Non-clinical job roles

AfC Band /VSM	Disabled head count	% of non-clinical roles	% last year	2025 v 2024 status
AfC Bands 1 & under to 4	141	7.8%	7%	Improved

AfC 5 to 7	16	5.8%	5.4%	Improved
AfC 8a to 8b	6	7.2%	7.9%	Declined
AfC 8c to 9 & VSM	1	2.4%	2.4%	Same

Metric 1 Clinical job roles

AfC Band / VSM	Disabled head count	% of clinical roles	% last year	2025 status
AfC Bands 1 & under to 4	91	6.4%	7%	Declined
AfC 5 to 7	193	6.7%	5.4%	Improved
AfC 8a to 8b	5	3.6%	7.9%	Declined
AfC 8c to 9 & VSM	0	0%	2.4%	Declined
Medical Dental Consultants	10	3.2%	1.5%	Improved
Non Consultant career grade	2	1.8%	1.8%	Same
Staff & trainee grade	19	4.9%	4.7%	Improved

Metric 2 - Recruitment likelihood of interview and appointments

This metric compares the likelihood of disabled and non-disabled applicants being appointed from shortlisting, using TRAC recruitment data for 1 April 2025 to 31 March 2026.

	Disabled	Non-disabled	Disability Unknown
Number Shortlisted	305	2837	51
Number Appointed	45	500	46
Likelihood of shortlisting / appointed	0.15	0.18	0.9

The relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants is 1.19. This has worsened from 0.72 last year, shifting from disabled applicants being more likely to be appointed to non-disabled applicants being more likely this year.

Metric 3 – Capability. Employee relations

This metric uses a two-year rolling average to compare disabled and non-disabled colleagues entering the formal capability process for performance reasons, based on Employee Relations case data.

	Disabled	Non-disabled	Disability Unknown
Average number of employees on formal capability over 2 years	3	10.5	1.5
Likelihood of staff entering the formal capability process	0.006	0.002	0.004

The relative likelihood of disabled colleagues entering the formal capability process compared to non-disabled colleagues is 3.918, based on the NHS England data collection framework. This has worsened from 3.336 last year, meaning disabled colleagues are now almost four times more likely to enter formal capability processes.

Metric 10 Board voting membership

The data showed that there are no Board members with a declared disability as at 31 March 2026.

5. DBTH 2025 Staff Survey WDES results

It is important to note that the NHS Staff Survey WDES data is based on colleagues declaring a long-lasting health condition or illness, rather than disability specifically. Results show these colleagues continue to report a more challenging workplace experience. The relevant WDES Staff Survey graphs are provided in Appendix 1.

There has, however, been a marked improvement in positive indicators relating to reasonable adjustments.

6. Conclusion

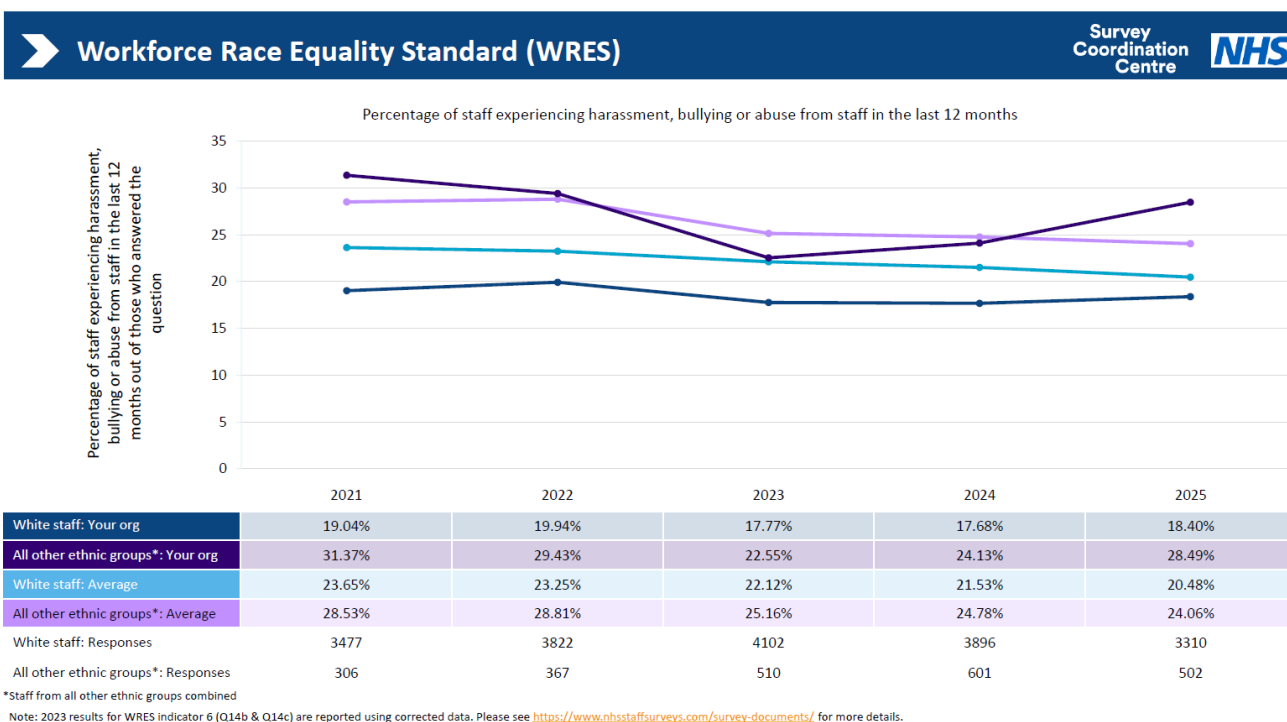
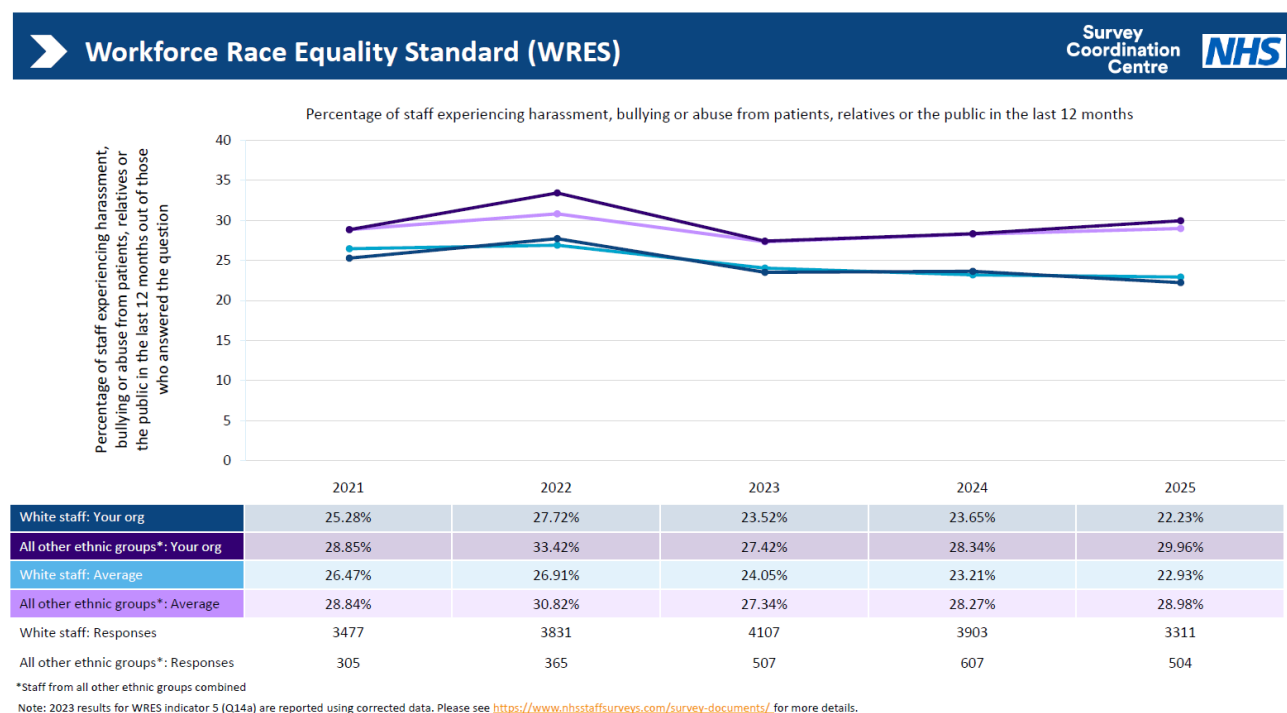
The Trust has complied with WRES and WDES reporting requirements and demonstrates progress in representation and aspects of workforce experience. However, inequalities remain in recruitment outcomes, employee relations and senior leadership diversity. Continued action, accountability and cultural development are required to improve equity of experience and opportunity for all colleagues.

The 2025 NHS Staff Survey also indicates that ethnic minority colleagues and colleagues with a long-lasting health condition or illness continue to report a different experience of working at DBTH.

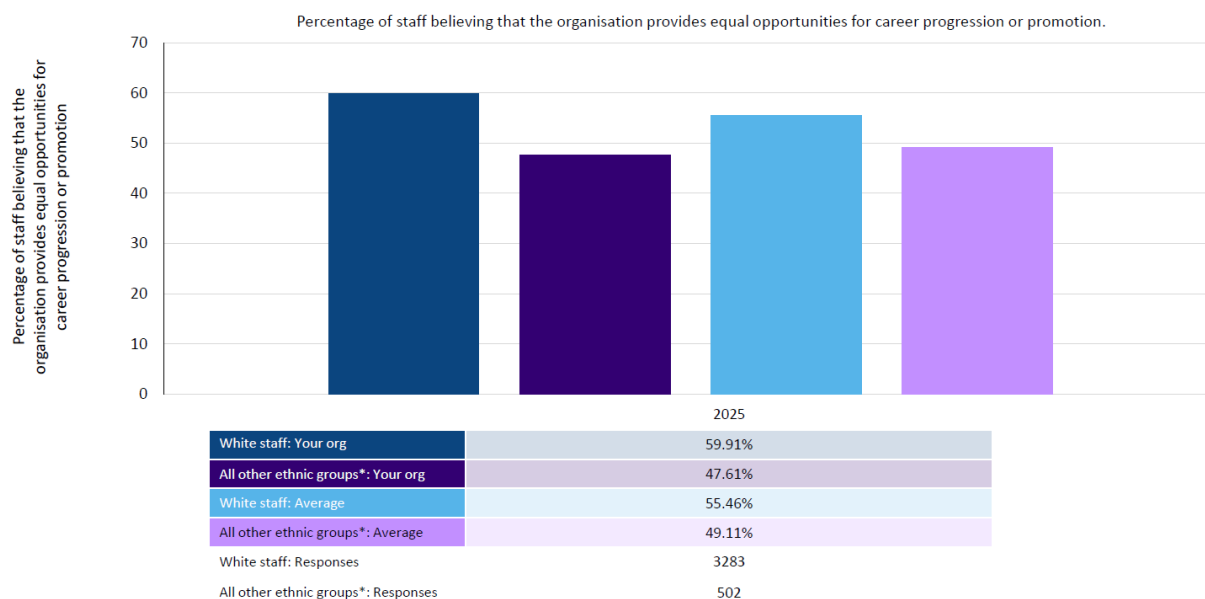
The Trust's EDI Improvement Plan sets out actions to address these gaps, supported by the We Care values and DBTH Way, which emphasise shared responsibility for ensuring colleagues feel safe, included, valued and respected. In addition, the EDI work is aligned with the wider Culture and Leadership programme.

The Board is asked to note the report and that the submission was completed by the national deadline of 31 May 2026. The Board is also asked to note that the People Committee took significant assurance from the EDI Annual Report presented at the June meeting, which sets out the actions being taken to address identified inequalities.

Appendix 1: DBTH 2025 NHS Staff Survey WRES and WDES Graphs



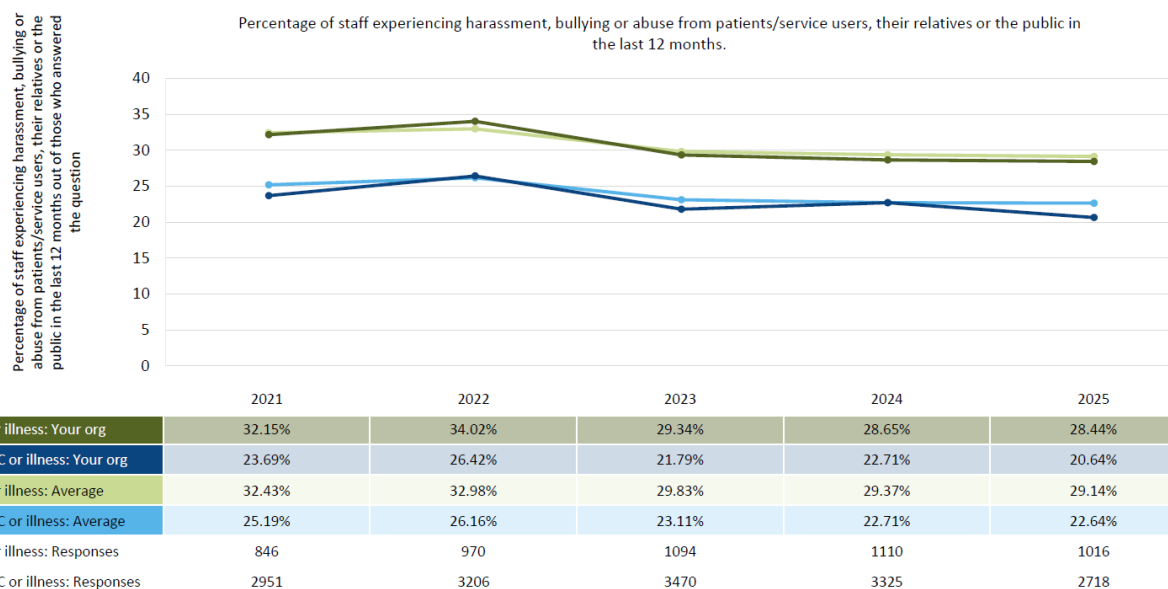
Workforce Race Equality Standard (WRES)



*Staff from all other ethnic groups combined.

Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported. For more information, please refer to the *Technical Guide*: <https://www.nhsstaffsurveys.com/survey-documents/>

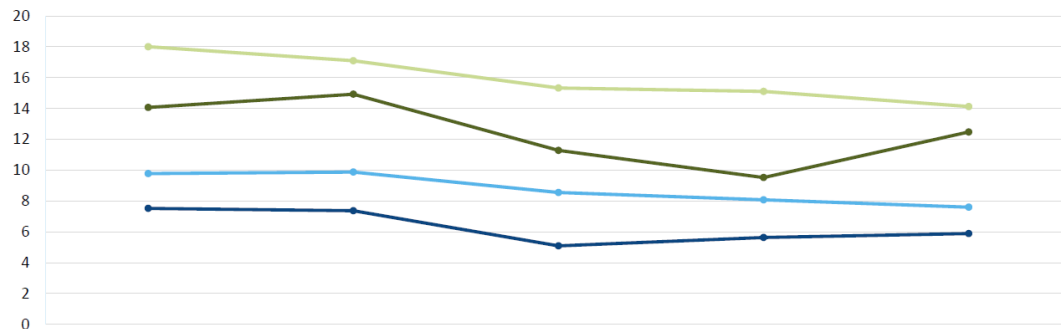
Workforce Disability Equality Standards



Note: 2023 results for WDES metric 4a (Q14a) are reported using corrected data. Please see <https://www.nhsstaffsurveys.com/survey-documents/> for more details.

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months out of those who answered the question

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

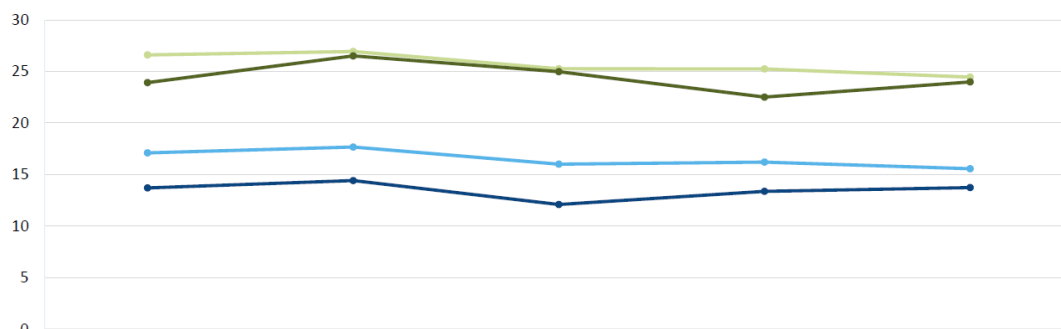


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	14.06%	14.92%	11.28%	9.52%	12.48%
Staff without a LTC or illness: Your org	7.52%	7.37%	5.09%	5.63%	5.88%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	839	965	1090	1103	1018
Staff without a LTC or illness: Responses	2939	3189	3457	3304	2702

Note: 2023 results for WDES metric 4b (Q14b) are reported using corrected data. Please see <https://www.nhsstaffsurveys.com/survey-documents/> for more details.

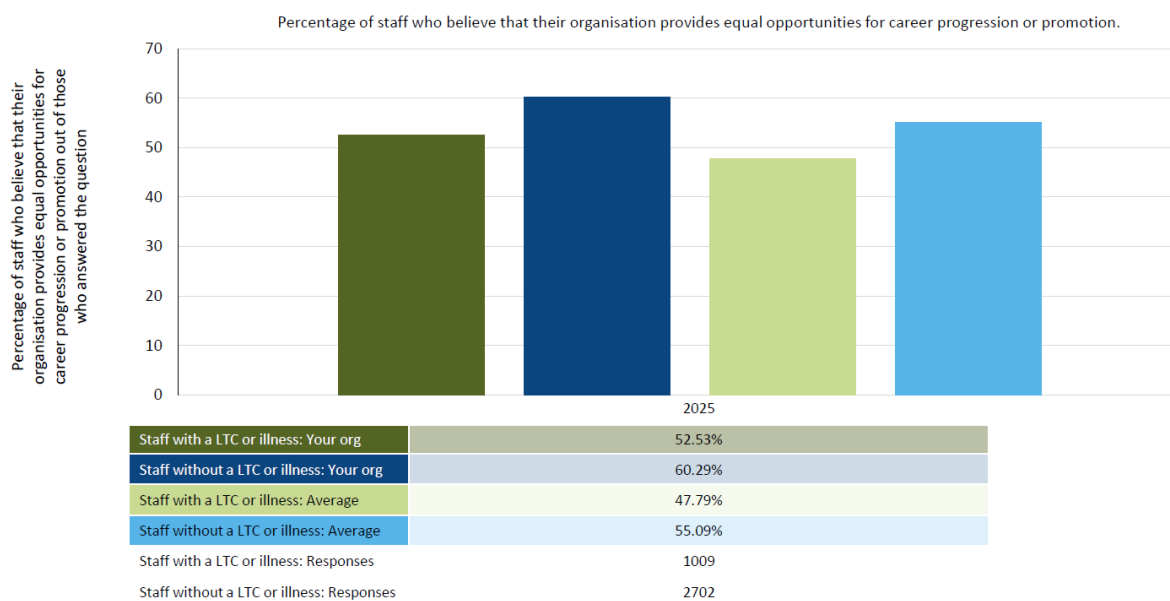
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

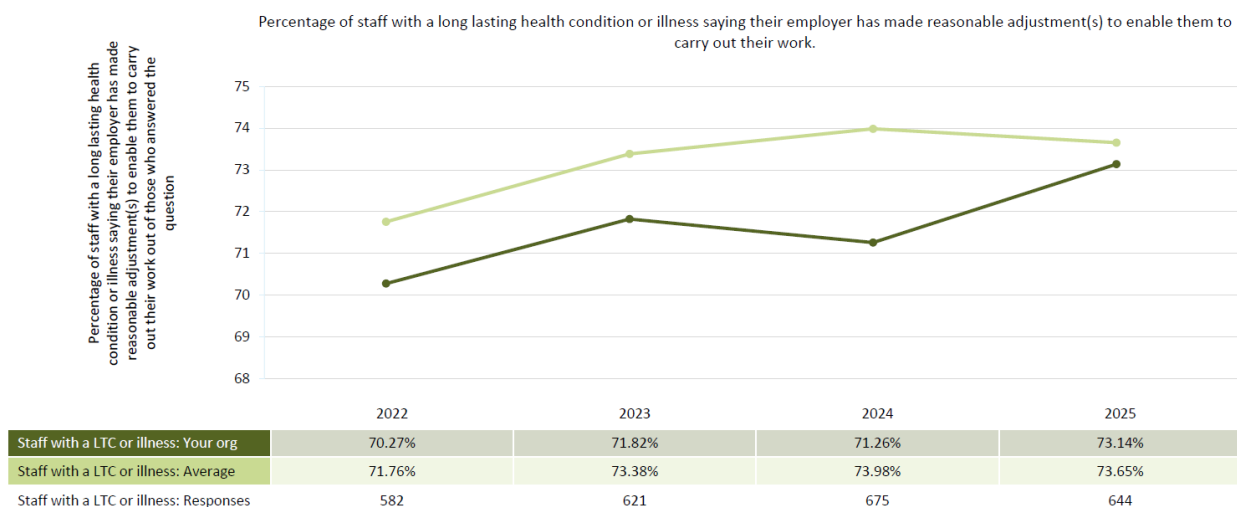


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	23.92%	26.51%	24.98%	22.51%	23.99%
Staff without a LTC or illness: Your org	13.70%	14.42%	12.10%	13.38%	13.74%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%
Staff with a LTC or illness: Responses	832	962	1089	1106	1013
Staff without a LTC or illness: Responses	2927	3169	3455	3297	2701

Note: 2023 results for WDES metric 4c (Q14c) are reported using corrected data. Please see <https://www.nhsstaffsurveys.com/survey-documents/> for more details.



Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 (Q15) are not reported. For more information, please refer to the Technical Guide: <https://www.nhsstaffsurveys.com/survey-documents/>



BREAK 11:15 - 11:30

2607 - F1 MATERNITY & NEONATAL SAFETY REPORT

● Discussion Item

👤 Simon Brown, Deputy Chief Nurse

🕒 11:25

Lois Mellor, Director of Midwifery

10 minutes

REFERENCES

Only PDFs are attached



F1 - Perinatal Safety & Quality Interim Report.pdf



F1 - Appendix 1 - Q4 2025-2026 PMRT Report.pdf



F1 - Appendix 2 - Maternity Metrics March 2026.pdf



F1 - Appendix 3 - Data measures - Perinatal Quality Oversight Tool.pdf

Report Template					
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026	
Report Title/ Ref:	Perinatal Safety & Quality Interim Report (<i>previously the Maternity and Neonatal Update</i>)				
Executive Sponsor:	Karen Jessop, Chief Nurse				
Authors:	Lois Mellor, Director of Midwifery Danielle Bhanvra, Deputy Director of Midwifery				
Appendices:	Appendix 1 - PMRT Q4 report Appendix 2 - Maternity Metrics Appendix 3 - PQOM Data Measures				
Purpose of the report	Assurance	Approval/ Decision	Information	Discussion	
Proposed assurance Level (For assurance papers only)	Significant Assurance				
Assurance Rationale	The Board is asked to take significant assurance that the maternity and neonatal service is progressing with the national requirements and that the metrics remain within expected ranges. There are actions and / or business cases in place to address the outstanding requirements for BAPM medical and nursing standards for the single delivery plan that will be completed by the end of Q2. Where training is below 90% it is proactively managed with allocated dates for all staff groups and oversight from the line managers.				
Impacts on Strategic Risks (BAF 1-7)	BAF1, BAF2, BAF6, BAF7				
For decision papers only:	Highlight only where this report is outside of the Board Risk Appetite and a decision is requested <i>[delete section if no decision required]</i>				
Is this in line with Current risk appetite YES/NO	Avoid	Minimal	Cautious	Open	Seek
			Regulatory Quality	Finance	People
Executive Summary – Key messages and Issues					
This paper previously called Maternity & Neonatal safety & quality report 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. This report needs to be triangulated with any escalations and discussions from the Quality Committee held on the 4 June, and the people committee where the bi-annual midwifery workforce paper was discussed and approved (16 June). This paper concludes Q4, and reporting to Trust Board going forward will be on a quarterly basis, with more detailed review at the Quality Committee.					

Board assurance summary (March Quarter 4 January - 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.
- PQOM data measures (Appendix 2).

Key areas requiring ongoing focus

The three-year single delivery plan concluded on 31 March 2026, however there are two outstanding actions to complete. These are to ensure that both the nursing and midwifery staffing are compliant with the British Association of perinatal medicine (BAPM) recommendations. The business cases for these have been approved and recruitment is in progress, this is expected to be completed by the end of Q2.

Compliance with training remains an issue, however, is on an improving trajectory with oversight from the line managers and senior teams. The service has declared August as the midpoint reporting for the MIS Year 8 standards where all training should be and remain above 90%.

Recommendations	
The Board is asked to receive and discuss this update, take significant assurance from the report 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 Q4 PMRT report, Trust Quality Metrics, data measures and the MOSS update have been reviewed/noted as appropriate.	
Healthier together – delivering exceptional care for all	
Patients	<i>We deliver safe, exceptional, person-centred care</i>
People	<i>We are supportive, positive, and welcoming.</i>
Partnerships	<i>We work together to enhance our services with clear goals for our communities.</i>
Pounds	<i>We are efficient and spend public money wisely</i>
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	
Assurance Route	
Previously considered by - including date:	The Paediatric and Perinatal Safety Quality Group Divisional Governance Meetings Quality Committee
Any outcomes/next steps / time scales	Support to continue improvements in maternity & neonatal service, and achieve MIS year 8 standards

Perinatal Safety & Quality (Interim) Report

1. Report Overview

This interim report previously called Maternity & Neonatal safety & quality 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 June 2026 as documented in the Quality Committee Chair's Assurance Log and the bi annual midwifery workforce report was also previously reviewed and approved by the People Committee on behalf of the trust board in June 2026 as documented in the People Committee Chair's Assurance Log on the agenda.

It also presents the Trust Board with the Perinatal Mortality Review Tool (PMRT) update for Quarter 4, 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 and
- Perinatal Quality Oversight Data measures

2. Perinatal Mortality Rate

A summary of Quarter 4's data is provided below for Board scrutiny. The full report is attached at Appendix 1. 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 metrics have been included in Appendix 2 which were discussed at the Quality Committee.

These are interim metrics whilst the SPC dashboards are being developed, the exact timeline for completion is being assessed. There are no metrics currently causing concern.

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. Perinatal Quality Oversight Data Measures

The Trust perinatal oversight data measures has been included in Appendix 3.

These are nationally agreed metrics that should be available to the trust board, currently some elements of training compliance are below 90%. All dates have been allocated to the relevant staff, and attendance to the allocated training is being monitored. Any staff not attending training are followed up by their line manager and repeat non-attendance is escalated to the relevant senior team for a plan.

5. Ockenden Final Report into Nottingham Maternity Service

This report was published on the 24 June, the service is currently working through the report and the 18 Immediate and Essential Actions. A more comprehensive update will be given at the next board meeting together with the recommendations from the Amos report expected to be published in the last week of June.

6. Recommendation

The Board of Directors is asked to receive this report and take significant assurance from the information provided in this report and the discussion undertaken at the Quality Committee on 4 June 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:

- PMRT Q4
- Trust Quality metrics
- Perinatal Quality Oversight Data Measures
- MOSS update noted

PMRT - Perinatal Mortality Reviews Summary Report

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

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

Quarter 4 period: 01/01/2026 to 31/03/2026

1. Introduction

This quarterly report is produced by the Children and Families Division and is reported through established governance routes to the Perinatal Mortality and Morbidity Divisional Meeting, the Trust Mortality Governance Committee and the Trust Board. It provides assurance on the use of the National Perinatal Mortality Review Tool (PMRT) and summarises completion of reviews, key learning and resulting actions for all:

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

Termination of pregnancy (TOP) for abnormality, and babies with a birth weight under 500 g where gestation is not known at birth, are excluded from this reporting scope.

In line with the requirements of the Clinical Negligence Scheme for Trusts (CNST) – NHS Resolution, all stillbirths and neonatal deaths eligible for review using the PMRT (on a rolling basis from 1 December 2024) are included within the quarterly reports submitted to the Trust Board. The report provides assurance on review completion and sets out associated action plans arising from identified learning.

This report also provides assurance against the required standards within Safety Action Standard 1, including confirmation of any gaps and the mitigating actions in place.

The Maternity & Newborn Safety Investigations (MNSI) programme also undertakes independent reviews where the published criteria are met and the family provides consent. Where a review is accepted by MNSI, this is recorded and highlighted within the quarterly report.

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

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

The definition of labour used by MNSI is

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4cm cervical dilatation.

- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).

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

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

The most recent MBRRACE-UK report (births in 2023) reports a national stillbirth rate of **3.22 per 1,000 births**, a slight reduction from **3.35 per 1,000** in the previous year. National figures are calculated from births at $\geq 24+0$ weeks' gestation and exclude terminations of pregnancy. Data for births in 2024 is expected to be published in June 2026.

The Trust's stabilised annual stillbirth rate for calendar year 2025, for pregnancies $\geq 24+0$ weeks' gestation across both sites, was **2.79 per 1,000 births**, equating to 12 stillbirths. During the same period, there were two terminations of pregnancy for fetal abnormality at ≥ 24 weeks' gestation. In addition, between 22+0 and 23+6 weeks' gestation, there were two late fetal losses and three terminations of pregnancy for fetal anomaly.

Stillbirth data are reviewed and reported quarterly to enable early identification of any emerging trends. These quarterly figures represent crude rates, which are subject to variation due to small numbers, while rolling annual figures provide a more stable assessment of performance.

Quarter 4 (1 January 2026 – 31 March 2026)

During Quarter 4 of the 2025–2026 reporting year, there were:

- Three stillbirths at ≥ 24 weeks' gestation (two antenatal and one intrapartum), all occurring at DRI

During this period, there were 1,076 births across the Trust (725 at DRI and 351 at BDGH).

There were:

- No late fetal losses between 22+0 and 23+6 weeks' gestation
- Two medical terminations of pregnancy for fetal abnormality at ≥ 24 weeks' gestation
- Three medical terminations of pregnancy for fetal abnormality, between 22+0 and 23+6 weeks' gestation

This results in a quarterly crude stillbirth rate of **2.79 per 1,000 births**. This is higher than Quarter 3 of 2025–2026 (1.85 per 1,000 births) and is consistent with expected variation given the small number of cases.

Continued quarterly monitoring, PMRT review completion and tracking of actions provide assurance that learning is identified, reported through governance and acted upon.

Rolling Annual Position

When combining data from Quarters 1–4 of the 2025–2026 reporting year, the Trust’s rolling stabilised stillbirth rate is **2.31 per 1,000 births**, equating to 10 stillbirths from ≥ 24 weeks’ gestation across 4,333 births at both sites. This remains below the national stillbirth rate, indicating sustained performance in this domain.

All stillbirths born at $\geq 22+0$ weeks’ gestation and weighing ≥ 500 g meet the criteria for Perinatal Mortality Review Tool (PMRT) review.

3. NEONATAL DEATHS

The latest MBRRACE-UK report (births in 2023) reports a national neonatal death rate of 1.63 per 1,000 live births, a reduction from **1.69 per 1,000** for births in 2022. These figures apply to babies born at $\geq 24+0$ weeks’ gestation and include deaths occurring up to 28 days of life. Data for births in 2024 are expected in June 2026.

For Trust reporting, neonatal deaths include babies born within the Trust and dying within the neonatal period, excluding deaths following termination of pregnancy when calculating Trust rates.

The Trust’s stabilised neonatal death rate for calendar year 2025 was **1.42 per 1,000 live births** for babies born from $22+0$ weeks’ gestation, equating to four early neonatal deaths. During the same period, there were an additional four neonatal deaths following medical termination of pregnancy for fetal abnormality, which are reported separately and excluded from Trust performance rates.

As with stillbirths, neonatal death figures are reviewed quarterly to support oversight and identification of any emerging themes. Quarterly rates represent crude data and fluctuate with small numbers; rolling annual trends and case review findings provide the primary basis for assurance and improvement planning.

Quarter 4 (1 January 2026 – 31 March 2026)

During Quarter 4 of 2025–2026, there were:

- No neonatal deaths in babies born $\geq 22+0$ weeks’ gestation
- No neonatal deaths following medical termination of pregnancy at $\geq 22+0$ weeks’ gestation
- One neonatal death following termination of pregnancy below $22+0$ weeks’ gestation (excluded from Trust rates)

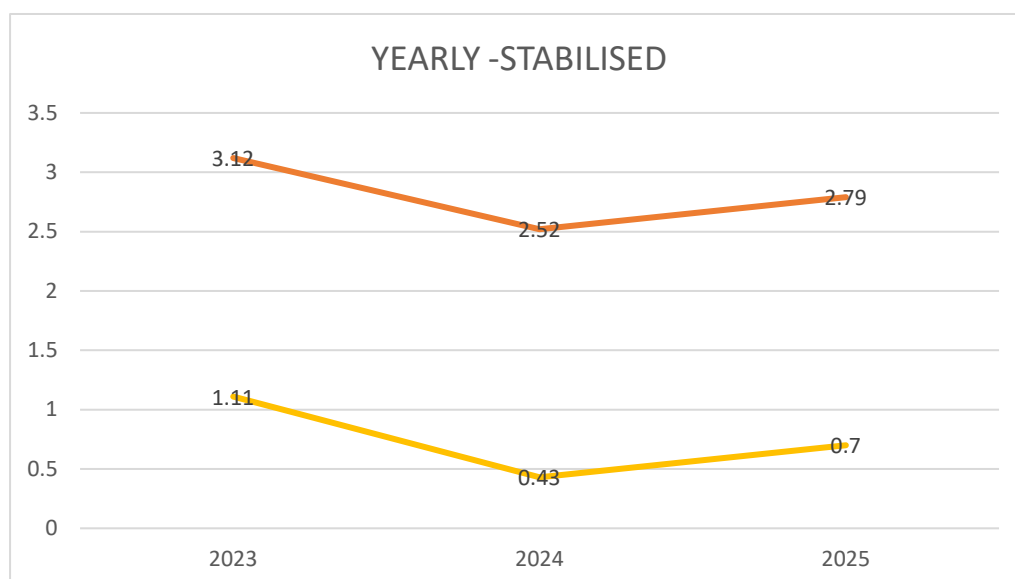
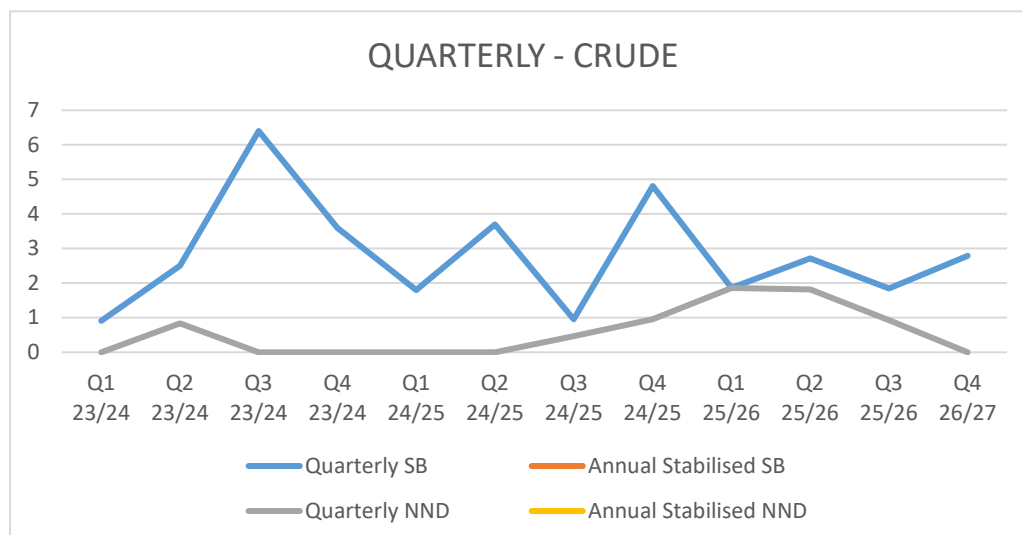
There were **1,076 births** across both sites during this period (725 at DRI and 351 at BDGH).

This results in a quarterly crude neonatal death rate of **0 per 1,000 live births**, compared with Quarter 3 of 2025–2026 (0.93 per 1,000 births). This position is interpreted in the context of low event numbers. Ongoing surveillance and governance review provide assurance that any concerns are identified promptly and escalated appropriately.

Rolling Annual Position

Across Quarters 1–4 of the 2025–2026 reporting year, excluding deaths below 22+0 weeks and those following termination of pregnancy, there were four neonatal deaths. This equates to a rolling stabilised neonatal death rate of **0.92 per 1,000 births** from 22+0 weeks' gestation across 4,333 births, which remains below the national neonatal mortality rate. Governance oversight and completion of case reviews provide assurance that learning is identified, actions are agreed and progress is monitored.

All neonatal deaths from 20 weeks' gestation are reported to MBRRACE-UK. However, only those occurring in babies born at $\geq 22+0$ weeks' gestation and weighing ≥ 500 g meet the criteria for Perinatal Mortality Review Tool (PMRT) review.



CNST Year 7 – Safety action 1

Requirements	CNST requirement compliance	CNST Trust Compliance to date
a) All eligible perinatal deaths from 1 December 2024 should be notified to MBRRACE-UK within seven working days.	100%	100%
b) For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards	95%	100%
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. (from 2 nd April 2025)	95%	100%
	75%	100%
	50%	69%
d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.		Q1 2025-2026 presented to Quality Committee (QC) (delegated subcommittee of the Trust Board) October 2025 and Trust Board November 2025 Q2 2025-2026 presented to QC (delegated subcommittee of the Trust Board) in December 2025 and Trust Board in January 2026 Q3 2025-2026 presented to QC (delegated subcommittee of the Trust Board) in February 2025 and Trust Board in March 2026 Q4 2025-2026 detailed within this report will be reported at QC (delegated subcommittee of the Trust Board) June 2026 and Trust Board July 2026



This report provides assurance that stillbirths and neonatal deaths within scope are identified promptly, reviewed using the PMRT in line with CNST requirements, and reported through the Trust's established governance routes. Learning and contributory factors are captured consistently, actions are agreed and tracked, and any risks or recurring themes are escalated for oversight through divisional and Trust mortality governance. Ongoing quarterly reporting and rolling annual trend monitoring support sustained scrutiny and continuous improvement.

The following pages are regarding the details, themes and grading's of the cases discussed through PMRT

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 3

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in Progress	Reviews Completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
5	2	2	1	0

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

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

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

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

Patient identifiable information has been removed

Case ID (NND)	Date	Gestation and Age	Initial review findings care until the birth of the baby & Initial review findings care of the baby	PMRT and investigation /review outcome

Social, economic and deprivation data (SB)		Gestational age at birth						Total
		Unknown	22-23	24-27	28-31	32-36	37+	
Age	<18							
	19-25							
	26-35				1	1	1	3
	36-45							
	46+							
Smoking status	Never smoked					1		1
	Non-smoker stopped before conception							
	Non-smoker stopped after conception				1			1
	Smoker						1	1
	Unspecified							
Ethnicity	White						1	1
	Black				1	1		2
	Asian							
	Chinese/other							
	Mixed							
	Unspecified							
IMDD	1-4				1		1	2
	5-7					1		1
	8-10							
	Not available							
Employment	Employed				1		1	2
	Not employed					1		1
	Student							
	Homemaker							
	Sick/Disabled							
	Unknown							
Marital status	Married / Civil Partner					1		1
	Single							
	Cohabiting				1		1	2
	Unspecified							
Learning or communication difficulties	Yes							
	No				1	1	1	3

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

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

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

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

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

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

*Includes coronial/procurator fiscal post-mortems

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

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	2	100% (1)
Ambulance Team	0	0%
Bereavement Team	1	100% (1)
Community Midwife	0	0%
External	1	100% (1)
Management Team	4	100% (1)
Midwife	12	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	2	100% (1)
Neonatologist	7	100% (1)
Obstetrician	8	100% (1)
Other	0	0%
Risk Manager or Governance Team	2	100% (1)
Safety Champion	1	100% (1)
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

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

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

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

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	0 causes of death out of 0 reviews
Stillbirths	1 causes of death out of 1 reviews
	Intrauterine death at this gestation and under these circumstances is usually considered to be the result of an acute hypoxic-ischaemic event, the nature of which may or may not be determined on post mortem, and unfortunately did not come to light
Neonatal deaths	0 causes of death out of 0 reviews
Post-neonatal deaths	0 causes of death out of 0 reviews

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
---	------------------	-----------------

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

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

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

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

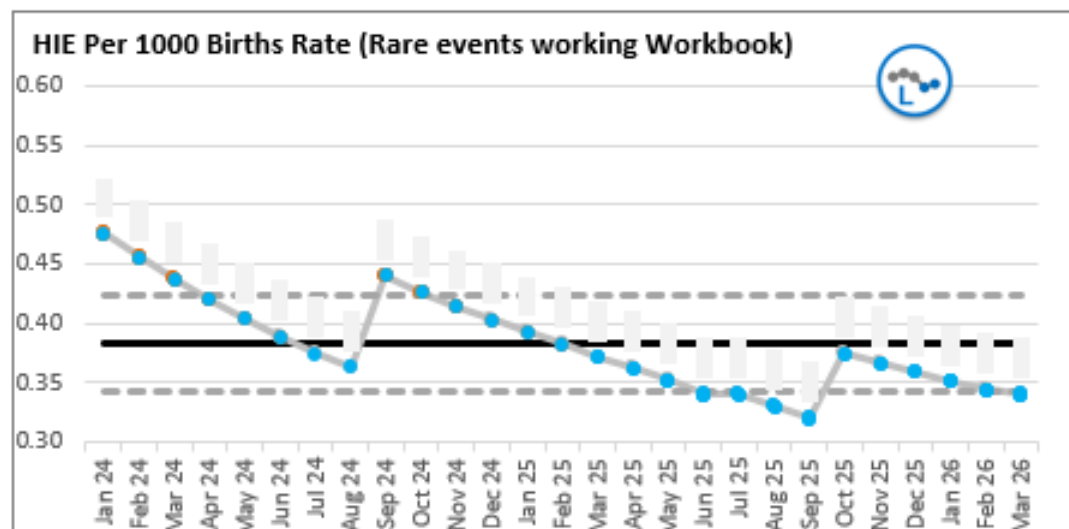
Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

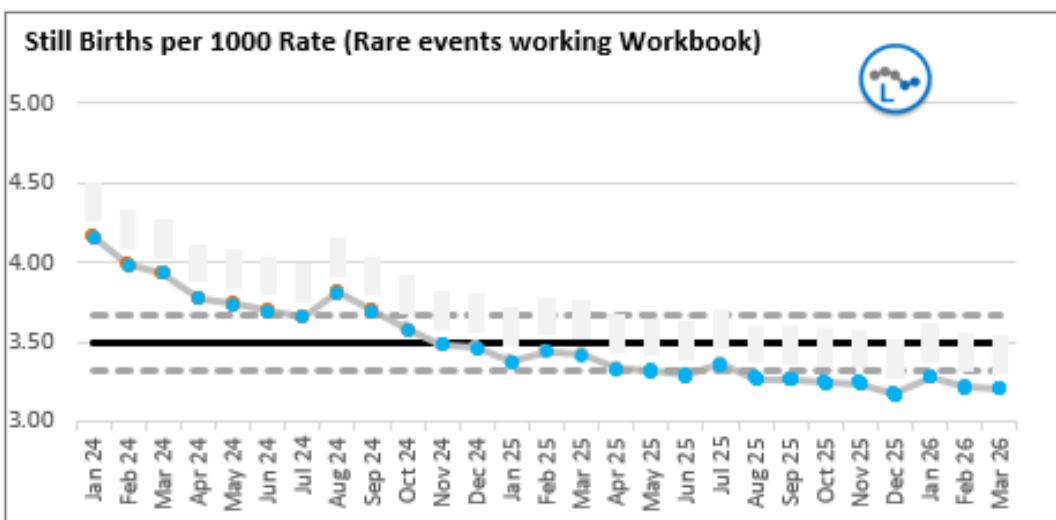
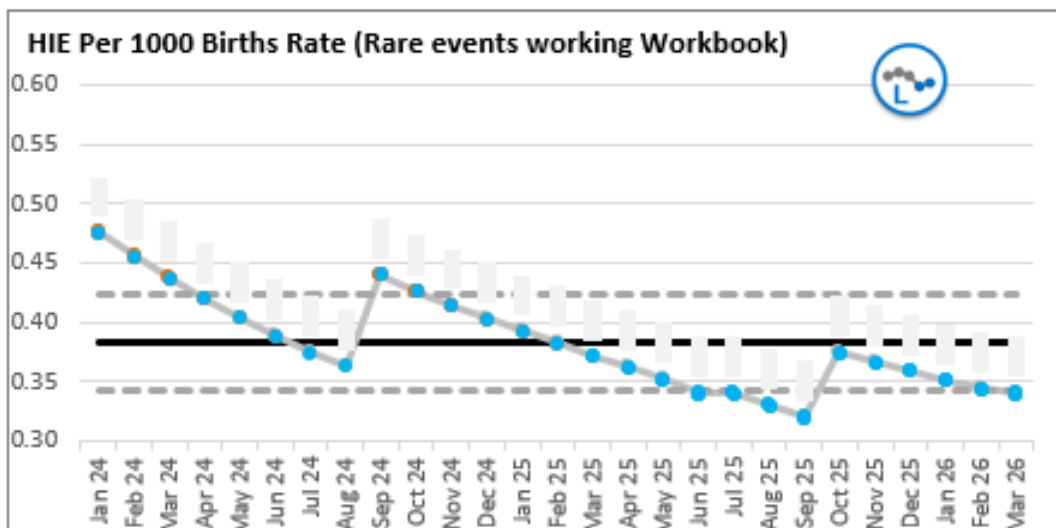
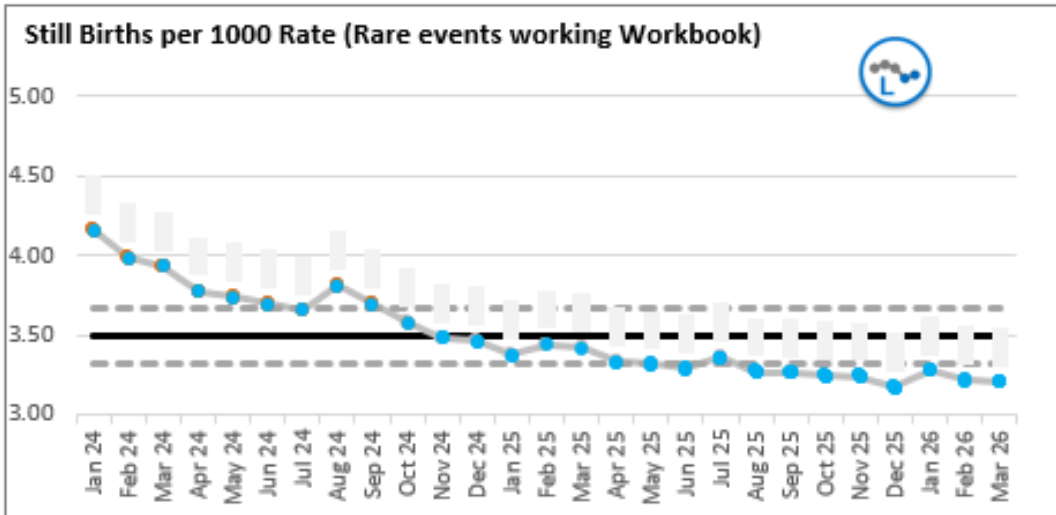
Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
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Maternity Metrics

March 2026

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Spontaneous Vaginal Delivery (Line 24)	Mar 26	146	-			149	115	183
Instrumental Delivery (Total) (Line 30)	Mar 26	9%	-			8%	5%	12%
Ventous Births (Line 31/Line 10)	Mar 26	3%	-			3%	1%	6%
Forceps Births (Line 33/Line 10)	Mar 26	6%	-			5%	1%	9%
Emergency CS (Line 40)	Mar 26	33%	-			34%	26%	42%
Elective CS (Line 37/Line 10)	Mar 26	18%	-			16%	11%	22%
Inductions of Labour (Line 28)	Mar 26	36%	-			40%	32%	48%
3rd & 4th Degree tears per 1000 births (Any Delivery)	Mar 26	11.11	-			13.43	-1.07	27.93
PPH 500 - 1000ml (Line 59/ Line 10)	Mar 26	39%	-			39%	31%	46%
PPH 1000 - 1499ml (Line 62)	Mar 26	11%	-			12%	7%	18%
PPH >1500ml (Line 64)	Mar 26	2%	-			4%	0%	8%
Pre-term Births per 1000 (Workings Sheet Line 9)	Mar 26	91.67	-			84.80	48.57	121.03
Maternity Incidents (Data to populate Trends Line 22)	Mar 26	155	-			162	92	232
Shoulder dystocia (Data to populate Trends Line 19)	Mar 26	0	-			1	-2	3
Breast Feeding Initiation (Data to populate Trends L	Mar 26	62%	-			62%	49%	75%
Smoking at Booking (Data to populate Trends Line 2	Mar 26	9%	-			11%	6%	16%
Still Births per 1000 Rate (Rare events working Workt	Mar 26	3.21	-			3.50	3.32	3.68
Neonatal Deaths per 1000 births Rate (Rare events w	Mar 26	0.73	-			0.69	0.61	0.77
HIE Per 1000 Births Rate (Rare events working Workt	Mar 26	0.34	-			0.38	0.34	0.42





DATA MEASURES – PERINATAL QUALITY OVERSIGHT TOOL

	2026										2027	
	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
1.Number of reported perinatal deaths	1											
2. Number of MNSI cases	0											
2. Safety prompts from completed MNSI investigations	No reports											
Report on:												
2a. The number of patient safety incidents logged	179											
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (%)												

Prompt												
Consultants / SAS drs %	84%											
Drs %	74.29%											
Midwives %	93.57%											
MSW's %	88.06%											
Consultant anaesthetists %	92.86%											
Anaesthetic drs %	96.30%											
Fetal Monitoring and surveillance												
Consultants / SAS drs SD / CA %	89.4%											
Drs SD/CA %	90%											
Midwives SD/CA%	87.55% / 85.54%											
Neonatal resus training												
Consultants %	95%											
Drs %	100%											
Nurses %	95%											
ANNP %	100%											
Midwives %	93.18%											

2c. Minimum safe staffing in maternity services: midwife minimum safe staffing planned cover versus actual prospectively (%)	91%											
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas (all rota gaps are covered with locum, therefore % of locum cover)	100%											
3.Service User Voice Feedback – Themes	No MNVP chair – review in progress System One access											
4.Staff feedback from frontline champion and walk-about – themes												
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	None											
6.Coroner Reg 28 made directly to Trust	None											
7.Progress in achievement of CNST Year 7 10 safety actions March 26 /	10											

MIS Year 8 6 safety actions from April 26 (reset April annually)												
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8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually 2025 – 71%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually 2025 – 50%

2607 - G1 2025/26 ESTATES RETURN INFORMATION COLLECTION

● Decision Item

👤 Sam Wilde, Chief Finance Officer

🕒 11:35

5 minutes

REFERENCES

Only PDFs are attached

 G1 - 2025-26 Estates Return Information Collection.pdf

Report																	
Meeting Title:	Board of Directors			Meeting Date:	7 July 2026												
Report Title/ Ref:	2025/26 Estates Return Information Collection (ERIC)																
Sponsor:	Sam Wilde, Chief Finance Officer																
Authors:	Sean Tyler Head of Compliance (Estates and Facilities)																
Appendices:	Appendix 1: ERIC Return Trust Level Report 2025/2026																
Purpose of the report	Assurance	Approval/decision	Information	Discussion													
Proposed assurance Level (For assurance papers only)	Significant Assurance																
Assurance Rationale	The Board is asked to take Significant Assurance that robust processes are in place to deliver the ERIC return and manage estate performance. A material level of backlog maintenance and infrastructure risk remains, with mitigation dependent on continued capital investment and delivery of multi-year programmes.																
Impacts on Strategic Risks (BAF 1-7)	BAF4: Report demonstrates measures to ensure the estate is fit for purpose enabling DBTH to continue to deliver services and reduce the impact of the estate on outcomes & experience for patients and colleagues. BAF5: Impacts on delivery of DBTH financial plan to ensure DBTH will be able to deliver services enabling the Trust to be financially sustainable in long term.																
For decision papers only: Is this in line with Current risk appetite YES	Highlight only where this report is outside of the Board Risk Appetite and a decision is requested <table><tr><td>Avoid</td><td>Minimal</td><td>Cautious</td><td>Open</td><td>Seek</td><td>Mature</td></tr><tr><td></td><td></td><td>Regulatory Quality</td><td>Finance</td><td>People</td><td></td></tr></table>					Avoid	Minimal	Cautious	Open	Seek	Mature			Regulatory Quality	Finance	People	
Avoid	Minimal	Cautious	Open	Seek	Mature												
		Regulatory Quality	Finance	People													
Executive Summary – Key messages and Issues																	
The Estates Return Information Collection (ERIC) forms the central collection of Estates and Facilities data from all NHS organisations in England providing NHS funded secondary care during the fiscal year ending 31 March 2026. ERIC data provides the Government with essential information relating to the safety, quality, running costs and activity related to the NHS estate and also supports work to improve efficiency. The report provides data collected for the 2025/2026 ERIC return for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) at Trust Level (Appendix 1) and individual Site Level (Appendix 2). The data provided has been gathered using inputs from Estates and Facilities, Finance, Capital Planning, and external consultants Bellrock, with financial data verified against the general ledger, delivering confidence in the level and accuracy of the information provided. Data confidence is further strengthened by the use of a formal six-facet survey. The report presents the main variances in the 2025/2026 ERIC return compared to 2024/2025. These variances are summarised below: - In total, backlog maintenance has increased from £151.3m to £162.4m (8.5%). This is the net effect of: - A £4.3m inflationary increase (3.8% BCIS uplift); - An £8.2m deterioration across the estate, primarily mechanical and electrical infrastructure and statutory compliance; and - A £1.4m reduction in backlog maintenance as a result of the Trust’s capital investment programme. Capital investment for the period increased to £65.7m (from £49.8m), representing a £15.9m increase overall. There was £26.3m invested in improving existing buildings - an increase of £13.6m (107%). including Department																	

of Critical Care (DCC) relocation and enabling works for Statutory Fire Safety Improvement. £7.2m was invested in maintaining buildings an increase of £1.7m (31%), focused on critical infrastructure, with £31.9m invested in equipment, an increase of (43%), including major diagnostic and digital (EPR) investments. New build spends reduced significantly to £0.2m following completion of major schemes in the prior year.

Overall, the information indicates that while there are strong controls in place around capital investment, there remains a significant level of underlying estate risk, particularly relating to backlog maintenance and ageing infrastructure.

Public Dividend Capital (PDC) at DRI rose by £0.9m (19%) due to higher capital funding. MH saw a smaller increase of £51k (6%), while BH reduced slightly by £0.1m (7%).

Income from contributions to costs fell by £124k (11%) from non-NHS sources, mainly due to lower accommodation income, partly offset by reduced spend. NHS income also decreased by £26k (20%), linked to prior ICB funding for the nitrous oxide project. Car parking income increased overall by £0.3m.

Lease costs reduced across all sites following the end of Create Living properties in 2025/26, with savings of £0.2m (72%) at DRI, £0.1m (78%) at BH and £27k (76%) at MH.

Energy usage remained stable. Electricity costs fell at DRI by £0.4m (10%) and at MH by £0.1m (27%), with minimal change at BH. Gas costs reduced at DRI by £0.2m (11%) and were broadly unchanged elsewhere.

Water costs increased across all sites due to new buildings and capital activity, particularly at MH (£0.2m, 50%) and BH (£0.2m, 20%), with a smaller rise at DRI.

Investment in the quality of buildings to remove physical backlog increased by £17.2m (51%) to £33.7m in 2025/2026. It should be noted that while £33.7m has been reported as investment in backlog, approximately £19m of this relates to the enabling works to relocate the Department of Critical Care (DCC) and £3.8m enabling works for Statutory Fire Safety Improvement within the Gynaecology ward and theatres at DRI. Both these projects are multi-year projects that will positively impact the backlog position in a future reporting period.

Finally, waste management costs rose marginally by 1.1%, despite a 4.6% inflation uplift, due to improved segregation. Higher-cost waste streams reduced by 30%, recycling increased by 11%, and further improvements are expected next year.

Recommendations

The Board of Directors is asked to **take significant assurance** from the robust processes that are in place to deliver the ERIC return and manage estate performance and **support its submission** to EFM Information, HSCIC (NHS DIGITAL) which took place on 29/06/2026. This will be released into the public domain in October 2026 as part of the full ERIC returns report.

Healthier together – delivering exceptional care for all

Patients	Patient safety, patient experience and the quality of care provided is directly linked to the provision of a safe, suitable environment, therefore; the effective management of The Trust Estate, its Facilities, related backlog maintenance and capital investment is imperative to the continued delivery of the core business and its services.
People	The health and wellbeing of the workforce are strongly linked to patient safety and the patient experience whilst attending hospital. Therefore, the effective management of the Estate and its Facilities as well as its capital expenditure and associated backlog maintenance including critical infrastructure is directly relating to delivering a safe environment for colleagues as well it also contributing to the quality of care delivered to the patient.
Partnerships	Ensure efficient management of public money, through delivery of the Trust capital infrastructure investment continually reducing the Trust backlog maintenance total as part of the annual capital infrastructure investment programme.
Pounds	Patient safety, patient experience and the quality of care provided is directly linked to the provision of a safe, suitable environment, therefore; the effective management of The Trust Estate, its Facilities, capital investment and related backlog maintenance is imperative to the continued delivery of the core business and its services.

Health Inequalities	The continued delivery of financially sustainable Estates and Facilities services enables the Trust to directly contribute to reducing the unequal burden of adverse health events experienced by vulnerable communities, ethnic minorities, and other disadvantaged groups, therefore addressing a critical dimension of health inequalities, improving patient safety and clinical outcomes.
Legal/ Regulation:	The key legal and statutory frameworks that underpin the Estates Return Information Collection (ERIC) are: • Health and Social Care Act 2012 (Section 259) • NHS Standard Contract • Data Provision Notices (DPNs) • Health and Social Care Act 2008 Regulations (CQC “Fundamental Standards”) Regulation 12 • Health and Social Care Act 2008 Regulations (CQC “Fundamental Standards”) Regulation 15
Partner ICB strategies	The ERIC return supports Partner ICB strategies by providing robust estates data to inform system-wide planning, prioritise capital investment, and improve efficiency, safety and sustainability across the health economy.
Assurance Route	
Previously considered by - including date:	None
Any outcomes/next steps / time scales	Data provision from the ERIC return to inform expenditure and provide evidence required to support business cases for the expenditure. ERIC provides evidence in relation to Estates & Facilities, also including any local investment planning. Data collected through ERIC is also used to benchmark the Trust against other Trusts to determine levels of efficiency, safety and quality.

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1. Introduction

The following report provides an overview of the data collected for the reporting period 2025/2026 Estates Return Information Collection (ERIC) return for Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH), highlighting any significant variances from the previous year's return. The data is presented at both a Trust level (Appendix 1) and individual site level (Appendix 2).

The data presented was collated by Estates and Facilities, the Capital Planning Unit and the Finance Department. The information was supplemented by an updated six-facet survey on 20% of the Trust's estate across all sites, and a desktop review of existing six-facet data by external consultants, Bellrock. The financial data in the return has been verified against the financial ledger by the Finance Department.

2. Backlog Maintenance

Backlog maintenance costs for 2025/2026 were established via a site survey covering 20% of the physical estate at Doncaster Royal Infirmary (DRI), Bassetlaw Hospital (BH) and Montagu Hospital (MH), and a desktop review of remaining data 80% to determine changes since the previous reporting period.

Changes between reporting periods may be categorised as increased backlog costs as a result deterioration, inflationary cost increases, and consequential reductions as a result of the Trust's capital investment programme.

Costs are reviewed annually and increased for inflation using BCIS PUBSEC Tender Price Index of Public Sector Building Non-Housing, in accordance with the ERIC data definitions. An inflationary uplift of 3.8% was applied for the reporting period, leading to an increase of **£4.3m** split between the three sites as follows:

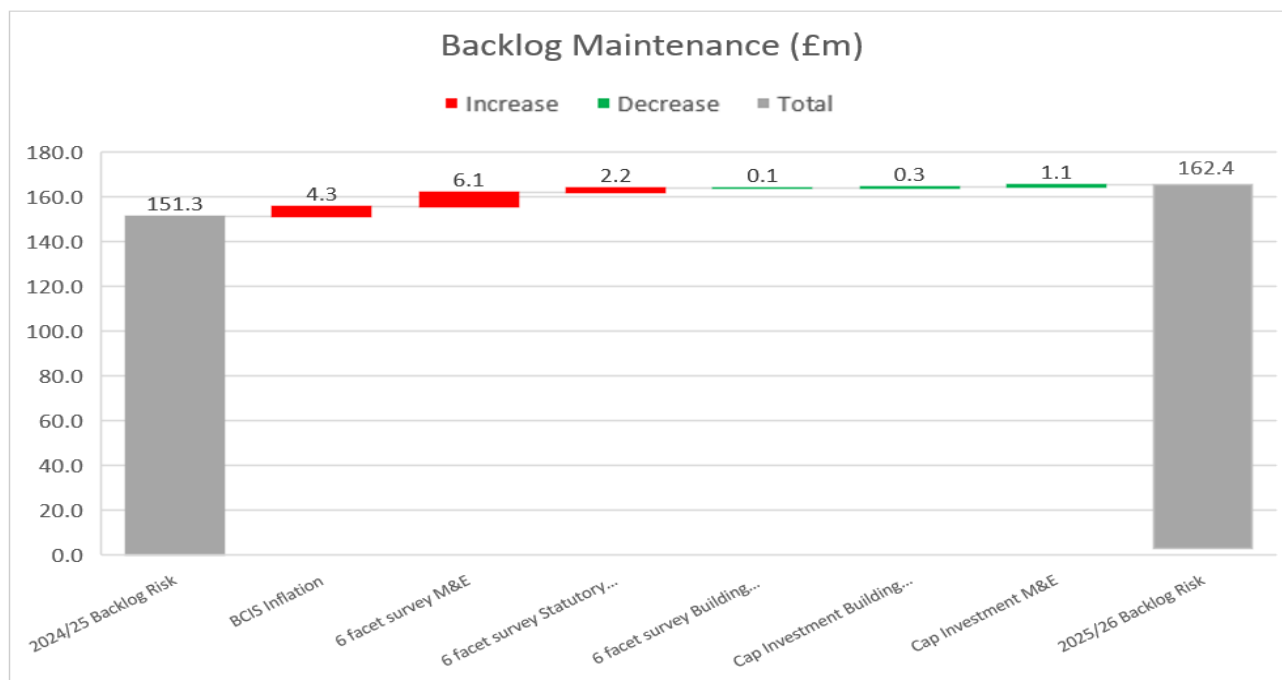
- **£3,190,145** at DRI
- **£951,242** at BH
- **£149,644** at MH

Further deterioration of the estate has also led to an increase in backlog of **£8.2m** with mechanical and electrical infrastructure and statutory compliance elements primarily attributing to this increase.

Lastly the Trust's capital investment programme has led to a consequential **£1.4m** reduction in the reported backlog during the reporting period.

Figure 1 illustrates the changes described above, indicating a net increase of **£11.1m** in the total backlog maintenance costs reported.

Figure 1: Backlog Maintenance Increase for 2025/2026 Including Investment to Reduce Backlog



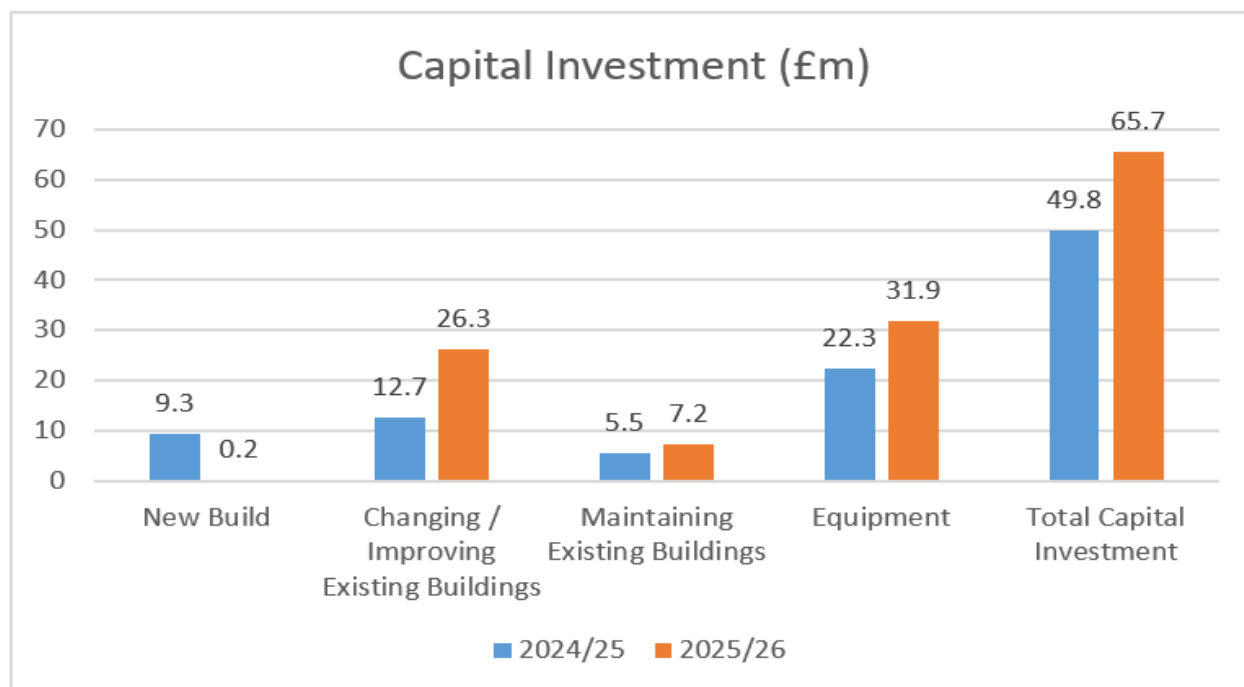
3. Capital Investment

Capital investment increased by **£15.9m** (31%) overall compared to the previous year, increasing from **£49.8m** in 2024/2025 to **£65.7m** in 2025/2026. The variations in investment from the previous reporting period are summarised below and presented in figure 2.

- **New Build Investment:** A total £0.2m was invested in new build elements for 2025/2026 for work Community Diagnostic Centre (CDC) expansion project representing a reduction in capital investment for new build of £9.1m (-97%).
- **Changing/Improving Existing Buildings:** £26.3m has been invested in changing or improving buildings in 2025/2026, an increase of £13.6m (108%) on investment in 2024/2025 of £12.6m. The investment includes £19.7m funding allocated for the relocation of Department of Critical Care (DCC) and £3.8m enabling works for Statutory Fire Safety Improvement within the Gynaecology ward and theatres at DRI.
- **Maintaining Existing Buildings:** £7.2m of capital funding was allocated in 2026/2027 to maintaining existing buildings, representing a £1.7m (31%) increase from the £5.5m invested in 2025/2026. This increase is partly due to additional investment (£0.9m) required for electrical infrastructure, including Phase 6 of the long-term programme, and £0.6m for critical infrastructure projects. A further £0.3m was also needed for lease contract renewals.
- **Equipment:** There has been a significant increase in equipment investment for 2025/2026, totalling £31.9m (43%), compared to £22.3m in 2024/2025. The 2025/2026 investment included completion of key acquisitions including the CT scanner, SPECT CT and Pharmacy Robot, Da Vinci Robot with a combined total of £2.6m. Additionally, a further £10.3m was

spent on other medical equipment, alongside £16.6m invested in IT hardware and software, including the Electronic Patient Record (EPR) system. Funding for these investments has been drawn from a mix of sources, including PDC funding and the Trust's CDEL allocation.

Figure 2: Capital Investment Report for 2025/2026



4. Main ERIC Return Variances

Public Dividend Capital (PDC): PDC at DRI increased by £0.9m (19%), reflecting higher capital funding received during the year. MH also saw a modest rise of £51k (6%), while BH decreased slightly by £0.1m (7%).

Contribution to Costs: There was a reduction in income from contribution to costs from non-NHS organisations by -£124k (-11%) compared to last year. This is mainly due to a reduction in accommodation income offset by a corresponding reduction in expenditure. Income from NHS organisations has also decreased by -£26k (20%) due to income from the ICB for nitrous oxide waste project. Income from car parking increased overall by £0.3m including both staff and patient /visitor car parking.

Leases and rent: Lease costs reduced across all three sites following the end of Create Living properties during 2025/2026. This resulted in decreases of £0.2m (-72%) at DRI, £0.1m (-78%) at BH, and £27k (-76%) at MH

Electro Bio Medical Equipment Maintenance: Costs at DRI have increased by £0.7m (34%). This is mainly due to a £0.4m (41%) budget transfer from BH for 2025/26, along with additional maintenance contracts for new medical equipment. There has also been a smaller increase at MH of £28k (8%), driven by extra maintenance contract requirements.

Energy: Both gas and electricity consumption have remained broadly stable across the three main Trust sites. Electricity costs have decreased at DRI by £0.4m (-10%) and at MH by £0.1m (-27%), with only a small increase at BH of £11k (0.8%). Gas costs have reduced at DRI by £0.2m (-11%), with minimal changes at BH (£4k, 0.6%) and MH (£11k, 4%)

Water: Water costs have increased across all three sites, mainly due to new building occupancy and additional capital programme construction activity. The most significant rises were at MH (£0.2m, 50%) and BH (£0.2m, 20%), with a smaller increase at DRI of £20k (5%).

Quality of Buildings: The proportion of the capital programme that includes elements of physical backlog removal totalled £33.7m in 2025/2026, an increase of £17.2m (51%) on the previous reporting period.

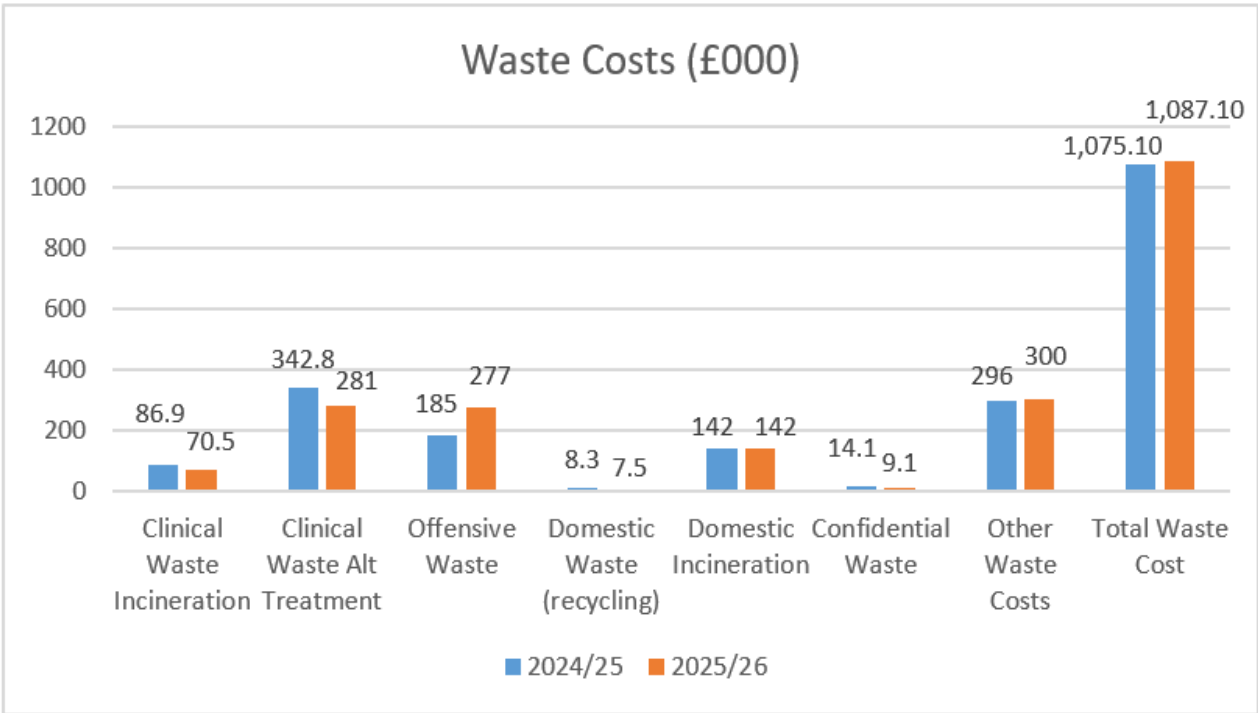
Food Waste: Food waste reporting has increased due to the introduction of a new reporting requirement. This now includes waste generated by restaurants or cafés that are rented or leased to commercial or charitable organisations. As a result, additional waste streams that were not previously captured have been incorporated into the Trust's reporting figures, leading to increase of 48% (54.6 tonnes) at DRI from the previous year's figure of 36.9 tonnes and 49% (26.9 tonnes) at BH from 18 tonnes reported in 2024/2025. The change has also led to a re-categorisation of waste at MH, leading to a reduction of 10% (3.76 tonnes) from 4.2 tonnes reported on 2024/2025. The result of changes ensures that all applicable food waste is now more accurately recorded and aligned with the updated ERIC return.

Currently 66% of the waste generated is removed from site by ReFood where the waste is converted into renewable energy and nutrient rich fertilisers. The remaining 34% is discharged through onsite biodigesters which reduce waste sent to landfill whilst also supporting improved waste segregation on site.

Waste Management: Waste management costs increased by £11.8k (1.1%) compared to 2025/2026. This was in part due to a 4.6% RPI uplift applied to the waste contract from December 2025. Despite this, significant improvements were made to waste segregation. Clinical incineration and Alternative treatment waste reduced by 30% (more expensive waste stream) while offensive waste increased by 35%.

Recycling volumes also increased by 11% during the year. These improvements helped offset the inflationary cost pressures, limiting the overall increase in waste expenditure to 1.1%. Further improvements to waste segregation and recycling are expected within the next reporting period as part of the overarching waste management/simpler recycling improvement programme.

Figure 3: Waste Management Variance Report for 2025/2026



5. Appendices

Appendix 1: ERIC Return Trust Level Report 2025/2026

Trust Profile	Unit	Value
Number of sites: General acute hospital	No.	3
Number of sites: Specialist hospital (acute only)	No.	0
Number of sites: Mixed service hospital	No.	0
Number of sites: Mental Health (including Specialist services)	No.	0
Number of sites: Learning Disabilities	No.	0
Number of sites: Mental Health and Learning Disabilities	No.	0
Number of sites: Community hospital (with inpatient beds)	No.	0
Number of sites: Other inpatient	No.	0
Number of sites: Non inpatient	No.	5
Number of sites: Support facilities	No.	0
Number of sites: Unoccupied	No.	0
Total number of sites	No.	8
Sites included above that are unreported	No.	0
Sites leased from NHS Property Services	No.	2
Sites occupied without charges	No.	0

Sustainability	Unit	Value
Estates Development Strategy	Yes/No	No
Energy managers	WTE	0.00
Does the trust have a waste reuse scheme	Yes/No	Yes
Waste re-use scheme: Cost savings	£	34,226
Waste re-use scheme: Carbon savings	CO2e (tonnes)	54.79
Waste managers	WTE	1.00
WEEE waste cost	£	10,079
WEEE waste weight	Tonnes	22.38
Estates and Facilities staff employed by an NHS wholly owned subsidiary company	WTE	0.00
Estates and facilities staff enrolled on an apprenticeship programme	No.	8

Finance	Unit	Value
Capital investment for new build	£	206,000
Capital investment for changing/improving existing buildings	£	26,298,000
Capital investment for maintaining (lifecycle) existing buildings	£	7,210,000
Capital investment for equipment	£	31,947,000
Private sector funding investment	£	0
Public sector funding investment	£	65,391,000
Charity and/or grant investment	£	270,000
Number of energy efficient schemes	No	2
Energy efficient schemes costs	£	280,320
Carbon savings from investment in energy efficient schemes	CO2e (tonnes)	36.50

Contribution to costs	Unit	Value
Contribution to costs from areas leased out for retail sales	£	-118,756
Contribution to costs from non-NHS organisations	£	-1,001,722
Contribution to costs from NHS organisations	£	-102,352
Contribution to costs from local authorities	£	0
Income from car parking: patients and visitors	£	-1,134,485
Income from car parking: staff	£	-359,393
Total contributions	£	-1,222,830

Fire Safety	Unit	Value
Fires recorded	No.	0
False alarms: No call out	No.	60
False alarms: Call out	No.	62
Deaths resulting from fires	No.	0
Injuries resulting from fires	No.	0
Patients sustaining injuries during evacuation	No.	0

Medical Records	Unit	Value
Medical Records cost: Onsite	£	3,049,363
Medical Records cost: Offsite	£	77,806
Type of Medical Records	Select	3. Mixed
Medical Records service provision	Select	Internal

Appendix 2: ERIC Return Site Level Report 2025/2026

Facilities Management (FM) Services		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Depreciation	£	1,815,833	5,771,132	795,239	0	0
Public Dividend Capital (PDC)	£	1,830,303	5,817,121	801,576	0	0
Public Dividend Capital (PDC): assets under construction	£	0	0	0	0	0
Leases and rent	£	31,602	74,337	8,697	90,882	266,674
Rates	£	775,969	1,345,568	236,347	0	0
Interest on Capital	£	41,970	133,389	18,381	0	0
Other Estates and Facilities finance costs	£	217,634	555,667	79,887	0	0
Indirect accommodation subsidies	£				0	0
Estates and property maintenance	£	1,573,527	3,983,853	463,443	0	
Grounds and gardens maintenance	£	16,886	47,504	7,765	0	
Electro Bio Medical Equipment maintenance	£	480,981	2,830,434	328,459	0	0
Other Hard FM (Estates) costs	£	484,516	1,262,854	171,142	0	
Other Soft FM (Hotel Services) costs	£	1,690,920	4,004,034	695,562	0	
Management (Hard and Soft FM) costs	£	185,968	442,254	47,404	0	
Estates and facilities finance costs	£	4,713,311	13,697,214	1,940,127	90,882	266,674

Areas		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Gross internal floor area	m ²	42,487	109,757	15,764	1,157	2,045
Core gross internal floor area	m ²	37,320	71,030	15,294	0	0
Flex gross internal floor area	m ²	3,425	16,111	470	1,157	0
Tail gross internal floor area	m ²	1,742	22,434	0	0	2,045
Site heated volume	m ³	111,881	275,632	38,525	4,393	5,177
Land area owned	Hectares	10.70	11.24	3.30	0.00	
Land area not delivering services	Hectares	1.51	0.16	0.57	0.00	
Private patient	m ²	0	1,992	0	0	0
Pathology	m ²	895	3,720	439	0	0
Clinical Sterile Services Dept. (CSSD)	m ²	0	10	0	0	0
Clinical space: other	m ²	26,012	67,210	8,845	688	1,797
Medical records	m ²	869	1,977	238	0	0
Human Resources	m ²	204	1,297	0	0	0
Information Technology	m ²	21	487	76	0	0
General Administration	m ²	1,148	1,972	886	0	0
Restaurants and cafés	m ²	1,114	1,358	374	0	0
Staff Accommodation	m ²	1,405	3,031	57	0	0
Non-clinical space: other	m ²	6,636	14,532	3,404	469	126
Retail sales area: Commercial	m ²	380	325	117	0	0
Internal floor area: unoccupied site	m ²				0	
Buildings on site	No.	35	42	14	4	3

Function and Space		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Not functionally suitable: occupied floor area	m²	23,005	96,367	6,778	0	0
Not functionally suitable: clinical space	m²	15,074	68,550	4,886	0	0
Floor area: empty	m²	804	1,327	0	0	0
Floor area: under used	m²	0	1,211	0	0	0
Single bedrooms for patients with en-suite facilities	No.	32	0	19	0	0
Single bedrooms for patients without en-suite facilities	No.	29	93	3	0	0
Isolation rooms	No.	0	15	0	0	0

Quality of Buildings		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Cost to eradicate high risk backlog	£	7,831,258	6,260,501	380,293	0	
Cost to eradicate significant risk backlog	£	11,003,939	101,155,429	2,571,829	0	
Cost to eradicate moderate risk backlog	£	14,814,199	10,420,877	3,263,269	0	
Cost to eradicate low risk backlog	£	958,247	3,418,819	385,741	0	
Percentage of GIA surveyed using risk adjusted backlog guidance	Select	81 - 100%	81 - 100%	81 - 100%	Not Applicable	
Methodology used to review costs to eradicate backlog	Select	Formal 6 facet survey	Formal 6 facet survey	Formal 6 facet survey	Not Applicable	
Methodology used to review costs to eradicate backlog: Reason	Notes					
Formal survey year	Select	2025/26	2025/26	2025/26		
Review year	Select					

Quality of Buildings		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Investment to reduce backlog maintenance: Critical Infrastructure Risk	£	459,044	28,560,007	100,692	0	
Investment to reduce backlog maintenance: non-Critical Infrastructure Risk	£	2,335,777	2,281,472	35,543	0	
Inflation element of the total cost to eradicate backlog maintenance	£	951,242	3,190,145	149,644	0	
Relevant occupied floor area	m²				0	

Age Profile		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Age profile: 2025 to 2034	%	0.00	0.00	0.00	0.00	0.00
Age profile: 2015 to 2024	%	4.17	0.25	0.25	0.00	0.00
Age profile: 2005 to 2014	%	5.90	0.13	0.13	31.05	0.00
Age profile: 1995 to 2004	%	12.92	3.42	3.42	20.55	23.26
Age profile: 1985 to 1994	%	35.44	9.45	9.45	0.00	0.00
Age profile: 1975 to 1984	%	28.54	0.00	0.00	0.00	0.00
Age profile: 1965 to 1974	%	2.25	49.15	49.15	26.56	64.06
Age profile: 1955 to 1964	%	1.07	24.17	24.17	0.00	0.00
Age profile: 1948 to 1954	%	0.00	0.00	0.00	0.00	0.00
Age profile: pre 1948	%	9.71	13.43	13.43	21.84	12.68
Age profile: total (must equal 100%)	%	100.00	100.00	100.00	100.00	100.00

CHP		BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	
Fossil-fuel led CHP units operated on site	No.	0	1	1	0	
CHP unit/s size: electrical	kW		1,150	110		
CHP unit/s size: thermal	kW		4,900	177		
Fossil energy (Gas) input to CHP system/s	kWh		0	0		
Fossil energy (Other) input to CHP system/s	kWh		0	0		
Electrical energy output of CHP system/s	kWh		0	0		
Thermal energy output of CHP system/s	kWh		0	0		
Exported electricity	kWh		0	0		
Exported thermal energy	kWh		0	0		
Thermal energy discharged to waste	kWh		0	0		

Energy		BASSETLAW DISTRICT GENERAL HOSPITAL RP5BA	DONCASTER ROYAL INFIRMARY RP5DR	MONTAGU HOSPITAL RP5MM	OTHER REPORTABLE SITES RP5ORS	RETFORD HOSPITAL RP5RE
Electricity: green electricity tariff costs	£	1,310,092	3,072,972	495,553	0	
Electricity: green electricity consumed	kWh	5,200,910	12,411,085	2,249,412	0	
Electricity: trust owned solar costs	£	500	500	500	0	
Electricity: trust owned solar consumed	kWh	17,662	17,979	16,423	0	
Electricity: third party owned solar costs	£	0	0	0	0	
Electricity: third party owned solar consumed	kWh	0	0	0	0	
Electricity: other renewables costs	£	0	0	0	0	
Electricity: other renewables consumed	kWh	0	0	0	0	
Electricity: other costs	£	0	0	0	0	
Electricity: other consumed	kWh	0	0	0	0	
Electricity purchased from CHP costs	£	0	0	0	0	
Electricity purchased from CHP consumed	kWh	0	0	0	0	
Thermal energy purchased from CHP costs	£	0	0	0	0	
Thermal energy purchased from CHP consumed	kWh	0	0	0	0	
Gas costs	£	510,380	1,465,965	249,128	0	
Gas consumed	kWh	4,639,732	26,231,000	2,468,197	0	

Energy	Unit	BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
		RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Oil costs	£	0	0	0	0	
Oil consumed	kWh	0	0	0	0	
Non-fossil fuel: renewable costs	£	0	0	0	0	
Non-fossil fuel: renewable consumed	kWh	0	0	0	0	
Other energy costs	£	0	7,450	0	0	
Steam consumed	kWh	0	0	0	0	
Hot water consumed	kWh	0	0	0	0	
Solar electricity generated	kWh	17,662	17,979	16,423	0	
Maximum electrical demand	kW	888	2,207	886	0	
Available electrical capacity	kVA	900	4,400	2,000	0	
Number of primary heating gas boilers older than 10 years (100kW and above)	No.	22	4	2	0	0
Number of primary heating gas boilers older than 10 years (less than 100kW)	No.	9	6	2	0	0
Heat pumps installed on site	No.	4	0	8	0	0
Buildings with an electricity meter	No.	28	15	5	0	0
LED lighting coverage	%	80.00	40.00	75.00	0.00	0.00
Oil-led heating sources	No.	0	0	0	0	0
Fossil fuel heating replacement date	Select	Already Implemented	Already Implemented	Already Implemented	No plan	
Heat decarbonisation plan	Select	No	No	No		Not applicable - Site is leased and the lease is due to expire before 2032 with no plans for renewal
Relevant occupied floor area	m ²				0	

Water Services		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Water and sewerage cost	£	147,167	459,095	70,750	0	
Water volume (including borehole)	m³	33,465	106,277	17,841	0	
Buildings with a water meter	No.	9	8	4	0	0
Relevant occupied floor area	m²				0	

Waste		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Incineration (clinical waste) cost	£	14,461	54,670	1,389	0	
Incineration (clinical waste) weight	Tonnes	10.48	45.15	1.00	0.00	
Alternative Treatment (clinical waste) cost	£	58,288	207,448	15,272	0	
Alternative Treatment (clinical waste) weight	Tonnes	42.14	222.68	10.79	0.00	
Offensive waste cost	£	77,211	171,251	26,837	2,177	
Offensive waste weight	Tonnes	167.90	537.79	58.81	0.14	
Clinical waste (excluding incineration) processed on site cost	£	0	0	0	0	
Clinical waste (excluding incineration) processed on site weight	Tonnes	0.00	0.00	0.00	0.00	
Clinical waste processed at municipal waste plants cost	£	394	1,472	0	0	
Clinical waste processed at municipal waste plants weight	Tonnes	0.92	4.62	0.00	0.00	
Domestic waste (landfill) cost	£	0	0	0	0	
Domestic waste (landfill) weight	Tonnes	0.00	0.00	0.00	0.00	
Domestic waste (recycling) cost	£	5,697	850	968	0	
Domestic waste (recycling) weight	Tonnes	31.61	5.46	8.07	0.00	
Domestic waste (incineration) cost	£	30,497	96,621	14,721	0	
Domestic waste (incineration) weight	Tonnes	150.60	584.13	58.46	0.00	
Domestic waste (food) cost	£	0	0	67	0	
Domestic waste (food) weight	Tonnes	0.00	0.00	0.22	0.00	

Domestic waste (excluding incineration) processed on site cost	£	0	0	0	0	
Domestic waste (excluding incineration) processed on site weight	Tonnes	0.00	0.00	0.00	0.00	
Confidential waste cost	£	2,338	6,047	644	80	
Confidential waste weight	Tonnes	57.15	178.09	21.31	0.40	
Other waste costs	£	76,497	195,314	28,080	0	
Relevant occupied floor area	m²				0	

Car Parking		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Parking spaces available	No.	846	1,558	257	0	0
Car parking services cost	£	30,921	101,468	24,786		
Designated disabled parking spaces	No.	55	66	46		
Electric vehicle charging points	No.	0	0	0		
Average fee charged per hour for patient/visitor parking	£	1.57	1.57	1.57		
Average fee charged per hour for staff parking	£	0.10	0.10	0.10		
Is there a charge for disabled parking	Yes/No/None	No	No	No		

Cleaning services		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Cleaning service provision	Select	In-house	In-house	In-house	Not Applicable	
Cleaning service cost	£	1,768,982	5,906,389	717,557		
Cleaning staff	WTE	54.27	202.05	22.22		
Relevant occupied floor area	m²					

Food Services		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Food service provision	Select	Inpatient meals only	Inpatient meals only	Inpatient meals only	No meal provision	No meal provision
Inpatient food service cost	£	1,437,287	3,861,713	483,015		
Inpatient food ingredients and ready meal cost	£	334,076	1,133,734	88,868		
Inpatient main meals requested	No.	196,038	665,418	52,161		
Inpatient food model type	Select	Cook-freeze pre-plated	Cook-freeze pre-plated	Cook-freeze bulk/buffet		
Inpatient meal preparation	Select	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider		
Inpatient meals ordered with a digital or electronic meal ordering system	%	100.00	100.00	100.00		
Other food services costs	£	0	0	0	0	
Meals provided to A&E and urgent care patients	No.	2,883	7,426	0		
Staff/visitor restaurant food model type	Select	Cook-freeze bulk/buffet	Cook-freeze bulk/buffet	Cook-freeze bulk/buffet		
Where are the staff/visitor main course options cooked	Select	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider	External food supplier - Ordered by catering FM provider		
Staff/visitor meals served	No.	33,358	44,481	3,400		
Catering staff	WTE	9.00	28.00	2.00		

Food Waste		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Total food waste (all destinations and EWC codes)	Tonnes	26.90	54.64	3.76		
Food waste generated from production	Tonnes	5.07	0.29	0.30		
Food waste generated from plate waste	Tonnes	13.94	39.13	1.78		
Food waste generated from unserved meals	Tonnes	5.46	14.88	1.43		
Food waste generated from spoilage	Tonnes	2.42	0.34	0.25		

Laundry & Linen		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Laundry and linen service provision	Select	Contracted – Full service	Contracted – Full service	Contracted – Full service	No service provision	Laundry and linen service provision
Laundry and linen (contracted full service) cost	£	468,825	1,182,799	199,816		Laundry and linen (contracted full service) cost
Laundry service cost	£					Laundry service cost
Linen service cost	£					Linen service cost
Laundered pieces per annum	No.	623,746	2,148,455	226,374		Laundered pieces per annum
Bed linen replacement cost	£	15,071	53,530	4,076		Bed linen replacement cost
Other laundry and linen expenditure	£	0	0	0		Other laundry and linen expenditure
Onsite laundry	Select	No	No	No		Onsite laundry
Relevant occupied floor area	m ²					Relevant occupied floor area

Portering Services		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	
Portering service provision	Select	In-House	In-House	In-House	No portering service	
Portering service cost	£	778,563	1,985,874	287,684		
Portering staff	WTE	24.05	63.12	8.98		
Portering job allocation method	Select	Digital System (App/ Hand-held Device)	Digital System (App/ Hand-held Device)	Digital System (App/ Hand-held Device)		
Relevant occupied floor area	m ²					

Safety		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Clinical service incidents caused by estates and infrastructure failure related to Critical Infrastructure Risk	No	2	3	1	0	0
Clinical service incidents caused by estates and infrastructure failure related to non-Critical Infrastructure Risk	No	3	5	1	0	0
Clinical service incidents caused by estates and infrastructure failure: other	No	1	1	0	0	0
Estates and facilities related incidents related to Critical Infrastructure Risk	No.	5	7	2	0	0
Estates and facilities related incidents related to Non-Critical Infrastructure Risk	No	12	15	4	0	0
Estates and facilities incidents related: other	No	1	2	1	0	0
Overheating occurrences triggering a risk assessment	No.	0	0	0	0	0
Estates and facilities RIDDOR incidents	No	2	2	1	0	0
Flood occurrences triggering a risk assessment	No	0	0	0	0	0

Safety - Incidents		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Most clinically impactful: Incident type	Select	Ventilation systems	Electrical systems	Lifts & Hoists		
Most clinically impactful: Cost to rectify estates and infrastructure failure	£	0	10,000	60,000		
Most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	12	0		
Most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	4	0		
Most clinically impactful: Lost clinical income	£	0	27,000	0		
Most clinically impactful: Number of recurring incidents	No.	0	0	0		
Second most clinically impactful: Incident type	Select	Internal fabric and fixtures	Hot and cold-water systems	Hot and cold-water systems		
Second most clinically impactful: Cost to rectify estates and infrastructure failure	£	5,000	30,000	2,000		
Second most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	0	0		
Second most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	0	0		
Second most clinically impactful: Lost clinical income	£	0	0	0		
Second most clinically impactful: Number of recurring incidents	No.	0	3	0		
Third most clinically impactful: Incident type	Select	Hot and cold-water systems	Lifts & Hoists	Ventilation systems		
Third most clinically impactful: Cost to rectify estates and infrastructure failure	£	3,000	5,600	8,000		

Safety - Incidents		BASSETLAW DISTRICT GENERAL HOSPITAL	DONCASTER ROYAL INFIRMARY	MONTAGU HOSPITAL	OTHER REPORTABLE SITES	RETFORD HOSPITAL
	Unit	RP5BA	RP5DR	RP5MM	RP5ORS	RP5RE
Third most clinically impactful: Down time as a result of estates and infrastructure failure	Hrs	0	0	0		
Third most clinically impactful: Lost clinical time as a result of estates and infrastructure failure	Hrs	0	0	0		
Third most clinically impactful: Lost clinical income	£	0	0	0		
Third most clinically impactful: Number of recurring incidents	No.	0	0	0		

2607 - G2 DEFICIT SUPPORT FUNDING

● Information Item

● Sam Wilde, Chief Finance Officer

● 11:40

5 minutes

REFERENCES

Only PDFs are attached



G2 - Deficit Support Funding.pdf



G2 - Appendix 1 NHSE Guidance Letter.pdf



G2 - Appendix 2 Quarterly Board Assurance Statement.pdf

Report Template				
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026
Report Title/ Ref:	Deficit Support Funding			
Sponsor:	Sam Wilde, Chief Finance Officer			
Authors:	Yasmin Ahmed, Deputy Director of Finance			
Appendices:	1 - NHSE Guidance Letter 2 - Quarterly Board Assurance Statement			
Purpose of the report	Assurance	Approval/decision	Information	Discussion
Proposed assurance Level (For assurance papers only)	N/A			
Assurance Rationale	N/A			
Impacts on Strategic Risks (BAF 1-7)	BAF5 - If DBTH cannot deliver the financial plan then DBTH will be unable to deliver services and the Trust may not be financially sustainable in long term			
Executive Summary – Key messages and Issues				
NHSE has confirmed the Trust is eligible for £15.7m Deficit Support Funding (DSF) in 2026/27. DSF is non-recurrent funding intended to support delivery of a breakeven plan while the Trust improves its underlying recurrent financial position. Appendix 1 shows a letter received from NHS England which confirms the regional expectations and payment arrangements applying to the quarterly assessments and payments. In summary: Financial implications - DSF is earned and awarded quarterly, not guaranteed upfront. - Funding is contingent on delivery of the agreed financial plan and achievement of the planned underlying exit run-rate. - For every £1 under-delivery against plan, a further £1 of DSF will be lost, up to the total DSF allocation. This creates a significant financial risk if plan delivery slips. NHSE expectation To secure DSF payments, the Trust must demonstrate: - Delivery of the in-year financial plan, including workforce and pay cost reductions. - Fully developed and implemented Cost Improvement Plans (CIPs). - Resolution of material contract issues and signed commissioning contracts. - Robust risk-assessed forecasts showing delivery of the approved plan and exit run-rate. - Continued Board assurance regarding delivery of the 2026/27 financial plan. Specific Board responsibilities - Ahead of each quarterly assessment, a Board Assurance Statement must be submitted and signed by the Chair and Chief Executive. - The statement must confirm confidence in delivery of the accepted plan and cover: - Pay reductions/retraction - CIP delivery - Contract position - Operational performance - Cash position - Financial forecast - Exit run-rate - Underlying financial position.				

NHS England will assess performance through:

- Monthly financial returns.
- Formal assurance meetings.
- Internal risk-adjusted forecasts.
- Monitoring of CIP development and delivery.

Where criteria are not met, additional assurance may be required before DSF is awarded.

Key milestones during 2026/27

The Trust will need to demonstrate:

- **Q2 (June):** All material contracts signed and 100% of planned CIP value developed or implemented.
- **Q3 (September):** Risk-adjusted forecasts show confidence in delivering the full-year financial outturn.
- **Q4 (December):** Exit run-rate and underlying financial position are on plan or better, supported by Board assurance.
- **February final adjustments:** Board-approved final forecast outturn.

The first quarterly Board Assurance statement is shown at appendix 2. This was reviewed by the Finance and Performance committee and approved for submission at its meeting held on 25th June 2026.

Recommendations

The Committee is asked to **NOTE**:

- (1) That receipt of the £15.7m DSF allocation is conditional on sustained delivery of the approved financial recovery plan. Continued Board oversight, assurance, and evidence of CIP, workforce, contract and forecast delivery will be critical to securing quarterly DSF payments and avoiding loss of funding.
- (2) The first quarterly Board Assurance statement submitted by the Trust following approval by the Finance and Performance committee.

Healthier together – delivering exceptional care for all

Patients	
People	
Partnerships	
Pounds	Conditions for receipt of Deficit Support Funding
Health Inequalities	
Legal/ Regulation:	
Partner ICB strategies	

Assurance Route

Previously considered by - including date:	Executive Team Meeting 17 th June 2026 Finance and Performance Committee 25 th June 2026
Any outcomes/next steps / time scales	NHS England is expected to make decisions on DSF awards following submission of the first quarterly Board Assurance Statements during week commencing 29 th June 2026, with cash payments expected to follow on 15 th July 2026.

To: • Richard Parker, Chief Executive
Doncaster and Bassetlaw Hospitals
NHS Foundation Trust

North East and Yorkshire Region
NHS England
7 and 8 Wellington Place
Leeds
LS1 4AP

cc. • Sam Wilde, Director of Finance
Doncaster and Bassetlaw Hospitals
NHS Foundation Trust
• Hamish McLure, SRO, NHSE NE&Y
• Julie French, HoLF, NHSE NE&Y

22 May 2026

Dear Richard,

Deficit Support Funding (DSF) 2026/27 – Regional Expectations and Payment Arrangements

I am writing to formally confirm the regional expectations and arrangements that will apply to the quarterly assessment and payment of Deficit Support Funding (DSF) for 2026/27 for your organisation.

1. Eligibility and purpose of DSF

Your organisation has been confirmed as eligible for £15,700k DSF in 2026/27. DSF remains non-recurrent funding, intended to support delivery of a breakeven financial plan whilst the organisation improves its underlying recurrent financial position. Consistent with national policy, DSF will reduce over time, as outlined in your medium-term plans.

2. Quarterly assessment

DSF will be earned and awarded on a quarterly basis, subject to regional assurance on delivery of the accepted financial plan for the year (criteria and timetable set out in Annex A). If the financial plan is not achieved, for every £1 an organisation under-delivers against its plan, a further £1 of DSF will be lost, up to the total DSF available for the year. This reinforces the expectation that DSF is contingent on delivery of the accepted plan for the year, including delivery of the planned underlying exit run-rate.

3. Regional expectations for earning DSF

In determining whether DSF should be awarded each quarter, the region will apply regional judgement on delivery of the forecast outturn. In practice, organisations can expect DSF to be awarded where there is sufficient confidence in delivery of the full-year financial plan, including evidence of:

- Delivery of the planned in-year financial plan, including WTE and pay run rate reductions
- Cost Improvement Plans (CIPs) fully developed and implemented in line with milestones;
- Resolution of all material contract issues and confirmation of signed commissioning contracts;
- Risk-assessed organisational forecasts demonstrating delivery of the approved plan and the planned exit run-rate; and
- Ongoing Board assurance on delivery of the 2026/27 financial plan.

Ahead of each quarterly decision point, a Board assurance statement is required, signed by Chair and Chief Executive, confirming confidence that the accepted plan will be delivered. This statement should cover, as a minimum: pay retraction, CIP delivery, contracts, operational performance, cash, forecast, exit run-rate and the underlying financial position.

4. Regional oversight

Progress against the agreed criteria will be reviewed at each quarterly decision point through monthly financial returns, formal regional assurance meetings, trusts internal risk adjusted forecasts and progress against CIP programme development (Annex B). Where the agreed criteria are not met, organisations will be expected to provide additional assurance to support any recommendation to award DSF, which will be considered as part of the regional decision-making process.

It is requested you ensure the Board receives a copy of the letter via the relevant committee.

The region will continue to work closely with your organisation through established oversight arrangements. Should you wish to discuss the interpretation of these arrangements ahead of a quarterly decision point, please contact your organisations nominated regional finance team lead.

Yours sincerely,



Tarryn Lake

Regional Director of Finance

NHS England – North East and Yorkshire Region

Annex A – timetable and NEY regional criteria for the award of DSF in 2026/27

	RD decision timing and basis of assurance	Primary source of assurance (cumulative)	Expected progress with conditions of plan acceptance and regulatory requirements
Q1	30 April – decision delayed, assurance on plan delivery unavailable, no evidence of workforce retraction/or reduced pay run rate	1. Acceptance of compliant plan 2. Assurance on in-year financial plan delivery, including, but not limited to, delivery of plan run rate & cost improvement plans 3. Confirmation of continued board assurance on 26/27 plan delivery 4. Completion of independent workforce retraction plan reviews or ICB review (<i>exception Sheffield Health Partnerships</i>)	Organisations monthly financial returns to NHSE. Regional assessment based on status at most recent formal assurance meeting. Assurance from attendance at organisations financial recovery board
Q2	30 June – assurance based on M2 results	5. All material contracts signed 6. 100% of value of planned CIP fully developed or implemented 7. Confirmation of continued board assurance on 26/27 plan delivery	(where NHSE in attendance) and/or receipt of Finance Committee Papers and minutes.
Q3	30 September – assurance based on M5 results	8. Organisations internal risk-adjusted forecast demonstrates confidence on delivery of FOT, independently reviewed by NHSE regional finance team & supported by confirmation of board assurance from Chair and CEO.	
Q4	31 Dec – assurance based on M8 results	9. Organisational forecast exit run rate and underlying position on plan or better than MTP & supported by confirmation of board assurance from Chair and CEO. 10. Board signed off final forecast outturn.	
ICB final adjustments	22 Feb – assurance based on M10 results	11. Board signed off final forecast outturn.	
Provider final adjustments	22 Feb – assurance based on M10 results		

Annex B – CIP Programme & Development

Efficiency Programme scheme development & guidance

Category criteria & requirements

The following table re-iterates the key CIP categories aligned to scheme development, and the supporting criteria:

WRP category	Meets four tests	Aligned development* risk adjustment	Summarised definition	Criteria to meet the category
Pre-pipeline	X	N/A – 0%	High level idea, requires validation, could be from benchmarking / ideas generation workshops.	- Initial idea identified and recorded on ICB / provider tracker with potential indicative value, and reported on WRP template. - Plan (with target dates) in place to develop respective scheme to meet the '4 tests' criteria and validate savings. - Movement into 'Opportunity' dictated by approval mechanism within local governance structure, to ensure that scheme meets the '4 tests' criteria.
Opportunity	✓	High risk – 25%	Validated, costed opportunity with stakeholder buy in that meets the four tests	Scheme satisfies the '4 tests' criteria and target date to transition scheme to 'Plans in progress' – key areas: - There is basic outline costing (not just a number from a benchmarking tool); - There is a basic calculation of WTE impact where relevant; - There is evidence that the idea has been reviewed by relevant operational and/or clinical colleagues who agree that it is potentially feasible; and - There is a target implementation date and evidence that relevant operational and/or clinical colleagues agree this is feasible. Project Initiation Document (PID) initiated to capture the key information within all parts of the '4 tests' - Movement into 'Plans in place' dictated by approval mechanism within local governance structures.
Plans in progress	✓	Medium risk – 50%	Validated, costed opportunity with stakeholder buy in that meets the four tests and has a PID in development	- As per criteria on slide 4, ongoing development of a Project Initiation Document (PID) capturing, in particular - Clear scheme scope & ownership - Detailed activity plan with milestones / actions and supporting ownership - Risk and issues captured with supporting mitigation measures - Check, challenge & phasing of non-financial KPIs to enhance monitoring - Check, challenge & phasing of financial benefits Completed & signed off QIA/EIA - Movement into 'Fully developed' dictated by signed off QIA and fully approved PID reviewed through local governance structures.
Fully developed	✓	Low risk – 75%	Validated, costed robust plan with stakeholder buy in that has been fully signed off by all scheme stakeholders with a fully signed off QIA / EIA (as applicable)	As per the criteria on slides 4, 'Fully developed' PID – with the following: - The PID is highly robust with a clear, detailed, and comprehensive project scope that is easy to understand and follow. - The opportunity is fully supported by comprehensive activity and financial analysis, demonstrating clear and substantial benefits and feasibility. - The financial opportunity is fully phased and accurately mapped to all relevant budgetary lines, ensuring clear alignment and transparency. - KPIs are clearly defined, regularly tracked, and effectively support comprehensive benefit monitoring and reporting. - Clear, specific milestones with detailed action plans and timelines are identified, ensuring the opportunity can be effectively realised. - Potential risks have been thoroughly identified and documented, ensuring comprehensive understanding and mitigation strategies are in place. - QIA / EIA completed and fully agreed upon by all relevant stakeholders, ensuring compliance and alignment with project objectives.

Aligned development* risk adjustment

This column refers to the **development risk** rather than the **delivery risk**.

We understand that each organisation will also assess their CIPs for their delivery risk when they move into 'Fully developed' and therefore there may be schemes classified as 'Fully developed' that are low risk in terms of development as they have robust, worked up and signed off plans but classified as high risk in terms of delivery, for instance, if there are internal or external factors influencing the realisation of savings.

Scheme development & guidance

Scheme & Project Initiation Document robustness

It is essential that all schemes are support with robust documentation to enable delivery – PIDs should be assessed against the following criteria:

Rating 1) Is the scheme robust and does it have a comprehensible project scope?		Score
 The PID is highly robust with a clear, detailed, and comprehensive project scope that is easy to understand and follow.		2
 The PID is generally robust with a mostly clear project scope, though some areas may need further clarification or detail.		1
 The PID lacks robustness and has an unclear or incomplete project scope, making it difficult to comprehend and implement.		0
Rating 2) Is the opportunity supported and validated by activity and financial analysis?		Score
 The opportunity is fully supported by comprehensive activity and financial analysis, demonstrating clear and substantial benefits and feasibility.		2
 The opportunity is supported by adequate activity and financial analysis, showing potential benefits but with some areas needing further validation.		1
 The opportunity lacks sufficient activity and financial analysis, with significant gaps that do not demonstrate its potential benefits.		0
Rating 3) Is the financial opportunity phased and mapped to budgetary lines?		Score
 The financial opportunity is fully phased and accurately mapped to all relevant budgetary lines, ensuring clear alignment and transparency.		2
 The financial opportunity is partially phased and mapped to most budgetary lines, with minor gaps that need addressing.		1
 The financial opportunity is poorly phased and lacks proper mapping to budgetary lines, resulting in unclear financial tracking.		0
Rating 4) Have KPIs been identified and tracking in place to support benefit monitoring?		Score
 KPIs are clearly defined, regularly tracked, and effectively support comprehensive benefit monitoring and reporting.		2
 KPIs are identified and tracked, but there are occasional gaps in supporting benefit monitoring.		1
 KPIs are poorly defined or not tracked, hindering effective benefit monitoring and reporting.		0
Rating 5) Are there actionable milestones identified to realise the opportunity?		Score
 Clear, specific milestones with detailed action plans and timelines are identified, ensuring the opportunity can be effectively realised.		2
 Milestones are identified but lack some detail or specificity, requiring further refinement to fully realise the opportunity.		1
 Milestones are vague or missing, making it difficult to take actionable steps to realise the opportunity.		0
Rating 6) Have risks been identified to realise the opportunity?		Score
 Potential risks have been thoroughly identified and documented, ensuring comprehensive understanding and mitigation strategies are in place.		2
 Most significant risks have been identified, but some minor risks may still need to be addressed to ensure full opportunity realisation.		1
 Few/no risks have been identified, indicating a lack of thorough risk assessment.		0
Rating 7) Has a QIA been completed and agreed?		Score
 QIA completed and fully agreed upon by all relevant stakeholders, ensuring compliance and alignment with project objectives.		2
 QIA completed but pending final agreement from some stakeholders, minor adjustments required for full compliance.		1
 QIA not completed or agreed upon, significant gaps in compliance and stakeholder alignment.		0
Overall PID robustness assessment		RAG Rating Overall
The PID is comprehensive, well-structured, and clearly outlines objectives, timelines, and responsibilities, ensuring successful project delivery.		12+
The PID covers essential elements but lacks detailed clarity in some areas, requiring minor adjustments for optimal project execution.		8-11
The PID is incomplete or poorly organised, missing critical information, and requires significant revisions to meet project standards.		2<7

Board Assurance Statement

Doncaster and Bassetlaw Teaching Hospitals

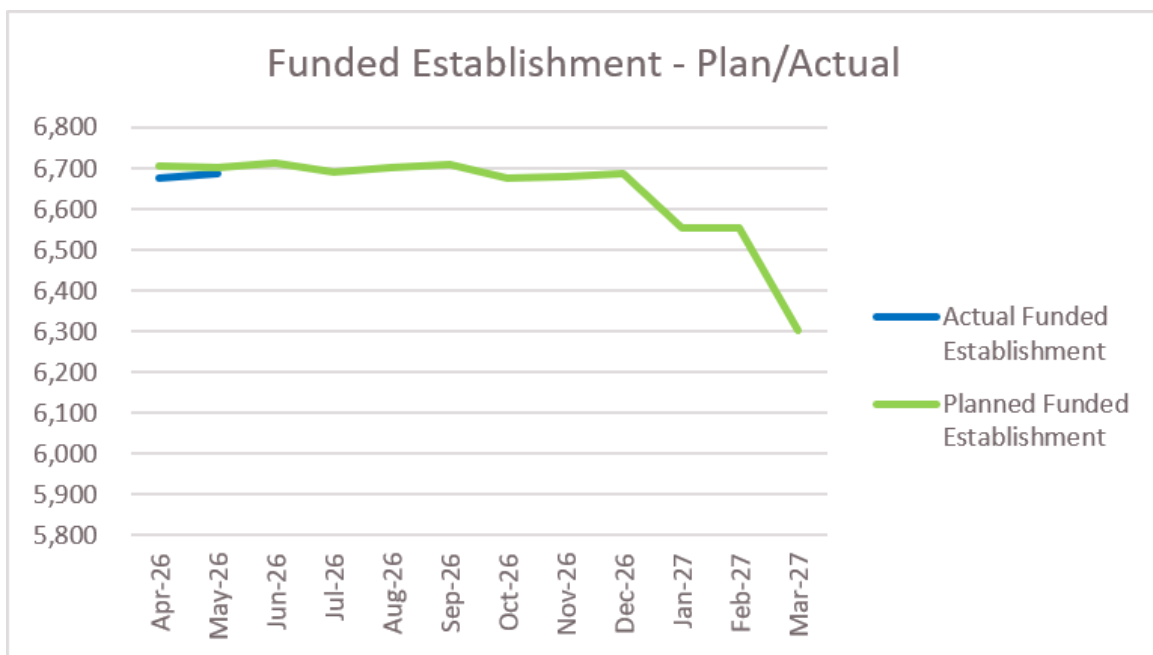
2026/27 Deficit Support Funding (DSF) Quarterly assessment

Approved by Finance & Performance Committee 25th June 2026

This statement confirms confidence in delivery of the Trust's committed financial plan.

Pay Reductions/Retraction

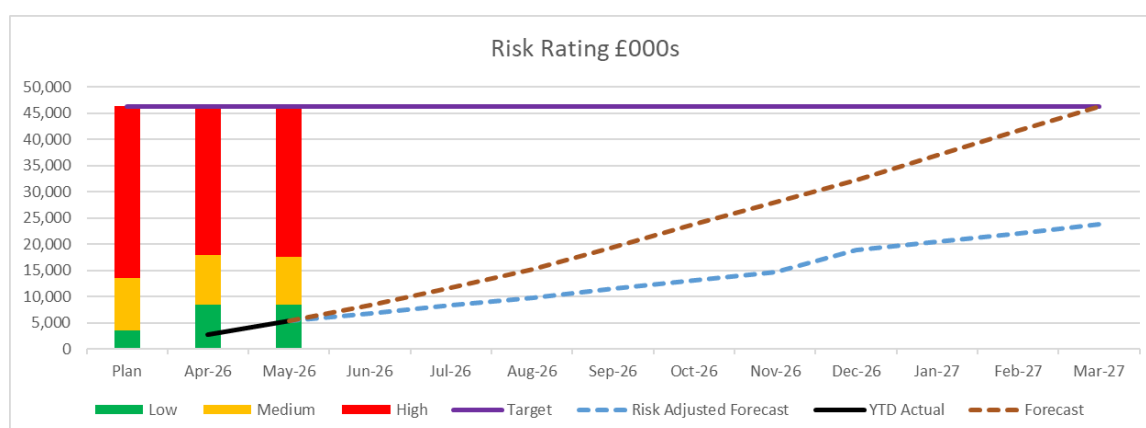
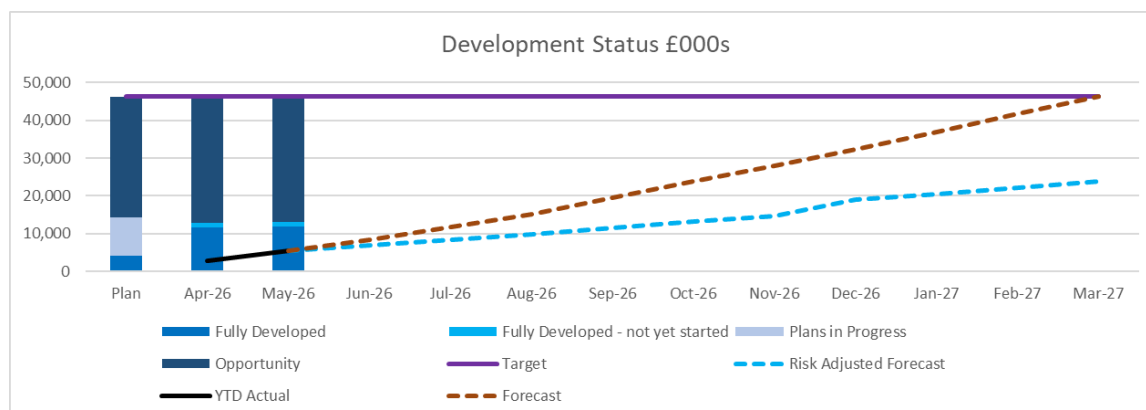
Month 2 year-to-date pay costs of £73.2M are better than plan (£73.3M). At the end of May the funded establishment of 6,686 WTE is also below plan (6,700 WTE).



CIP Delivery

Year to date CIP delivery is on plan at £2.7M at the end of month 2. Forecast full year savings of £46.3M are in line with plan. There are no unidentified plans and

both plan development status and risk ratings have improved markedly since the planning submission:



Contracts

Signed contract variations to the previously agreed multi-year contracts are in place for NHSE and SYICB, however associates remain unsigned and we are chasing them.

The SYICB contract variation includes a side letter which requires a review and rebasing of the block contract. This analysis has been completed by the Trust in line with the agreed timeline. The side letter requires the outcome of the review to be used to agree appropriate adjustments to the contract value (including both changes to block values and changes to the levels of variable activity planned to be funded) by the end of quarter 1. At the time of writing those changes to contract value have not been formally agreed. A £6.5M mitigation of an identified risk is planned in respect of this work.

Operational Performance

Detailed delivery plans are in place to support the delivery of the operational performance plan for 2026/27. The plans translate the Reset Programme work into actions, trajectories, governance and escalation for 2026/27, covering RTT recovery to 70.6%, four-hour performance to 82%, DM01 recovery to 81.6%, FDS at or above 80% and 62-day cancer recovery to the planning requirement.

Key risks remain in T&O admitted capacity, UEC flow, ambulance handovers, MRI, non-obstetric ultrasound, Audiology and cancer capacity.

Operational performance at the end of month 2 is summarised below:

- **Urgent and emergency care:** off plan overall, driven by non-admitted performance at Doncaster and ambulance handover delays at Bassetlaw. UEC improvement plan in place.
- **Diagnostics:** off plan, driven by MRI and Audiology. Recovery plan in place for Audiology and in development for MRI.
- **Elective:** off plan, driven by T&O and ENT. Recovery plans in place with oversight through Tier 2 meetings.
- **Cancer:** on plan for 31 days and 62 days. Off plan for FDS, driven by a deterioration in breast performance, recovery plan in place and recovery forecast for Q2.

Category	Measure	Apr-26			May-26		
		Plan	Actual	Variance	Plan	Actual	Variance
UEC	Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	76.0%	74.6%	-1.4%	76.0%	71.1%	-4.9%
UEC	Percentage of attendances at Type 1 A&E departments, departing in less than 4 hours.	69.1%	71.4%	2.3%	69.1%	67.5%	-1.6%
UEC	Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	96.2%	95.3%	-0.9%	96.5%	94.7%	-1.8%
UEC	Percentage of Ambulance handovers over 15 minutes	37.5%	42.1%	4.6%	36.3%	44.4%	8.1%
UEC	Percentage of Ambulance handovers over 45 minutes	2.4%	1.8%	-0.6%	2.0%	3.0%	1.0%
Beds	Overnight total general and acute bed occupancy %	96.3%	94.0%	-2.3%	94.1%	93.1%	-1.0%
Discharges	Percentage of patients discharged on discharge ready date	82.7%	78.3%	-4.4%	82.9%	78.8%	-4.1%
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	19.5%	29.0%	9.5%	22.1%	24.2%	2.1%
Elective RTT	RTT % within 18 weeks	64.2%	61.6%	-2.6%	64.8%	62.6%	-2.2%
Outpatient	Percentage waiting for a first appointment at the snapshot date that have been waiting less than 18 weeks	75.3%	74.3%	-1.0%	75.9%	74.4%	-1.5%
Cancer	Percentage of people waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	81.2%	69.9%	-11.3%	80.3%		
Cancer	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days of receiving a decision to treat/earliest clinically appropriate date	95.2%	96.3%	1.1%	95.5%		
Cancer	Percentage of patients receiving a first definitive treatment for cancer within 62 days of receipt of an urgent GP (or other referrer) referral for urgent suspected cancer/breast symptomatic referral/an urgent screening referral/consultant upgrade	71.1%	80.0%	8.9%	71.9%		

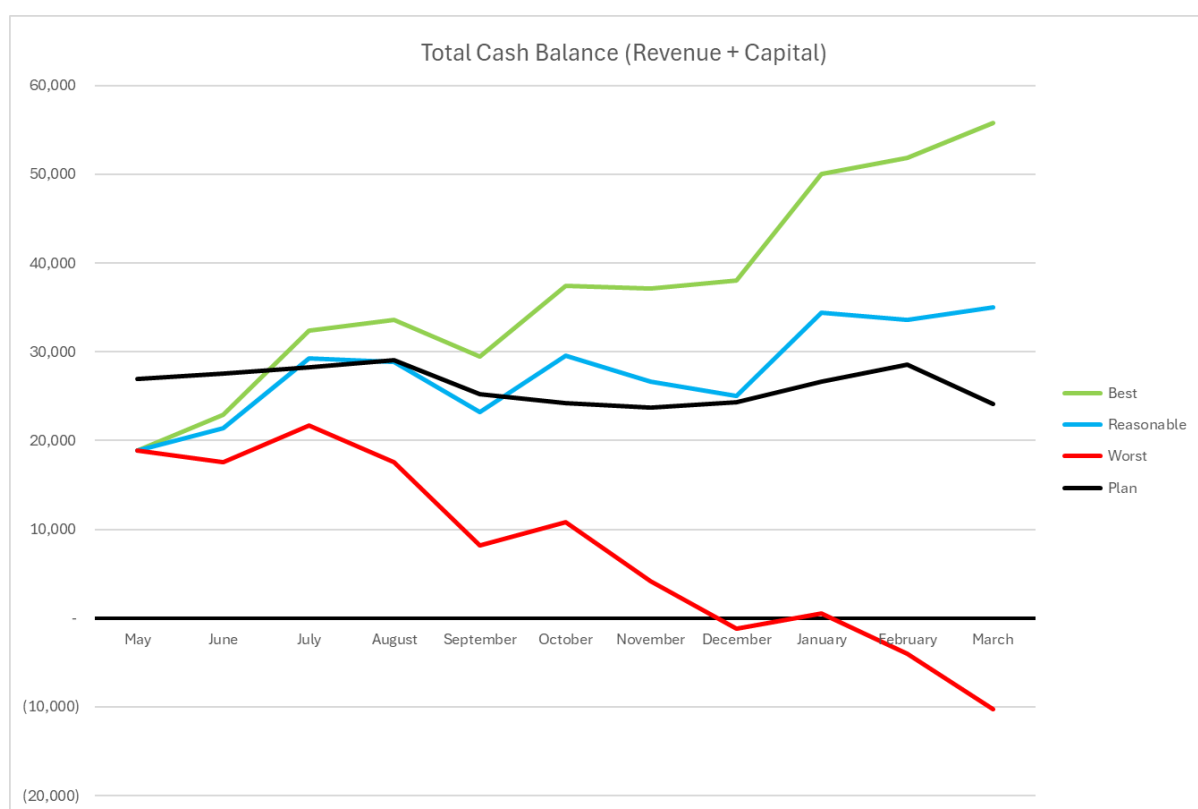
Additional resources are in place to support the delivery of the plan and Reset Programme for 2026/27.

Cash

The cash balance at the end of month 2 is £18.9M, which is £8.1M adverse to the £27.0M plan. This is driven by not having received cash in respect of deficit support funding for:

- Q4 2025/26 - £4.3M (expected to be received on 1st July 2026)
- Months 1 and 2 2026/27 - £2.6M

Cash projections for the remainder of the year are ahead of plan in both the reasonable and best-case scenarios:



Delivery of the In-Year Plan and Forecast

Excluding DSF, the year-to-date performance at the end of month 2 is a £4.3M deficit in line with plan.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust									
M02 May 2026									
Income and Expenditure vs. Budget									
Performance Indicator	Annual budget	Monthly Performance				YTD Performance			
		Budget	Actual	Variance to budget		YTD Budget	YTD Actual	Variance to budget	
		£'000	£'000	£'000		£'000	£'000	£'000	
Income	(645,452)	(53,525)	(50,948)	2,577	A	(106,958)	(104,165)	2,792	A
Pay	432,451	37,026	36,660	(366)	F	73,283	73,243	(39)	F
Non Pay	204,333	16,567	16,848	282	A	33,876	34,210	333	A
Financing Costs	9,455	788	581	(207)	F	1,576	1,111	(465)	F
(Profit)/Loss on Asset Disposals	0	0	0	0	F	0	0	0	F
(Surplus)/Deficit for the period	787	856	3,141	2,285	A	1,777	4,398	2,621	A
Donated Asset Adjustment	(787)	(66)	(69)	(3)	F	(131)	(137)	(6)	F
Impairment Adjustment	0	0	(0)	(0)	F	0	(0)	(0)	F
Adjusted Financial Performance (Surplus)/Deficit	0	790	3,072	2,282	A	1,646	4,261	2,615	A
<i>Remove Deficit Support Funding</i>	<i>15,700</i>	<i>1,308</i>	<i>(1,308)</i>	<i>(2,617)</i>	<i>F</i>	<i>2,617</i>	<i>0</i>	<i>(2,617)</i>	<i>F</i>
Adjusted Financial Performance (Surplus)/Deficit excluding Non-Recurrent Deficit Funding	15,700	2,099	1,764	(335)	F	4,263	4,261	(2)	F

Income

Expenditure

Key

Over-achieved **F**

Under-achieved **A**

Underspent **F**

Overspent **A**

F = Favourable A = Adverse

Full year forecast remains in line with plan (£15.7M deficit excluding DSF, breakeven including DSF).

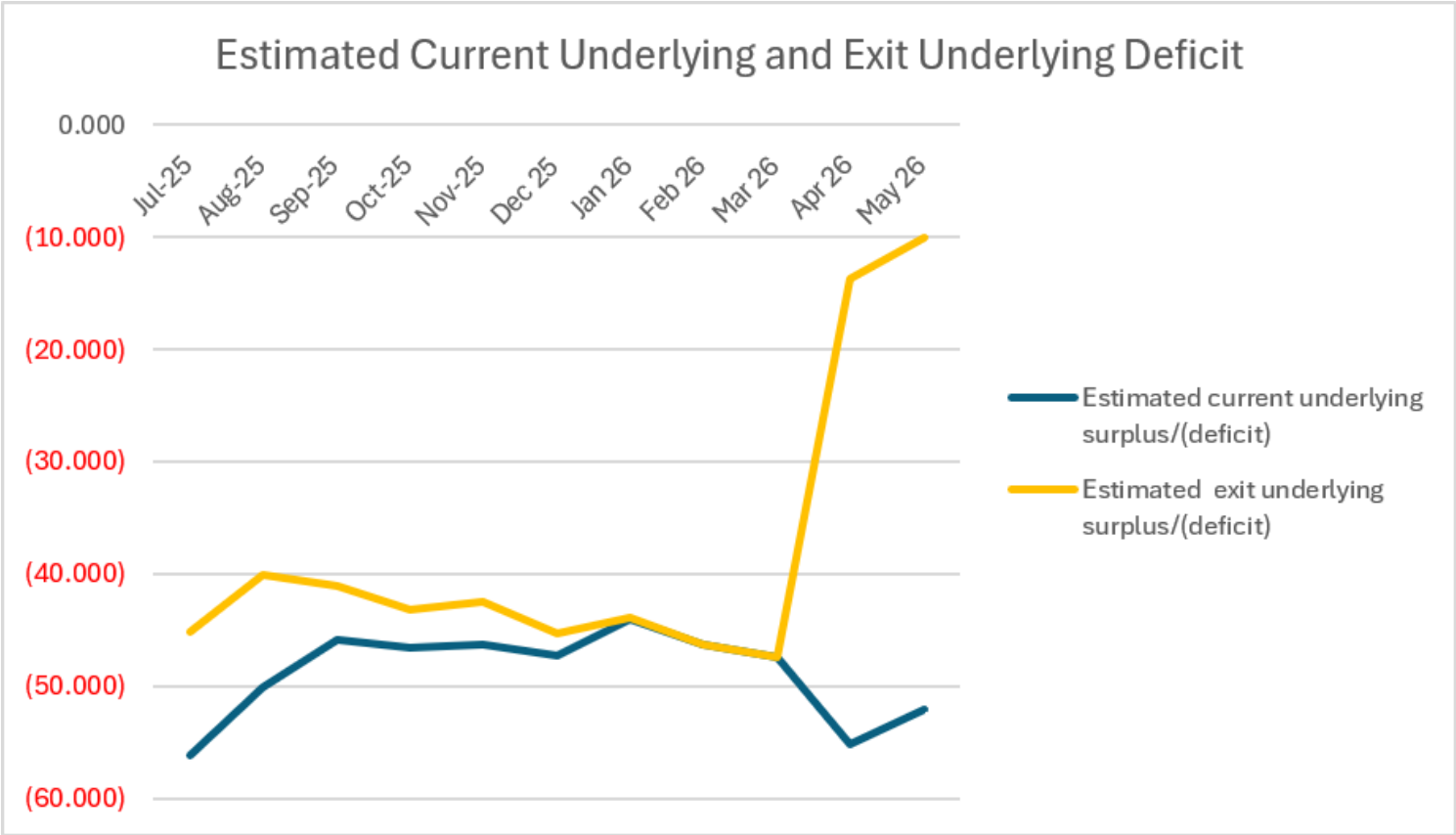
Both gross and net risk levels have improved markedly since the planning submission. The net risk position has improved from £38.9M in the planning submission to £21.7M at the end of month 2.

Key Risks	Risks (R)				Key Mitigations	Mitigations (M)				26/27 Plan Net Risk	M2 Net Risk	(Increase) Decrease in month
	26/27 Plan	M1	M2	(Increase) Decrease		26/27 Plan	M1	M2	Increase (Decrease)			
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000			
Efficiency risk	(32,659)	(25,312)	(24,463)	849	Demand management system	6,786	6,786	6,786	0	(25,873)	(17,677)	849
Commissioner Growth and clawback	(8,700)	(8,700)	(8,700)	0	Negotiation with SY ICB	0	6,525	6,525	0	(8,700)	(2,175)	0
Delays to acceleration of structural changes	(3,700)	(3,700)	(3,700)	0	Reset Programme	0	1,850	1,850	0	(3,700)	(1,850)	0
Incremental drift	(500)	(500)	(500)	0	Non Recurrent technical	0	500	500	0	(500)	0	0
Potential error in estimation of revenue to capital transfer	(100)	(100)	(100)	0	Non Recurrent technical	0	100	100	0	(100)	0	0
Industrial Action	0	(340)	(680)	(340)	Non Recurrent technical	0	340	680	340	0	0	0
Total	(45,659)	(38,652)	(38,143)	509	Total	6,786	16,101	16,441	340	(38,873)	(21,702)	849

The remaining net risks relate to delivery of the efficiency programme, acceleration of structural change and securing growth funding/avoiding claw back from commissioners.

Exit Run Rate and Underlying Financial Position

The underlying deficit exiting 26/27 committed in the medium-term plan is £10.1m. At the end of month 2 the 26/27 exit rate is estimated at £10.1m in line with plan.

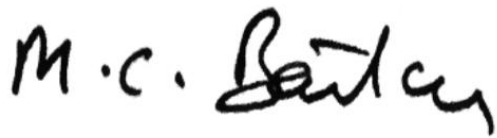


Approval For Submission

Handwritten signature of Zara Jones in black ink.

.....
Zara Jones, Acting Chief Executive

25th June 2026

Handwritten signature of Mark Bailey in black ink.A handwritten horizontal flourish or underline in black ink.

.....
Mark Bailey, Interim Chair

25th June 2026

2607- H1 CHAIR'S ASSURANCE LOG - FINANCE & PERFORMANCE

COMMITTEE

● Discussion Item

● Stephen Radford, Non-executive Director

● 11:45

5 Minutes

REFERENCES

Only PDFs are attached



H1 - Chairs Assurance Log - Finance & Performance Committee - 26 May 2026.pdf



H1 - Chairs Log Assurance - Finance and Performance - 25 June 2026.pdf

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

Subject:	Finance and Performance Committee	Board Date: 7 July 2026
Prepared By:	Stephen Radford, Chair of Finance & Performance Committee	
Approved By:	Finance and Performance Committee Members	
Presented By:	Stephen Radford – Chair of Finance & Performance Committee	
Purpose	The paper summarises the key highlights from the Finance and Performance Committee meeting held on 26 May 2026	

Matters of Concern/Escalation Items (with Partial or No Assurance)	Major Actions Commissioned / Work Underway
The Finance and Performance (F&P) Committee received Partial Assurance in the following areas: Financial Performance - Month 1 • For month 1, the Trust reported a £1.2m deficit which is £0.3m adverse to plan. Cost overrun related to additional costs incurred to provide cover during industrial action by resident doctors in April 2026. • In the year to-date, Trust Improvement Delivery Plan efficiency programme delivered recurrent full year savings of £7.4m and a 3.5 Whole Time Equivalents (WTE) recurrent reduction in the funded establishment. This is in line with plan. The full year requirement is £48.8m savings and a reduction WTE establishment. • Agency and bank costs were above NHSE target. The Trust benchmarked well for the level of bank costs as % of total salary costs, but poorly for agency costs against other Trusts in the month. The need to reduce bank/ agency costs is planned to be addressed by the Trust Reset programme. • In the month all areas of activity were below plan mainly due to the industrial action. • Cash reduced by £22.3m to £31.1m with the Trust paying £23.0m of capital creditors in the month. Cash forecast is very dependent on delivery of efficiency schemes. Worse case the Trust will require funding support around November 2026. • Capital spend was £0.9m under plan in month 1. • The F&P Committee assigned only partial nature given that the Trust is only in Period 1 and there still needs to be significant progress made against plan before a change in the level of assurance can be made. Operational Performance – April 2026 Emergency Care: • Emergency Department (ED) 4-hour performance dropped month on month to 74.6%, 1.4% off plan. • ED waits over 12 hours increased month on month to 4.1% but were ahead of plan. • Demand for A&E were 1.6% above plan in the month. • Key risks to ED performance are demand continuing to be above plan, delays to decision making regarding admission and delays to discharge. • Ambulance hand-over performance for both 15/30 minutes were also behind plan in the month.	

Elective Care: • Trust performance for Percentage of patients waiting less than 18 weeks from referral to treatment was off plan with 61.6% against a target of 64.2%. • Over 52 weeks were 2.2% of patients were waiting > 52 weeks for incomplete pathways, against the trajectory of 1.0%. • Diagnostic waits at 71% were 9.5% off plan. With delays in MRI & Radiology. • 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. • The Trust remains in Tier 2 for elective performance. Cancer: • The 28-day Faster Diagnosis, 31- and 62-day standards were all delivered ahead of plan. Board Assurance Framework – BAF 4 & 5 Trust Risk Register • BAF Risk 4 – Estates and BAF Risk 5 - Finance and were reviewed with updates having been made to wording, key controls, progress, and mitigating actions. • BAF Risk 4 still required updates, and it was felt by the F&P Committee that only Partial Assurance could be assigned. These would be updated prior to presentation to the Board • Wording for BAF Risk 5 had been revised which was endorsed by the Committee. • BAF Risk 5 – Finance was assigned Partial Assurance.	
Significant or Full Assurances to Provide	Decisions Made
The F&P Committee received Significant Assurance in the following areas: Digital & Data Quality Progress Report • The F&P Committee received progress report and noted the improvements made through inclusion of project 'Red Amber Green' rating and target delivery dates. • The report provided a detailed update on the Oracle Electronic Patient Record (EPR) development. Key issues highlighted were in areas of availability of specialist Trust resources to support the project. Following discussion, the F&P committee was assured that these were being managed, and actions were in hand to address these issues. • The Committee also noted progress made in other digital projects. Where issues had been encountered e.g. lack of available hardware these had been typically outside Trust control. • The F&P Committee assigned significant assurance. Estates Performance Annual Report 2025/26 • The F&P Committee received the Annual report and following discussion assigned significant assurance. • It was noted that most KPI's confirmed stable or improving performance, validated by assurance mechanisms such as The Royal Society for the Prevention of Accidents (RoSPA), Premises Assurance Model (PAM), and PLACE. • Areas requiring improvement included sickness & absence, planned maintenance and mandatory training compliance. Action plans are in place to address these, and other areas as required.	<u>Contract Award for Renal Satellite Managed Service</u> • The F&P Committee reviewed the procurement request to appoint a provider for renal dialysis managed services at two satellite centres. • The Trust conducted a Provider Selection Regime under the SBS framework. The process included mandatory requirements, qualitative and financial evaluation, and governance measures covering KPIs, compliance, and transition planning. • The initial term of the contract will be to 2031 with options to extend. • The Committee after due consideration recommended the Contract to the Trust Board for approval in line with the Standing Financial Instructions process. <u>Finance & Performance Committee – Terms of Reference</u> 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 Medium Term Plan.

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	
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.

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

Subject:	Finance & Performance Committee	Board Date: 7 July 2026
Prepared By:	Stephen Radford – Chair of Finance & Performance Committee	
Approved By:	Finance & Performance Committee Members	
Presented By:	Stephen Radford – Chair of Finance & Performance Committee	
Purpose	The paper summarises the key highlights from the People Committee meeting held on 25 June 2026	

Matters of Concern (<i>Moderate, Limited, or Weak Assurance</i>)	Work Underway / Major actions commissions
The F&P Committee received Moderate Assurance in the following areas: Financial Performance - Month 2 - For month 2, the Trust reported a £4.3m deficit in the year to-date which is £2.6m adverse to plan. The £2.6m adverse to plan due to Deficit Support Funding (DSF) not being received in line with the original plan. Decisions on award of DSF for Q1 are expected imminently from NHS England - The underlying deficit exit rate for 26/27 exit rate is estimated at £10.1m which is in line with the Medium-Term Plan. - In the year to-date, Trust Improvement Delivery Plan (IDP) efficiency programme delivered recurrent full year effect savings of £6.8m and 1.2 Whole Time Equivalents (WTE). The full year requirement is £48.8m savings and a reduction WTE establishment by 508.6 WTE recurrently. This equates to 395.1 WTE on average across the year. - Agency, bank costs and temporary staffing costs were significantly above target levels. This is 2nd month in which the Trust has exceeded plan. The need to reduce bank/ agency and temporary staffing costs needs to be addressed by the Trust Reset programme as a matter of priority. - DSF funding is now paid on a quarterly basis in arrears. Both performance and NHSE agreed financial targets are expected to be delivered in order to earn DSF. - Cash reduced to £18.9m and is adverse to plan by £8.1m mainly due to not yet having received DSF relating to Q4 2025/26 and Q1 2026/27. - Capital spend was £0.5m in the year-to-date against a plan of £2.3m. - The Committee assigned Moderate Assurance given that the Trust is only in Month 2. Significant progress will need to be made against the financial plan before a change in the level of assurance can be made.	Operational Delivery Plans for Elective, Urgent and Emergency Care, Diagnostics and Cancer 2026/27 - The Finance and Performance Committee received the 2026/27 Operational Delivery Plans for Elective, Urgent and Emergency Care, Diagnostics and Cancer - The plans have been 'operationalised' with operational ownership in place and monthly trajectories which are aligned to the medium term plan submission and Reset Programme.

Operational Performance – May 2026 Emergency Care: • 4-hour performance was 71.1%, 4.9% off plan and a deterioration compared to last month, however, demand for Accident & Emergency services remains above plan. • 12-hour performance deteriorated compared to last month but remains above plan. • Deterioration in 4-hour performance is driven by underperformance at DRI in both admitted and non-admitted pathways. Action plans are in place to address the under-performance. Elective Care: • Trust performance for percentage of patients waiting less than 18 weeks from referral to treatment improved slightly month on month with 62.6% against a target of 64.8%. • Over 52 week waits - 2.5% of patients were waiting <52 weeks against the trajectory of 0.83%. • The most significant risk to >18 week & 52-week performance targets is in Trauma and Orthopaedics (T&O). Significant improvements are required in T&O for the Trust to deliver 18-week and 52-week planned performance. The Trauma and Orthopaedics recovery plan will be presented to the Committee in July. • The Trust remains in Tier 2 for elective care. Cancer: • The 31- and 62-day Cancer standards were all delivered ahead of plan and the Trust benchmarked well against other Trusts. • There was a significant fall in the 28 Day Faster Diagnosis Standard compared to last month. Performance was 69.9%, against the plan of 81.2%. Performance deterioration was largely attributable to the Breast pathway due to insufficient capacity for one-stop clinics. This has now been resolved and performance is forecast to improve within two months. • Following review and discussion, the Committee assigned Moderate Assurance.	
Substantial, Significant, Assurances	Decisions Made
Health & Safety Bi-Annual Report 2025/26 • The F&P Committee received the biannual update on Health and Safety (H&S) Management at DBTH covering the period October 2025 to March 2026. • It was noted that most KPI's confirmed stable or improving performance, validated by assurance mechanisms such as RoSPA, PAM and NHS Workplace standards. Where weaknesses have been identified action plans are in place or being developed. • Improved triangulation with the results of the Annual Staff Survey is being developed. • The Trust retained of RoSPA (Royal Society for the Prevention of Accidents) Gold Accreditation for a second consecutive year (April 2026). The Trust continues to progress towards ISO45001 accreditation. • Incident data over the six-month period continues to demonstrate a predominantly low-	Deficit Support Funding (DSF) – Q1 2026 – NHSE Return • The F&P Committee received the draft NHSE Quarterly Assurance Statement for consideration. After review/discussion the return was approved for signing by the Chair and Chief Executive Officer • Not all parts of the return were fully compliant. It is not known what the impact on DSF payment due for Q1 will be at this time. Board Assurance Framework – BAF Risks 3 & 7 • BAF Risk 3 - Demand, Capacity & Flow and BAF Risk 7 - Digital & Cyber were reviewed with updates having been made to wording, key controls, progress, and mitigating actions.

harm profile, remaining within expected control limits. Following review and discussion the F&P Committee assigned Significant Assurance. Continued progress/improvement will need to be maintained to ensure that this level of assurance is maintained.	Following review, the updated BAF risks were commended to the Board for review and approval.
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Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2607 - H2 CHAIR'S ASSURANCE LOG - QUALITY COMMITTEE

● Discussion Item

👤 Jo Gander, Non-executive Director

🕒 11:50

5 Minutes

REFERENCES

Only PDFs are attached

📄 H2 - Chair's Assurance Log - Quality Committee - 4 June 2026.pdf

Quality Committee Meeting - Chair's Highlight Report to Trust Board

Subject:	Quality Committee meeting	Board Date: 7 July 2026
Prepared By:	Jo Gander, Chair Quality Committee	
Approved By:	Quality & Effectiveness Committee Members	
Presented By:	Jo Gander, Committee, Chair Quality Committee	
Purpose	The paper summaries the key highlights from the Quality Committee meeting held on 4 June 2026	

Matters of Concern (Moderate , Limited or Weak)	Work / Major actions commissions
- Clinical Audit progress Report – continue to be an outlier for National Early Arthritis Audit (NEIAA) due to timing to first appointment and follow up and National Emergency Laparotomy Audit (NELA) due to data entry capacity challenges. However previously DBTH was not providing audit data for these two audits but now has plans to make progress on position. Obstetrics and Gynaecology and Paediatrics specialities are meeting Clinical Audit delivery expectations with Paediatrics being the main challenge leading to a Moderate Assurance being agreed by the committee. Moderate Assurance - Getting It Right First Time reporting still in development accounting for the current level of assurance. Moderate Assurance - Deep Dive Sepsis Management mortality data showing reduction giving confidence that current action plan on the right trajectory. Moderate Assurance	None to report

Substantial, Significant or Assurances to Provide	Decisions Made
- Maternity & Neonatal Safety report received giving significant assurance against the Perinatal Mortality Review Tool (PMRT) Report Q4, Single Delivery Plan (SDP) Final Report, Saving Babies Lives v3 (SBLv3) Local Maternity Neonatal System (LMNS) Assured position, Avoiding Term Admissions into Neonatal (ATAIN) units Q4 report and Trust Quality metrics. Significant Assurance - Single Delivery Plan update demonstrated that the vast majority of Single delivery Plan actions are now completed and embedded. The only outstanding action is the single workforce deliverable which is expected to be completed in Q2. Substantial Assurance	Quality Committee as a committee of the Trust Board took assurance from the detail provided within the Maternity & Neonatal Safety & Quality report and recorded in the Committee minutes to provide evidence for the Maternity Incentive Scheme the following; - Reviewed and approved on behalf of the Trust Board progress updates on SDP, CNST - Reviewed and approved on behalf of the Trust Board Q4 ATAIN - Reviewed and approved on behalf of the Trust Board SBLv3 - 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

- Patient Experience Report including Picker inpatient survey results
Significant Assurance
- CQC action plan for DRI Emergency Department and ongoing Governance arrangements.
Significant Assurance
- Patient Safety report inc. Martha's Rule implementation received 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
- Quality of Care trends via review of IQPR metrics.
Significant Assurance
- Learning from Deaths – evidenced that controls are largely effective with isolated weaknesses. Targeted actions in place to close gaps with clear timelines and accountability for delivery.
Significant Assurance
- Board Assurance Framework (BAF) 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 July 26.
Significant Assurance

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 Maternity Outcomes Signal System (MOSS) update
- Declared date of mid year compliance as August 2026 unless impacted by planned industrial action.
- Trust Quality Accounts approved on behalf of the Board.

Assurance ratings and descriptors

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2607 - H3 CHAIR'S ASSURANCE LOG - PEOPLE COMMITTEE

● Discussion Item

👤 Lucy Nickson, Non-executive Director

🕒 11:55

5 minutes

REFERENCES

Only PDFs are attached

📄 H3 - Chair's Assurance Log - People Committee.pdf

People Committee - Chair's Highlight Report to Trust Board		
Subject:	People Committee	Board Date: 7 July 2026
Prepared By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Approved By:	People Committee Members	
Presented By:	Lucy Nickson, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the People Committee meeting held on Tuesday 16 June 2026	
Matters of Concern (<i>Moderate, Limited, or Weak Assurance</i>)		Work Underway / Major actions commissions
There were two areas of split assurance showing moderate and significant due to the complexity of the issues and gaps in controls or partial stage of action plan implementation/wider context and pressures. See below for: - Violence Prevention Standards Report - Just Culture Report Workforce Supply and Demand Advanced Practitioner Workforce – <i>Moderate Assurance</i> The Committee received an update on progress against the Trust's three-year medium term plan submission, outlining the planned whole-time equivalent (WTE) reductions, with particular focus on year one. Overview of the workstreams and the identified additional resources allocated to support delivery of the workforce plans is clearly set out. The committee also heard about progress being made in relation to the Trust's sickness absence rates, and actions being taken to support a reduction of sickness absence rates. Appropriate governance and oversight mechanisms are in place to support delivery of the three-year plan - within the overall Reset Programme but the size and scale of the financial requirements of the plan are significant and, at this stage in the year, there are varying degrees of confidence in relation to the robustness and timelines of some of the plans to achieve the required pay cost and WTE reduction. Work continues at pace to further develop plans with Executive oversight. The sickness reduction plan remains on track, and the Trust has been highlighted as an		

example of good practice by NHSE.

Bi-annual Allied Health Professionals Workforce Review – *Moderate Assurance*

The Committee received an overview of Allied Health Professional (AHP) workforce capacity, safe staffing and sustainability across Therapies and Radiology. Workforce controls are established and there is evidence of improvement in vacancy levels, reduced reliance on temporary workforce and development of recruitment pipelines and skill mix reviews.

However, there are persistent workforce risks, identified establishment gaps and ongoing gaps between capacity and demand in some areas. Key workforce risks remain within children's and adult speech and language therapy, neurorehabilitation, and the core Radiology workforce, where vacancy pressure, limited specialist supply and identified establishment gaps continue to present a risk to service resilience. There have been improvements since last reporting with vacancy levels in Therapies remaining below the reported national benchmark, and dependency on temporary staffing reducing across both Therapies and Radiology through targeted recruitment, apprenticeship routes, and workforce pipeline development. There is a clear plan for continued improvement for the next six months, especially around vulnerable professions.

Substantial or Significant Assurances

Engagement and Leadership – *Significant Assurance*

Under the Culture and Leadership pillar there are four schemes, Behaviours and accountability, Leadership development and management capability, Colleague engagement and leadership visibility, Learning culture, and civility. The People Committee took significant assurance that the Culture and Leadership programme has been developed from external reviews and triangulation with other workstreams, data and metrics, and that appropriate governance is in place to ensure oversight of progress against actions. The assurance on delivery of actions and impact on outcomes will be assessed and felt later in 2026/27 and beyond via interim measures and future survey results. The work needs time to embed and impact, given its complexity. In taking assurance the committee was able to have a thorough conversation about this work, its relationship to other parts of the People Plan and wider strategy.

Decisions Made

Future reporting to the Board was explored and then agreed out of People Committee in conjunction with the Committee Chair, Lead FTSU Guardian, the Chief People Officer and the Chief Nurse.

Education Report - *Significant Assurance*

SET compliance for the end of April was 85.32% which is reflective of the changes to IPC training requirements and the recovery from the winter workforce pressures. This remains below the 90% target. A draft report from a recent external audit has been received and the action plan is being finalised with 360. DBTH continues to align with the national NHSE MandStat reform taking us from competency to outcome focused statutory training.

The committee was updated on detail regarding the national transformation of the apprenticeship levy to the national growth and skills levy - with an outline of oversight on impact and consideration of alternative plans. A timetable of planned external activity for DBTH education quality was also shared.

Violence and Prevention Standards (VPS) Report – Split Assurance *Significant / Moderate Assurance*

The Committee took significant assurance in relation to established processes in place to oversee and support VPS but agreed partial assurance for the standard and associated workplan, pending further implementation. Robust governance, performance management, and oversight arrangements are in place - supported by evidence of stable or improving performance.

Clear processes within Urgent and Emergency Care (UEC) enable the consistent sharing of security reports and the completion of Datix incidents where security support is required directly. This is strengthening organisational visibility and supporting effective risk response. Areas requiring improvement are recognised and understood, with active VPR action plans in place to address these.

Just Culture Report – Split Assurance *Significant / Moderate Assurance*

Recent activity has seen the 'Speaking Up' peer review being shared, an 'Avoiding Harm' action plan (in relation to conduct investigations) being developed. Mapping the Just Culture workstream and actions with the wider Culture and Leadership programme to ensure alignment is imminent. The committee heard about employee relations casework data from April 2025 to March 2026. Analysis of the data shows a significant increase in casework activity for the same period in 2024/25 (36%), with most of this increase being linked to sickness absence cases. The impact of this increase in casework is significant in terms of capacity to deal with it and timescales for resolutions with subsequent potential impact. The Committee took significant assurance that actions around embedding the Just Culture workstream are being delivered but took moderate assurance on the

significant year-on-year increase in the casework data and demands on the capacity of the people involved, as well as the wider context and strategic challenges of the three-year plan.

Annual Equality Diversity & Inclusion (EDI) Report – Significant Assurance

As of January 2026, 91% of actions from the previous plan (December 2025) had been completed within timescales. Remaining actions are incorporated into the 2026–2027 programme and were featured in the annual report. EDI remains a continuous priority and significant progress has been made in embedding EDI into core organisational governance and culture. Board-level accountability has strengthened through measurable EDI objectives, while inclusive recruitment initiatives are improving workforce diversity and pipeline development. The Committee was asked to take significant assurance that a robust level of scrutiny and oversight has been applied over the past year to evaluate the impact and effectiveness of the Plan given the measurement of metrics, data, feedback and surveys, external accreditation, and internal audit.

Workforce Race Equality Standards (WRES) & Workforce Disability Equality Standards (WDES) 2025-2026 – Significant Assurance

The Committee noted the information provided in the report and that the data was submitted in line with the national deadline of 31 May 2026. The submission should be read in conjunction with the Equality, Diversity & Inclusion annual report. A report on the WRES and WDES data will also be presented to Board in July 2026 for information.

Speaking Up (FTSU) Annual Report 2025-26 – Significant Assurance

The Committee took significant assurance that FTSU Guardian service systems and processes are working effectively based on feedback and external peer review and that they are in line with national guidance and best practice. It is recognised that there are differing perceptions about detriment associated with speaking up. However, committee is assured that appropriate mitigations are in place to prevent negative impact.

The report also discusses the key national changes to Speaking Up and subsequent impact at Trust level. FTSU Guardian Services will transition from National Guardian's Office (NGO) to NHS England - responsibilities of the NGO will transfer to NHSE from 1 July 2026. There will be no National Guardian Role going forward but integrated directly into existing NHSE FTSU Structures. NHSE will not be

responsible for monitoring contract and best practice compliance of FTSU – this will be considered by the CQC as part of their well-led inspection process. Locally, at Trust level, the committee is assured that all practice is aligned to wider work regarding engagement, leadership, and culture.

Organisational Development Annual Report 2025-26 – Significant Assurance

The Annual Report outlines comprehensive activity during 2025/26 aimed at enabling colleagues to thrive and strengthening an inclusive, compassionate culture aligned to the Trust's strategic priorities with many notable achievements and successes. However, data from the NHS Staff Survey results highlights challenges in equitable access to development opportunities, particularly for those in clinical roles, alongside limitations in demonstrating measurable organisational impact from some legacy programmes. In response, activities will be refocussed to ensure scalable, evidence-based interventions aligned to the Reset Programme's Culture and Leadership Pillar. Looking ahead, priorities include increasing accessibility, strengthening evaluation, and delivering targeted leadership development that supports improved culture, engagement, and workforce outcomes.

Bi-Monthly Safe Staffing Update Significant Assurance

The report outlined the current nursing and midwifery staffing position, associated risks, and mitigating actions in place. While daily staffing reviews, escalation processes, and use of temporary workforce arrangements have maintained patient safety and no significant harm events were reported, sustained pressure across emergency pathways continued to present an operational risk during this reporting period. Ongoing monitoring and executive oversight through bi-monthly reporting to the People Committee remain essential to ensure staffing resilience and patient safety.

Midwifery Workforce Paper Significant Assurance

The Committee took significant assurance from the report on the effectiveness of the controls, oversight, and workforce planning arrangements in place to support safe midwifery staffing, whilst noting the ongoing mitigated risks relating to sickness absence, temporary staffing and fluctuating clinical acuity. Controls include Birthrate Plus-informed workforce planning, Executive-approved establishment, a positive workforce position, twice daily staffing and acuity review, live red flag monitoring, clear escalation arrangements, planned supernumerary labour ward co-ordinator cover and 24/7 senior management support. The report provides evidence that these controls are operating effectively, including 100%

reported compliance with one-to-one care in labour and 100% planned coordinator cover across the reporting period.

The principal ongoing risk relates to high sickness absence and periods of fluctuating clinical acuity; however, these risks are recognised, actively managed and mitigated through temporary workforce deployment, redeployment of specialist staff, real-time operational oversight, and established escalation processes.

Healthcare Science Biannual workforce review – *Significant Assurance*

The committee was pleased and assured to receive the first Biannual workforce review paper for HCSs, recognising that reporting will evolve. A coordinated approach is being taken to strengthen the sustainability of the Healthcare Science workforce at DBTH, including:

- Prioritising recruitment to key pressure areas, particularly Audiology.
- Expand training routes & develop clear progression pathways for long-term sustainability.
- Develop targeted retention initiatives addressing pay, progression, and flexible working to reduce turnover.
- Establish a sustainable approach to CPD funding and protected development time.
- Strengthen Medical Technical Workforce through development pathways and increased in-house capability to reduce reliance on outsourcing.
- Improve data quality, particularly exit data, to better understand drivers of attrition.
- Review capacity, workload, and service demand to address staff wellbeing and ensure safe staffing levels.
- Implement structured succession planning for senior and specialist roles.
- Support services to progress towards national accreditation standards to ensure quality and consistency.

Resident Doctors 10-Point Plan – *Significant Assurance*

Since the previous update, the Trust has continued to make progress in delivering NHS England's 10-Point Plan to improve the working lives of resident doctors. Current assessment indicates that the majority of domains are rated compliant, with remaining areas either partially compliant or dependent on evolving national guidance. Improvement plans are in place for all identified gaps and are subject to regular review through the Improving Resident Doctors Working Lives Group, with

escalation to People Committee providing clear oversight and accountability. Leadership and engagement arrangements have been further strengthened with a Non-Executive Director (People Committee Chair) now in place to enhance Board level visibility and assurance. Dr Nick Mallaband, Chief Medical Officer, is the Executive Board lead and there is a Resident Doctor Peer Lead (Dr Vaibhav Sundaresan). Early outputs from peer-led engagement work, including the resident doctor survey, are informing local priorities and helping to triangulate assurance against the BAF.

Board Assurance Framework (BAF)- Significant Assurance

The 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 continue to be articulated in the BAF. The committee held a good discussion around all of the evidence presented in the risk report and was satisfied the committee business was appropriately relevant to and aligned with the articulated risks and controls.

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2607 - H4 CHAIR'S ASSURANCE LOG & COMMITTEE ANNAL REPORT - AUDIT & RISK COMMITTEE

● Discussion Item

👤 Kath Smart, Non-executive Director

🕒 12:00

5 minutes

REFERENCES

Only PDFs are attached



H4 - Chair's Assurance Log - Audit & Risk Committee - 23 June 2026.pdf

Audi & Risk Committee (ARC) - Chair's Highlight Report to Trust Board

Subject:	ARC Extraordinary Meeting	Board Date: 7 July 2026
Prepared By:	Kath Smart, Committee Chair & Non-Executive Director	
Approved By:	ARC Committee Members	
Presented By:	Kath Smart, Committee Chair & Non-Executive Director	
Purpose	The paper summarises the key highlights from the Audit & Risk Committee meeting held on 23 June 2026	
Matters of Concern (<i>Moderate, Limited, or Weak Assurance</i>)		Work Underway / Major actions commissions
a) Internal Audit Reports i. Head of Internal Audit Opinion – The opinion for 25/26 is yet to be finalised with the full opinion to be included in the Annual Report; It was recognised there were a few factual accuracy points that required correction. ii. Patient Flow Audit – This review concluded a “<i>Limited</i>” assurance” opinion with two medium risk recommendations. ARC will follow up on implementation of recommendations prior to their end date and Internal Audit will independently verify recommendation implementation.		a) ARC approved the following i)-iii), subject to receipt of a satisfactory and complete ISA 260 from External Audit, in which case delegated to the CEO; CFO and ARC Chair as required to sign appropriately – i) Annual Report & Annual Governance Statement; and the ii) Annual Accounts & Financial Statements and iii) Letter of Representation b) External Audit Results Report - ISA 260 from EY – The external audit work had not yet fully completed, with a small number of outstanding areas, most notably the VFM opinion. At the time of the meeting, it was indicated that the Trust will be unable to fully file a complete set of accounts without the ISA 260 being completed. A verbal update will be provided to Board. However, key messages included: - - At this point there was one uncorrected misstatement in relation to the current years audit; - There were 4 corrected misstatements; - Minor change had been required to the Remuneration report - Work carried out on Fraud risks 1-3 has resulted in no issues to bring to the attention of ARC - New ISA 260 Control Management Actions (2 moderate) reviewed by CFO and are agreed; - Follow-up of previous years recommendations (6) shows 3 areas for further action, 3 being satisfactorily completed - VFM – The VFM conclusion is not yet available - AGS – EY confirmed that the AGS is consistent with other information

	from their audit and have no other matters to report IX. Post audit de-brief to be held between Finance Team and EY and reported to a future ARC
<i>Substantial, Significant, Assurances</i>	Decisions Made
a) Internal Audit :- i. Audit Recommendations closure rate for high & medium risks -96 % (27/28) which is very positive & evidence of continual improvement; ii. SET Audit Report – <i>Significant Assurance</i> – This was a review of a key workforce system and audited the effectiveness of the Trust arrangements for Statutory and Essential Training. Two medium risk findings have been agreed. b) ARC Annual Report – This report detailed ARC’s activities during the year designed to fulfil its Terms of Reference and deliver the workplan.	a) DBTH Annual Report and Annual Governance Statement – This was approved by the Audit Committee, subject to receipt of a satisfactory External Audit ISA 260 and some minor amendments to the final HoIA Opinion b) DBTH Annual Accounts and Financial Statements – This was approved by the Audit Committee, subject to receipt of a satisfactory External Audit ISA 260 c) The Letters of Representation required from the Trust to the External Auditors were approved subject to receipt of a satisfactory External Audit ISA 260 d) ARC Annual Report – This was approved, albeit still in draft as the final conclusion from EY was not yet available.

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

2607 - H5 GOVERNANCE DOCUMENT REVIEW

● Decision Item

👤 Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

- Governance Manual
- Trust Risk Appetite
- Board Committee Terms of Reference
- Executive Team Term of Reference

10 Minutes

REFERENCES

Only PDFs are attached



H5 - Governance Documents Review.pdf



H5 - Appendix 1 - Corporate Governance Manual V3.pdf



H5 - Appendix 2 - Board and Committee Cover Sheet.pdf



H5 - Appendix 3 - ToR Board Committees.pdf



H5 - Appendix 4 - Executive Team ToR.pdf

Report Template																	
Meeting Title:	Board of Directors		Meeting Date:	7 July 2026													
Report Title/ Ref:	Governance Documents Review: Risk Appetite, Assurance framework, ToR etc.																
Executive Sponsor:	Zara Jones, Acting Chief Executive																
Authors:	Rebecca Allen, Associate Director Strategy, Partnerships and Governance																
Appendices:	Appendix 1: Corporate Governance Manual Appendix 2: Committee cover sheet Appendix 3: Board Committee Terms of Reference updated Appendix 4: Executive Team Terms of Reference updated																
Purpose of the report	Assurance	Decision	Information	Discussion													
Impacts on Strategic Risks (BAF 1-7)	All BAF risks are positively impacted by governance improvements																
For decision papers only: Is this in line with Current risk appetite YES	Highlight only where this report is outside of the Board Risk Appetite and a decision is requested <table border="1"> <thead> <tr> <th>None</th> <th>Minimal</th> <th>Cautious</th> <th>Open</th> <th>Seek</th> <th>Significant</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>Regulatory Quality</td> <td>Finance</td> <td>People</td> <td></td> </tr> </tbody> </table>					None	Minimal	Cautious	Open	Seek	Significant			Regulatory Quality	Finance	People	
None	Minimal	Cautious	Open	Seek	Significant												
		Regulatory Quality	Finance	People													
Executive Summary – Key messages and Issues																	
Purpose This report sets out the information for the Board of Directors to agree the usual updates as part of the boards annual governance cycle and additionally include the improvements suggestions made by external governance reviews. Background The trust continues to strengthen its governance arrangements across the Trust, using the tools and frameworks available to further embed good governance practice. There has been a series of board development sessions that have reviewed governance arrangements, hearing from external partners in order to learn and improve. Some of those decisions taken within these sessions are presented at the Board of Directors in line with the Standing Orders for the Practice and Procedure of the Board, Annex 8, paragraph 5.1.9, for final approval. These points for agreement include: 1. Corporate Governance Manual 2. The Trusts Risk appetite statements. 3. Alignment of the assurance ratings, together with the statements that demonstrate this 4. Update to the coversheet to more explicitly draw out the assurance requirements within the reporting. 5. Terms of reference for the board committees updated to include explicit requirements for the medium-term plan and reporting requirements. 1. Corporate Governance Manual The DBTH corporate governance manual collates the Trust's key governance documents, their use and the arrangements in place for board and committees. This is provided as an accompanying document that supports colleagues to understand how the Trust is directed and controlled, how decisions are made and how accountability and probity are maintained. It strengthens our governance by providing clarity and consistency, describing in practical terms, the framework in which the Trust operates. The framework is supported and enforced by legislation and regulatory requirements, and ensures the Trust Board has effective oversight, a																	

system of sound internal control, with timely escalation of risks and issues. This sets the governance direction for all working at DBTH and is the responsibility of all colleagues to uphold these expectations. This is shown in Appendix 1.

2. Risk Appetite statements

Background

The Board Development Session on 14 April 2026, invited our Internal Auditors to facilitate the discussion on risk appetite for the Board. This discussion developed the themes that had supported the Board over the 2025-26 financial year and focussed on the requirements needed for 2026-27.

The board considered the nature and extent of the principal risks it was willing to take to achieve its strategic priorities (its 'risk appetite') and for maintaining sound risk management and internal control systems.

The consensus in the room was to remain with the Good Governance Institute Framework, centred around the 4 areas of quality, regulatory, people and financial. There was a detailed discussion on inclusion of a risk appetite statement for Trust Reputation. It was agreed that reputational impact on the Trust in respect to the decisions of the Board, formed part of the overall process, but reputation in itself was not a contributory factor that outweighed the other factors in decision-making considerations.

General Principles

Methods of controlling risks must be balanced against the resources associated with their mitigation. The Trust may accept some high risks because of the cost of controlling them is too high or not possible, or to deliver transformation or use resources creatively when this may achieve substantial benefit. As a general principle the Trust has a low tolerance for, and will therefore seek to control, all risks which have the potential to:

- Expose patients, colleagues, visitors and other stakeholders to harm
- Compromise the Trust's ability to deliver operational services
- Have severe financial consequences which may impact on the Trust's future viability
- Cause non-compliance with the law and statutory obligations

Wider NHS Context

In setting the DBTH risk appetite statements, there was consideration of the environment the Trust is working in, and the changes that will be required for the delivery of the medium-term plan. This means that in 2026-27, DBTH is operating within a context of significant organisational, workforce and system transformation coupled with resource constraints and increasing demand.

Risk Appetite levels

The risk appetite levels and their mean are referenced below:

Risk Levels (Consequence)	Description	DBTH	Appetite score	Approximate Risk targets (in context)
Avoid	Avoidance of risk is a key organisational objective		None (0)	0
Minimal	A preference for ultra-safe delivery options that have a low degree of inherent risk and only a limited reward potential		Low (1)	1 -5
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited potential for reward	Regulatory Quality	Moderate (2)	5 - 10
Open	Willing to consider all potential delivery options, while also providing an acceptable level of reward and value for money	Finance	High (3)	10 -15

Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk	People	Significant (4)	15 -20
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.		Substantial (5)	20 - 25

When considering decisions across the Trust and at all levels, these risk appetite ratings should be considered and included within the decision making. There is a placeholder for these on the Board and Committee coversheet for when a decision is required. In setting target risk scores for any identified risks across the Trust, then the risk appetite should be considered when setting target risk scores, to support a proportionate response and associated actions are assigned to all risks.

Risk Appetite Statements

The statements were discussed at length and facilitated by internal audit, resulting in the following proposed risk appetite statements based on the Good Governance Institute Guide.

Quality: Cautious (2)

DBTH defines its quality as 'safe effective and caring' and our preference is for risk avoidance. The Board has a cautious appetite for risk in relation to quality. We will accept a limited level of risk where it is necessary to deliver services, improve outcomes, or implement evidence-based change, and where risks are clearly understood, robustly controlled, and subject to clear clinical and managerial oversight. We have little tolerance for risks that could result in avoidable harm, sustained deterioration in care quality, or loss of public confidence, recognising that failures in quality and safety carry significant reputational consequences and can undermine trust in the organisation.

Regulatory: Cautious (2)

The Board has a cautious appetite for regulatory risk, reflecting our responsibility to operate within statutory, constitutional, and regulatory requirements. We will accept limited and time-bound regulatory risk where there is strong justification, transparency with regulators, and a credible plan to return to compliance. We will consider the impact of those risks that could damage the organisation's standing with regulators, Governors, partners, or the public, recognising that regulatory non-compliance can quickly translate into enduring reputational harm and loss of system confidence.

Financial: Open (3)

The Board has an open appetite for financial risk where this supports the achievement of strategic objectives, long-term sustainability, and transformation of services. We are willing to invest, transform and pursue innovative approaches that carry short- to medium-term financial risk, provided there is a clear strategic rationale, defined limits, and appropriate financial controls. We will, however, avoid unmanaged financial risks that would compromise organisational credibility, public assurance, or confidence in our stewardship of public funds, recognising the reputational impact of financial instability or poor financial governance.

People: Seek (4)

The Board has a risk-seeking appetite in relation to people and workforce transformation, recognising that meaningful improvement in culture, capability, inclusion, and retention requires innovation, change, and a willingness to challenge established ways of working. We are prepared to actively pursue opportunities that carry risk where they support a healthy, engaged, and sustainable workforce. We will consider the impact of those risks that could damage our reputation as a fair, inclusive, and ethical employer, including poor culture, discrimination, or failures to act on colleague concerns, acknowledging the direct link between workforce experience, organisational reputation, and quality of care.

3. Assurance ratings

As part of the risk discussion, the board also discussed the assurance levels of actions and the levels of assurance that were used. The current 4 risk ratings were used by our internal Audit partners 360 Assurance until late 2023 when a new 5 risk rating was applied. Since that time, the Trust has continued with the 4 levels of assurance ratings, however it was considered that it would be appropriate to update the ratings, in line with the Internal Audit and also to provide greater clarity on the levels, to support triangulation with other information and clearly articulating the requirements and differences between those levels.

At the Board Development Session on the 2 June 2026 the board was asked to consider aligning its assurance framework to that outlined below, which also aligns with the internal Audit provider for the trust. Expanding the description to support with a consistent and open approach to assurance across all committees, the following levels and descriptions were agreed:

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
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Next Steps

These risk appetite statements and scores provide the reference point against which to benchmark risk management reviews and risk mitigation activity within the Trust. The risk appetite defines the boundaries within which risk-based decision-making can occur and outlines the expectations for the operation of the Trusts control environment.

The assurance framework enables the Board to assess the level of confidence in the risk mitigations, actions taken and delivery expectations, from the evidence presented, through a triangulated approach to risk management.

These Risk statements will be included in the Risk Management policy and shared more widely across the organisation to ensure these are embedded into operational practice and evidenced form the information that flows through to the committees and board.

4. Update to the coversheet

Updates on the cover sheet have been suggested to be more explicit on the assurance rating and understanding so that this is a focus of discussion within the committee, and its members are clear on the logic and reasoning behind the rating. The suggested coversheet is given in Appendix 2. It is based on the previous cover sheet, with suggestions from external governance review and will further strengthen and support the triangulation of information, and consistency of assurance throughout the Trust. The cover sheet includes guidance for report authors, and the relevant executive sponsor will ensure the templates completion before these are submitted for committee and Board review.

5. Terms of reference for the board committees

As part of the annual governance cycle, the Terms of reference for the board committees have been reviewed and updated to include explicit requirements for the medium-term plan within each of the relevant committees. The delivery of this is through the Reset Programme which is articulated within the updated ToR. In addition, this focusses on the requirement for triangulated information and assurance on the sources of the evidence provided. To note, the Audit and Risk Committee ToR are aligned to the HFMA model ToR and as part of their risk and governance oversight, would receive any issues via the individual committee chairs as is the expected arrangement for controls. The Terms of Reference are provided in Appendix 3.

6. Terms of reference for the Executive Team Meeting

The Terms of Reference for the executive team are approved by the Board of Directors, as the Board is the body that establishes this group, delegates authority to it, and retains overall accountability for the Trusts governance arrangements. These were reviewed as part of the governance cycle by the executive team, with the key updates being those made to the reporting groups, which reflects the changes made within the Trusts leadership structures. These are given in Appendix 4.

Recommendations

The board is asked to formally ratify the decisions taken at the board development session on 2 June 2026, in line with its Standing Orders, on:

- The Trusts Risk appetite statements
- Alignment of the assurance ratings, together with the statements that demonstrate this
- Update to the coversheet to more explicitly draw out the assurance requirements within the report
- Note the production of the Corporate Governance Manual for trust wide use. (Appendix 1)
- Terms of reference for the board committees updated to include explicit requirements for Reset programme which will deliver the medium-term plan (Appendix 3)
- Plus, the updated Terms of Reference for the executive Team meeting (Appendix 4)

Healthier together – delivering exceptional care for all

Patients	The risk appetite for quality remains at cautious which aligns to the statutory responsibility to deliver safe & effective quality care to patients.
People	The appetite for People is risk Seeking, which supports greater innovation and transformation, but only within the constraints of regulatory and statutory requirements.
Partnerships	The appetite for People is risk Seek, which includes those relationships with our partner organisations, and recognises that innovation and transformation should be actively embraced within the constraints of regulatory and statutory duties.
Pounds	The risk appetite for Finance remains at open, which supports greater transformation and risk, recognising that only by doing things differently will financial sustainability become possible.

Health Inequalities	The risk appetite statements and framework do not have a positive or negative impact on health inequalities
Legal/ Regulation:	The risk appetite for regulatory remains at cautious which aligns to the statutory responsibility of the Trust in all areas in which it operates.
Partner ICB strategies	The risk appetite statements and framework do not have a positive or negative impact on partner ICB strategies.
Assurance Route	
Previously considered by - including date:	Board Development Session 14 April 2026, facilitated by 360 Assurance Email correspondence 21 April 2026 for final feedback Email correspondence 18/05/2026 Board development session 2 June 2026 Email correspondence 4 June 2026
Any outcomes/next steps / time scales	Shared in the public board pack in July 2026 Implementation across the Trust



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



Corporate Governance Manual

Doncaster and Bassetlaw Teaching Hospitals



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Introduction

Corporate Governance in Foundation Trusts

Corporate governance is the system by which an organisation is directed and controlled at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability and probity. Corporate governance is largely about how the Board conducts its business and is separate from day-to-day operational management carried out by the executive directors and senior management team.

Fundamental to this is having the means to verify the effectiveness of strategic direction and control achieved through independent review and assurance.

Corporate governance is underpinned by statute, as are the roles of executive directors and non-executive directors who have legal duties and accountability collectively as the board and individually as directors under the NHS Act 2006.

Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust Board (DBTH) is a statutory NHS Body with those functions and duties conferred to it as set out within the Health and Care Act 2022. DBTH is an NHS Foundation Trust, which means it is a public benefit corporation as constituted under the NHS Act 2006. The Trust is part of two Integrated Care Systems (ICS), Nottingham and Nottinghamshire ICS and South Yorkshire and Bassetlaw ICS. It covers a diverse geographical and demographic area.

The DBTH vision is to be Healthier Together - Delivering Exceptional Care for All which it delivers through its strategy. This vision guides the direction of the Trust and reflects the ambition to deliver the very best outcomes for patients, while ensuring colleagues feel supported, respected and empowered. The priority statements are directly linked to the strategy and ensure continual focus on what matters most:

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

The board delegates delivery of the strategy to the executive team and takes assurance on its delivery through the board committees. Assurance on delivery of the strategy includes that it is being delivered in line with the DBTH values, the NHS Constitution and that the organisation is compliant with the NHS England frameworks regarding culture, risk management and quality of care.

Good governance is important as it underpins the delivery of safe, effective and sustainable healthcare services. Good governance is a duty of everyone working within DBTH and ensures that the Trust is well-run, accountable and effective. It is founded on the values of the Trust and keeps patients and people safe by clarifying roles and responsibilities for professional decision-making and ensures the Trust is responsive and able to learn quickly.

A mature governance culture is more than regulatory compliance, it supports our people to pro-actively drive quality care.



The Corporate Governance Manual

The DBTH Corporate Governance Manual sets out our corporate governance structures and arrangements. It incorporates the key governance documents that, in conjunction with key legislation, form the framework the Trust operates within.

Legal and Regulatory Context

NHS Foundation Trusts (FT) were created as legal entities in the form of public benefit corporations by the National Health Service Act 2006. DBTH became a foundation trust on 1 April 2004. In order to operate within the framework of this legislation, it has a number of statutory documents that form the cornerstones of its governance framework and set out exactly how it will operate, how it makes decisions and where those decisions are made. At the current time, the primary legislation is under review, with changes expected in April 2027, however, the below narrative describes the current legal and regulatory context.

The NHS statutory and regulatory duties are outlined in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and Health and Care Act 2022 and provides the legal duties of all NHS providers. These collectively promote a comprehensive health service, in a way that underpins its principles, tackles health inequalities, supports its staff and patients and uses resources efficiently within its revenue and capital limits and upholds the values of those in public office (Nolan Principles) in addition to the DBTH Way.

The key governance documents that are utilised by DBTH are:

The Trust Constitution (including Standing Orders for practice and procedures of the Board of Directors and the Council of Governors). This document aligns to the national standards setting out exactly how the corporate governance of the trust will operate, the committees that exist and the composition of the board of directors and the Council of Governors. The Constitution is owned and approved by both the board of directors and the Council of Governors.

The Standing financial Instructions (SFI's) provide a framework for the financial governance of the Trust. Defining at what level of the trust decisions are made, depending on the financial value of the decision.

Scheme of Reservation and Delegation of Powers of the Board (SoRDs) describe the powers reserved to and delegated by the Board for the various functions that are required in the operation of an NHS provider. These align to the SFI's but include a range of decisions that are not just financial.

These documents together provide a regulatory framework for the business conduct of the Foundation Trust and will support our people to drive forward quality and safety of services by proactively understanding and embedding governance principles into their roles.

Corporate Governance at DBTH

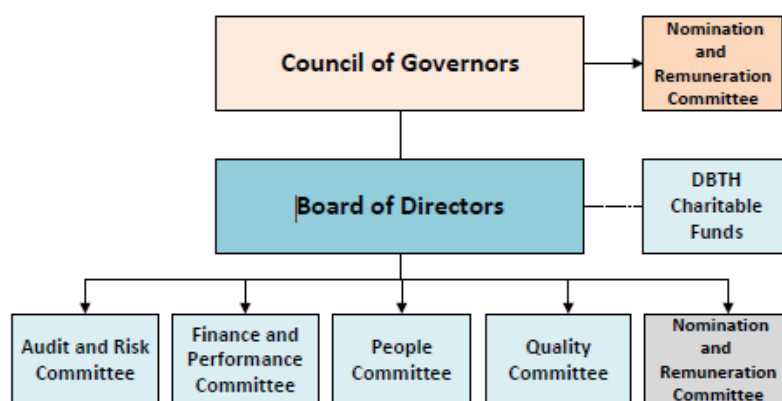
DBTH is governed by a Board of Directors made of executives and non-executive directors, and as a



foundation Trust, also by a Council of Governors. The Board has 5 board assurance committees, and the Council has one.

The DBTH Corporate Structure

Is outlined as in the infographic below:



The Role of Our Board

DBTH operates as a unitary Board, led by the Trust Chair. The board provides strategic leadership within a framework of practical and effective controls that enables risks to be effectively assessed and managed. The composition of the board is set out in line with the provisions in the Trust constitution Section 25.

The function of the board includes allocating resources, financial accountability for the public money it receives and for ensuring the delivery of safe, effective and sustainable care to its population.

For the delivery of this, the DBTH board delegates certain functions and budgets to its committees with the delivery of its strategic aims and objectives to the executive directors. The operational delivery is delegated through the internal governance structures of divisions and corporate teams to ensure the smooth running of the Trust and delivery of the strategy on a day to day basis. Assurance of the operational and strategic delivery is the feedback loop through reporting and the governance structure to the board of directors.

The Trust Chair: They are an appointed non-executive director and not an employee of the Trust. They lead the Board of Directors and the Council of Governors and are responsible for ensuring the effective governance and strategic oversight of the Trust. Their role includes setting the tone of the board culture, leading on accountability, and ensuring compliance with statutory and regulatory requirements of the board by facilitating constructive challenge. Appointment of the Chair requires NHSE approval and the Council of Governors. Each term of office for the chair is for a period of up to 3 years and with a maximum of 2 terms.

The Chief Executive Officer: is the Accounting Officer for the Trust, responsible for the overall management and delivery of services day-to-day and leading the executive team to implement the boards strategy. Under the NHS legislation they must ensure financial stewardship, compliance with the governance standards and adherence to the NHS Constitution. They are answerable to the



external regulators such as the CQC and NHSE for the Trusts performance and integrity and ensuring compliance with the NHS provider licence. Appointment of the CEO requires NHSE approval, plus ratification of the board's decision by the Council of Governors.

Non-executive Directors (NED): These are appointed positions and not employees of the Trust, providing independent oversight and assurance on behalf of the patients and public. They provide an external perspective and challenge to the executive team on delivery of the strategy. Their role is to uphold good governance, support strategic decision-making, hold the CEO and executives to account for the Trusts performance and the management of risk. Appointments of non-executive directors are made by the Council of Governors with each term of office for up to 3 years and a maximum of 2 terms.

Executive Directors are employees of the Trust and members of the Board of Directors. They are responsible for operational leadership and delivery of the Trusts strategy on a day-to day basis. They oversee specific portfolios such as finance, nursing, workforce, medical and operations and are responsible for ensuring compliance with the statutory and quality standards and provider licence requirements. They provide expert advice to the board's decision-making, and the management of risks.

Other key roles within the Trust

The Caldicott Guardian & Senior Information Responsible Officer (SIRO) together with the Data Protection Officer (DPO) are statutory roles with the SIRO held by the Executive Medical Director at DBTH. They are accountable for confidentiality and data protection including the annual Data Security Protection Toolkit (DPST) submission.

The Freedom to Speak Up (FTSU) Guardian and the FTSU function is a key part of the DBTH way in action and supports a transparent and learning culture. There is an appointed Board Member that meets regularly with the FTSU guardian and collectively they ensure the board are sighted on themes and actions to take forward. The FTSU guardian reports directly to the DBTH board regularly on their findings and presents actions that support the learning culture.

The Guardian of Safe Working Hours (GoSWH) is a key medically led role that links in with junior doctors to ensure their working hours are safe, and that there is adequate time allocated to both

their academic learning and clinical practice. This ensures that DBTH are providing a welcoming and safe environment for our doctors to learn and develop. The GoSWH reports directly to the DBTH board regularly on their findings and presents actions that support improvements.

The Board of Directors is a meeting held in public and meets alternate months where it receives information and assurance on the progress of the strategic delivery of the Trust, risks and performance information. The Integrated Quality Performance Report (IQPR) provides information on all aspects of the Performance, workforce, finance and Quality indicators at a Trust wide level. The report is collated from the information and escalations from ward to Board level.

Board Assurance Committees

There are five Board Assurance Committees at DBTH, whose role is to monitor and scrutinise the delivery of the Trust strategic objectives, via its operational performance, controls and risks within their strategic area. Each committee chair provides a highlight report to the next Board of Directors



meeting which provides a summary of its work, in particular any items for escalation. Each Board Committee has specific Terms of Reference (ToR) which articulate the work of the committee throughout the year. On an annual basis, the effectiveness of that committee is evaluated to ensure it has met its obligations stated within its ToR and has achieved these inline with the DBTH Values.

The Board committees are:

- Audit and Risk Committee.
- Quality Committee.
- Finance and Performance Committee.
- People Committee.
- Trust Board Nomination and Remuneration Committee.

Audit and Risk Committee

The Audit and Risk Committee is a non-executive director statutory committee that is chaired by a financially competent or financially qualified NED. Each chair of the other Board Committees is a member of this committee, and the Chief Finance Officer and Company Secretary also attend. It provides independent assurance to the Board on the adequacy and effectiveness of the Trust's systems of governance, risk management and internal control. It oversees the integrity of financial reporting, the annual accounts and Annual Governance Statement, and the assurance framework that underpins Board decision-making. The committee directs and reviews the work of internal audit, liaises with external audit, and monitors the management's response to audit recommendations to ensure their timely and effective closure. It also scrutinises counter-fraud, bribery and corruption arrangements, Declarations of Interest for all trust colleagues, key regulatory and compliance risks, and significant control issues, escalating material concerns to the Board of Directors.

Quality Committee

The Quality Committee provides assurance to the Board on the quality of care the Trust provides. It covers patient safety, clinical effectiveness and patient experience and the robustness of clinical governance. It monitors key quality indicators and outcomes, for example: safety incidents, mortality, Infection Prevention Control, safeguarding, learning from deaths, patient feedback. It oversees compliance with CQC fundamental standards, Maternity and Neonatal standards, and ensures that clinical audit drives measurable quality improvement. The committee tests the effectiveness of systems for identifying, escalating and mitigating quality risks, including serious incidents and never events, and seeks triangulation across data sources (quantitative and qualitative). It supports a culture of continuous learning, ensuring that actions and learning are embedded and sustained.

Finance and Performance Committee

The Finance and Performance Committee provides assurance on the Trust's financial sustainability and operational delivery against plan. It also has oversight of enabling functions that support this including estates and digital. A monthly Board Committee, it alternates between a focus on finance and performance each month. It scrutinises the annual and in-year financial position, cash, capital programme, efficiency and productivity (including IDP), and the robustness of forecasting and mitigations. The committee reviews operational performance against key access and constitutional standards (e.g., urgent and emergency care, elective recovery, cancer, diagnostics). It may also review where workforce capacity impacts on delivery, and critical enablers such as digital and estates affect



performance. It tests the credibility of the Trust plans and business cases, monitors major investments and benefits realisation, particularly around the ORBIT programme and capital estates work, and escalates material risks and variances to the Board with clear recovery actions.

People Committee

The People Committee provides assurance on the Trust's people strategy and the effectiveness of workforce policies and practices that proactively support a safe, inclusive and high-performing culture. It oversees workforce planning, recruitment and retention, safe staffing (including rostering and agency use), education, training and research, leadership development, talent and succession, equality, diversity and inclusion, and staff health and wellbeing. The committee monitors people metrics, for example vacancy, turnover, sickness, appraisal, mandatory training, staff survey outcomes, and ensures compliance with relevant regulatory standards and professional requirements. It evaluates the people implications of the Trust's strategic plans, ensuring that workforce risks are identified, mitigated and aligned with organisational affordability and quality of care. It has a strong focus on culture, gaining feedback on the impact of the DBTH way, and ensuring that the manner in which the Trust operates, from Board to ward, aligns to the Trust values in everything it does. It provides assurance to the Board of Directors on the DBTH way and how this is embedded across all areas of the Trust.

Trust Board Nomination and Remuneration Committee

The Trust Board Nomination and Remuneration Committee is a NED only committee that ensures the Board has the right leadership, composition and reward framework to deliver the Trust's strategy and statutory duties. Its remit includes succession planning for executive roles, recommending appointments to executive director posts, and the company Secretary role, and determining remuneration, terms and conditions, and performance objectives for very senior managers in line with NHS guidance and value-for-money principles. It safeguards fairness, transparency and equality, taking account of performance, market benchmarking and organisational affordability.

The Charitable Funds Trustees meeting

This meeting sits outside the DBTH Board structure as it is responsible for the DBTH Charity and as such is a distinct legal entity and separate to the DBTH Board of Directors. However, the Trust is the sole trustee of the Charity and therefore board members are appointed to take decisions on behalf of the Trust. As such the DBTH Charity may on occasion report to the DBTH Board of Directors.

Council of Governors

As an NHS foundation Trust, the Council of Governors are a statutory body and play a vital role in the governance framework of an NHS foundation Trust. The Council represents the interests of members of the public and staff and ensures the Trust remains accountable to the communities it serves.

The Council does not have executive powers or any role in the day-to-day operational management of the Trust. Individual Governors have no delegated authority to act; their powers lie as the whole Council. Its purpose is to provide advocacy and assurance and contribute to the Trust's transparency and responsiveness to its communities. The Trust Chair leads the Council of Governors as well as the



Board of Directors. The Council of Governors is made up of elected members of the Trust as set out in the DBTH Constitution, Section 14 and Annex 3.

The Council key functions include:

- Holding the non-executive directors individually and collectively to account for the performance of the Board, particularly in relation to the Trusts strategic objectives and use of resources.
- Representing the interests of members of the public, ensuring their views are reflected in the Trusts decision-making.
- Appointing or removing the Trust Chair and non-executive directors and approving the Board's appointment of the Chief Executive.
- Receiving the Trusts annual report and accounts and being consulted on significant transactions, mergers, acquisitions or changes to the Trusts Constitution.
- Appointing the External Auditors of the Trust.

The Lead Governor

In an NHS Foundation Trust, the Lead Governor is a member of the Council of Governors who is nominated by other Governors to act as the point of contact between the Council and NHS England in the limited circumstances where it would not be appropriate to communicate through the normal channels, usually the Chair or the Company Secretary. The role is intended to support effective governance by providing an independent communication route, on behalf of the Council, ensuring the proper conduct of appointments or elections or any other significant governance matter affecting the Trust.

The Lead Governor does not have any statutory powers to act; however, the role has an important facilitative and representative role within foundation trust governance.

The Council of Governors Nomination and Remuneration Committee

In line with its delegated authority the CoG Nomination and Remuneration Committee is a Governor committee led by the Trust Chair (or Deputy Chair or SID where there are items relating to the Chair) that ensures the Board has the right leadership, composition and reward framework for its non-executive directors. Its remit includes succession planning for NED roles and recommending NED appointments to the Council of Governors for approval. It also has a role in recommending the approval to the CoG, for the Board's appointment of the Chief Executive. It safeguards fairness, transparency and equality, in the appointment process.

Trust Members

At DBTH, members are the Trust's statutory membership body, made up of people from its public constituencies and its staff constituency. These are set out in the Trusts constitution and include members from Bassetlaw, Doncaster and the rest of England and Wales, together with eligible staff members. Membership is a core feature of NHS foundation trust governance and aligns with the National Health Service Act 2006, Schedule 7. Members provide the democratic link between the Trust and its communities, and they elect the Governors to the Council via elections run under the model election rules.



It is free to be a member of the Trust if individuals are over 16 years of age and meet the eligibility criteria set out in the constitution, which is based on being a 'fit and proper' person.

Foundation Trust Governance

Accountability for DBTH flows outwards to national healthcare regulators, as well as to the public and communities that we serve. The Council of Governors as a collective body connects DBTH with its membership, staff, wider stakeholders and community. The interaction between the Council of Governors, and the Board of Directors is therefore a key relationship in the governance of Foundation Trusts thus:



The Principles of Good Governance

Everyone working at DBTH has a responsibility to ensure good governance principles are embedded into their daily practice. This can look different whether at corporate governance or operational governance within the organisation, all are expected to adhere to these principles. This requires everyone to be accountable for the decisions and actions they take within their role. This is supported by clear definitions of responsibilities supported by governance frameworks and policies that are up-to-date, accessible and support colleagues with safe decision-making.

Good Governance requires good quality, accurate and timely information to support with evidence for assurance and ensuring delivery is on track. These information flows are critical to good governance and support the assurance and accountability within the Trust.

Governance principles also include the highest standards of transparency and probity which fosters a culture of openness and trust. Several controls are in place to support these, some of which are statutory requirements and or align to the Code of Governance for NHS providers and include the Duty of Candour. These principles are to be adhered to by all NHS personnel not just as a matter of compliance but also within the spirit of the duty.

The NHS Providers Code of Governance (2023) stipulates how good governance should operate within an NHS Provider and the various documents, roles and tasks that need to be completed to effectively



operate. This is on a 'comply or explain' basis. So, where adherence to the code is not followed, a clear explanation why not and the safeguards in place are required.

The principles of good governance provide assurance that the Trust is delivering on its strategic objectives while ensuring it maintains compliance with regulatory and legislative requirements regarding care quality and financial sustainability. This creates a golden thread that directs informed, evidence-based decision-making.

Key features of the Trusts Governance and Assurance Frameworks include:

- Ensuring that decisions are made in the right place and within agreed levels of risk and financial delegations.
- Risks are identified, actively managed and escalated effectively from line of sight – ward to board.
- The availability of accurate data is presented in a useful, balanced and timely manner.
- Streamlined governance arrangements, reducing duplication in meetings and reporting with the principle of form-follows-function for meeting structures.
- Reports are clear, concise and provide the information needed to support the group to evidence the level of assurance or decision that is required of it.

Transparency and Probity

DBTH holds itself to the highest standards of transparency and probity, fostering a culture of openness and trust. A number of controls and policies are in place to support this, several of which are highlighted in this section as statutory requirements and or best practice.

Fit and Proper Persons

The Fit and Proper Persons Test is a statutory and regulatory requirement which the Trust must complete for all individuals on the Board, on appointment and at least annually, plus for anyone who falls within the definitions laid out in Regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) (Amendment) (Regulated Activities) Regulations 2014 (the "Regulations").

The DBTH Board of Directors has adopted and endorses the principles set out in the Fit and Proper Persons Test Framework, as published in August 2023. The Company Secretary is responsible for the correct and robust discharge of this test, on behalf of the Chair who holds the legal duty. All completed tests are independently verified and signed off by the Trust Chair and the Senior Independent Director of the Board of Directors.

Managing Conflicts of Interest

The Trust is required to maintain a register of interests for all decision-making staff. DBTH has defined this as any member of staff band 8C+, Medical colleagues, consultants and speciality doctors, members of any advisory groups, Trust Governors, pharmacy, IT and procurement team colleagues, and anyone with a decision-making responsibility, at any banding, is also required to submit an interest.



The processes and details required for submitted declarations of interest, and declarations of gifts and hospitality is set out in the Trust policy, Standards of Business Conduct including Managing Conflicts of Interest which is written in line with the NHSE Model policy.

The registers of interests, and of gifts and hospitality, are available via the online portal and should be completed by all staff who are in receipt of any gifts or hospitality, irrespective of their grade or role in the Trust.

Internal Audit and External Audit functions

Collectively these functions form part of the key controls that are in place, both in terms of operational function and financial probity and responsibility. Internal Audit undertakes audits of the controls in place in operational, and sometimes strategic areas within the Trust. The recommendations made by Internal Audit are monitored by the Audit and Risk Committee. External audit is essential to produce the required Annual Accounts, and for ensuring robust systems are in place to manage the Trust's finances in a transparent, effective, and efficient manner. External Audit undertakes the annual audit and ensure the Trust's annual accounts are correct and in line with guidance and other requirements.

Counter Fraud

The Trust has an independent Local Counter fraud specialist who leads on counter fraud efforts and attends every Audit and Risk Committee to provide assurance on the current position, and on any risks or concerns that the Committee should consider. They lead on the investigation of any activity that may be fraudulent, handing cases over to the police where there is sufficient evidence of criminal activity, or to professional bodies where actions and behaviours warrant further action.

Freedom to Speak Up

In line with guidance and NHSE requirements, the Trust operates a Freedom to Speak Up function and employs a Freedom to Speak Up Guardian. There are champions in place across the Trust to encourage a culture of openness and disclosure.

The Board and the People Committee receive at least twice annually, reports on the current position and there is a non-executive director who is the board champion for FTSU and meets regularly with the guardian to ensure direct board oversight on any emerging themes and actions.

Use of the Seal

Authority to affix the seal to any document lies with the Chief Executive, who has delegated this to the Company Secretary. The seal is kept under key, and the Company Secretary ensures that the seal is affixed in line with contractual requirements, and that a register is kept of each usage. This is then reported to the Board of Directors at least annually.

The Trust Board Office

The corporate governance team within the Trust Board Office provide senior-level support to the Board and its Committees to ensure that meetings are managed effectively and appropriately, and to



be the key contact point for those reporting into these arenas. They are responsible for complete, objective record keeping which identifies items requiring follow-up and actions taken. This record is a legal document that evidences the discussions held and the outcomes arising from those discussions in a professional way that can be audited. All Trust minutes, not just those of the Board and its Committees are externally assessed and can be released under Freedom of Information requests. The Corporate Governance Team are responsible for ensuring the Committees remain consistent with their terms of reference and do not operate ultra vires.

Risk Management and Internal Control

The Trusts internal controls consist of processes and procedures which together ensure that the Trust is meeting the terms of its authorisations, running smoothly, effectively and keeping its risks to a minimum. Internal controls entail the Trust having identifiable objectives that align to its strategy and identifying any risks to achieving them.

The Risk Management Policy provides a framework for the continued development of the risk management process, building on our and plans linked to the Board Assurance Framework (BAF) and meeting requirements of its regulators and licence conditions. The Risk Management policy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the “Ward to Board” accountability and devolved governance structure.

The Trust uses the ‘three lines of defence’ model to understand what controls are in place for specific risks, and what mechanisms of assurances exist that can evidence those controls are working. This supports colleagues to understand the different roles and responsibilities in the management and assurance of risks, avoiding duplication or gaps in risk management, performance management and their governance and control arrangements.

Line of Defence	This involves:
1	The organisation’s first line of defence constitutes Operational Functions. These directly own and manage services and their associated risks. They comply with policies and operating procedures and report their compliance to these via performance metrics and targets. These are managed and monitored through team and divisional reporting structures that are responsible for correct and consistent application of controls. Examples of first line of defence controls include: • Authorisation of invoices prior to payment • Checking the suitability of staff prior to their employment, e.g. DBS check and employment references • IT system access controls, building access controls • Staff training and development to ensure they are appropriately skilled and competent for their role.



Line of Defence	This involves:
	Counter fraud arrangements The controls are designed to be 'preventative' and limit the possibility of risks being realised and also 'corrective' designed to limit and reduce the impact should a risk materialise
2	The second line of defence is the Management Activity that oversees risk. It is provided through the various risk management and compliance functions, such as policies, frameworks, tools and advice, and assurance groups that an organisation might put in place to support and monitor the effectiveness of the first line of defence. Examples of second line of defence functions include: - Risk Management Strategy and/or Policy - Risk registers, risk management system, assurance framework and review of them - Assurance Committee with responsibility for oversight of risk - Monitoring Trust, Board and employee compliance with laws and regulations - Quality monitoring arrangements such as Quality Committee - Contract monitoring arrangements - Monitoring of compliance with Trust policies and procedures These functions are established to ensure that the first line of defence is properly designed, in place, and operating as intended. Typically, these are 'directive', designed to ensure that a particular outcome is achieved, and 'detective', designed to identify occasions when undesirable outcomes have been realised. Key aspects for this second line of defence are maintaining policies and procedures, to reflect changes in strategic priorities & risks and to ensure that staff receive training & support to discharge their role in respect of the first line of defence. The management oversight is separate to those responsible for the delivery, but not independent of the Trusts management hierarchy.
3	The Third line of defence is supported by functions that provide independent assurance. The main one is the internal Audit function that provides independent assurance to the Board via the audit and risk committee and to senior management on the effectiveness of governance, risk management and internal controls, including the effectiveness of the first and second lines of defence. Some other providers of independent assurance include: - The Counter Fraud service - External Audit - The Care Quality Commission inspections of health and social care services - Accreditation and specialised inspection bodies - NHS England and the Oversight Framework



Line of Defence	This involves:
	• Risk Assessment Framework for Foundation Trusts

Whatever the line of defence, it is important that every report to senior management and to the board or audit committee advises about the level and source of assurance.

The three lines of defence model is a useful tool to help boards and committees understand where their assurance is coming from and to triangulate this against the various sources of evidence.

Board Assurance Framework

The Board needs to be confident that the systems, policies, and people it has put in place are operating in a way that is effective in driving the delivery of its strategic objectives. This needs an overarching focus on understanding the key factors involved and minimising risk. The Board has a key role in needing to demonstrate that it has been properly informed about the totality of its risks, both clinical and non-clinical and potential impacts on delivery of its strategy. Managing its risks is also a statutory requirement placed on the Board of Directors.

To do this, the Board needs to be able to provide evidence that it has systematically identified its objectives and managed the principal risks to achieving them. The Board Assurance Framework (BAF) fulfils this purpose. The BAF provides the Board and wider Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its strategic objectives.

For the BAF to be effective, the Executive Directors take the lead for risks assigned to them and ensure that the relevant information is kept up to date and reviewed at the relevant board committee. At the end of each financial year, the Chief Executive Officer considers the BAF and other sources of assurance to complete the Annual Governance Statements. This document is specified within the Annual Report for and is made available to the public through the public board papers.

Risk Appetite

The risk appetite is the amount of risk, or the level of potential impact, that an organisation is willing to accept in pursuit of the achievement of its strategic objectives. Defining risk appetite helps Boards and leadership teams make informed decisions about balancing transformation, service delivery, and patient safety against potential threats. The risk appetite levels support risk managers across the organisation to determine appropriate target risk scores, ensuring these are aligned to strategic priorities, this enables proportionate responses to risks across clinical, workforce, operational and financial domains



Summary

Collectively the documents referenced, the processes, and the duties stated in law support the Trust to operate in a transparent and efficient way. Recognising it is public money that is being spent to deliver safe and effective quality care for its population. The values that operate at DBTH outline the way this is delivered to ensure that the Trust delivers to the letter and the spirit of the law.

The following can be found on the DBTH Website:

- DBTH Constitution
- Standing Financial Instruction
- Scheme of Reservation and Delegation
- Committee Terms of Reference
- Standards of Business conduct Policy
- Fit and Proper Persons Process
- Counter Fraud Policy
- Risk Management Policy
- Freedom to speak up policy



Appendix 2: Board and Committee Cover sheet

Delete supporting notes **before submission to report sponsor**

Report Template																							
Meeting Title:				Meeting Date:																			
Report Title/ Ref:																							
Sponsor:	The name and title of the sponsoring Director, who is responsible for ensuring the cover page & paper are fit for purpose																						
Authors:																							
Appendices:																							
Purpose of the report	Assurance	Approval/decision	Information	Discussion																			
Proposed assurance Level (For assurance papers only) Delete as appropriate	Substantial Assurance Significant Assurance Moderate Assurance Limited Assurance Weak Assurance																						
Assurance Rationale	The [Committee / Board/] is asked to take [Assurance level] Assurance that [complete relevant to the appropriate assurance level and risks / issues identified]																						
Impacts on Strategic Risks (BAF 1-7)	Specify which BAF risk(s) this report aligns with or addresses																						
For decision papers only: Is this in line with Current risk appetite YES/NO Delete as appropriate	Highlight only where this report is outside of the Board Risk Appetite and a decision is requested [delete section if no decision required] <table border="1"> <thead> <tr> <th>None</th> <th>Minimal</th> <th>Cautious</th> <th>Open</th> <th>Seek</th> <th>Significant</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>Regulatory</td> <td>Finance</td> <td>People</td> <td></td> </tr> <tr> <td></td> <td></td> <td>Quality</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					None	Minimal	Cautious	Open	Seek	Significant			Regulatory	Finance	People				Quality			
None	Minimal	Cautious	Open	Seek	Significant																		
		Regulatory	Finance	People																			
		Quality																					
Executive Summary – Key messages and Issues																							
The summary should Identify the issue / exam question this report will answer with evidence - Analyse key evidence provided in the paper to demonstrate the proposed assurance level - Recognise the scale and nature of remaining unmitigated risks																							

· Emphasise key actions /evidence of impact and oversight arrangements · Offer a judgement on the effectiveness of controls in place · Offer insights into potential organisational impact · Indicate the level of confidence held in the data underpinning the report	
Recommendations	
Be clear what is being asked of the group, time scales and further actions.	
Healthier together – delivering exceptional care for all	
Patients	This report should relate to at least one of the strategic priorities – specify how
People	This report should relate to at least one of the strategic priorities – specify how
Partnerships	This report should relate to at least one of the strategic priorities – specify how
Pounds	This report should relate to at least one of the strategic priorities – specify how
Health Inequalities	This report should consider and reflect on the health inequalities impact of any decision – specify what that is here
Legal/ Regulation:	This report should consider and reflect the legal or regulatory impact of any decision
Partner ICB strategies	This report should consider and reflect the impact on our partner ICB strategies in relation to any action or decision
Assurance Route	
Previously considered by - including date:	
Any outcomes/next steps / time scales	

For reference: delete before submission

Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented to be reviewed as guidance
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.

Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. Several priority management actions have been accepted as urgently required.

Risk Appetite statements - delete before submission

Quality: Cautious (2)

DBTH defines its quality as 'safe effective and caring' and our preference is for risk avoidance. The Board has a cautious appetite for risk in relation to quality. We will accept a limited level of risk where it is necessary to deliver services, improve outcomes, or implement evidence-based change, and where risks are clearly understood, robustly controlled, and subject to clear clinical and managerial oversight. We have little tolerance for risks that could result in avoidable harm, sustained deterioration in care quality, or loss of public confidence, recognising that failures in quality and safety carry significant reputational consequences and can undermine trust in the organisation.

Regulatory: Cautious (2)

The Board has a cautious appetite for regulatory risk, reflecting our responsibility to operate within statutory, constitutional, and regulatory requirements. We will accept limited and time-bound regulatory risk where there is strong justification, transparency with regulators, and a credible plan to return to compliance. We will consider the impact of those risks that could damage the organisation's standing with regulators, Governors, partners, or the public, recognising that regulatory non-compliance can quickly translate into enduring reputational harm and loss of system confidence.

Financial: Open (3)

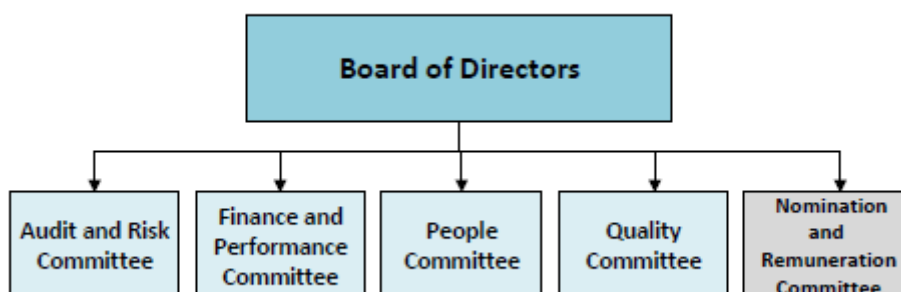
The Board has an open appetite for financial risk where this supports the achievement of strategic objectives, long-term sustainability, and transformation of services. We are willing to invest, transform and pursue innovative approaches that carry short- to medium-term financial risk, provided there is a clear strategic rationale, defined limits, and appropriate financial controls. We will, however, avoid unmanaged financial risks that would compromise organisational credibility, public assurance, or confidence in our stewardship of public funds, recognising the reputational impact of financial instability or poor financial governance.

People: Seek (4)

The Board has a risk-seeking appetite in relation to people and workforce transformation, recognising that meaningful improvement in culture, capability, inclusion, and retention requires innovation, change, and a willingness to challenge established ways of working. We are prepared to actively pursue opportunities that carry risk where they support a healthy, engaged, and sustainable workforce. We will consider the impact of those risks that could damage our reputation as a fair, inclusive, and ethical employer, including poor culture, discrimination, or failures to act on colleague concerns, acknowledging the direct link between workforce experience, organisational reputation, and quality of care.

Audit and Risk Committee

Terms of Reference 2026 FINAL



1. Constitution

The Audit and Risk Committee (the Committee) is a non-executive statutory committee and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

- 2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- 2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.
- 2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it considers necessary in the fulfilment of these terms of reference.
- 2.4 In conducting its role the Committee is authorised to seek reports and assurance from executive directors and managers and will support effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.
- 2.5 Any committee member will refer to or receive from other committees, pieces of work or information, to fulfil its terms of reference.

3. Purpose

The committee is established to:

- 3.1 Provide oversight and assurance to the Board of Directors on the adequacy of the Trusts, processes, and controls for the effective management of risk to support with

the delivery of the Trusts strategic objectives of People, Patients, Partnerships and Pounds.

- 3.2 Provide assurance to the Board of Directors that the Trust has in place an effective system of integrated governance, risk management and internal control, by means of independent and objective review of financial and corporate governance, risk management across the Trusts activities ensuring compliance with law, guidance and regulations governing the NHS.
- 3.3 Consider the wider impacts of Trust decision-making as part of the Integrated Care System, Provider Alliances, Partners, and the wider NHS.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to review the establishment and maintenance of governance systems, internal controls, and risk management across all activities of the Trust that enables achievement of the strategic objectives. To provide the Board of Directors with assurance, information on key issues and clear decision points in respect to each of the following:

4.1 Governance and Internal Control

- 4.1.1 To scrutinise and recommend to the Board of Directors the Trust's risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors.
- 4.1.2 To scrutinise the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in 4.1.1.
- 4.1.3 To scrutinise the policies and process for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification, including confirmation that all board committees have scrutinised their responsible policies.
- 4.1.4 To scrutinise internal controls at least annually regarding Standing Financial Instructions, the Scheme of Reservation and Delegation and Standing Orders.
- 4.1.5 To scrutinise the internal controls in place for monitoring compliance to Conflicts of Interest, gifts, and hospitality standards.

4.2 Internal Audit

- 4.2.1 To ensure there is an effective internal audit function resourced and established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board of Directors.
- 4.2.2 To scrutinise and approve the Internal Audit operational plan of work, ensuring it is consistent with the audit needs of the organisation as identified through a risk assessment including areas such as the Board Assurance Framework and Risk Registers.

- 4.2.3 To consider findings of internal audit work (and management responses) and ensure appropriate standing within the organisation and monitoring of the implementation of audit recommendations.
- 4.2.4 To review the effectiveness of Internal Audit annually.
- 4.2.5 To receive and review the Internal Audit annual report including Head of Internal Audit Opinion.

4.3 External Audit

- 4.3.1 To discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health system.
- 4.3.2 To discuss and agree with the External Auditors their evaluation of audit risks and assessment of the organisation as a going concern and the impact on the audit fee.
- 4.3.3 To review all External Audit reports, including agreement of the annual audit letter before submission to the Board of Directors and any work conducted, outside the annual audit plan, together with the appropriateness of management responses.
- 4.3.4 To report to the Board of Directors any identified matters and recommendations where action or improvement is required.
- 4.3.5 To ensure there is a clear policy for the engagement of External Auditors to supply non-audit services, considering relevant ethical guidance.
- 4.3.6 Ensure Trust compliance to ISA 260 requirements and delivery of any recommendations.
- 4.3.7 To complete an annual review of the effectiveness of External Audit.

It is the role and responsibility of the Council of Governors to appoint, or remove, the External Auditor. The Committee will therefore:

- 4.3.8 Develop and agree with the Council of Governors, and make recommendations to them on, the criteria for the appointment, re-appointment, and removal of the External Auditor.
- 4.3.9 Approve the remuneration and terms of engagement of the External Auditor.

4.4 Counter Fraud

The Committee will ensure that there is an effective counter fraud function that meets the standards for providers for bribery and corruption and provides appropriate independent assurance to the Committee, Chief Executive, and the Board of Directors:

- 4.4.1 To determine the specification for a counter fraud service through the procurement process to identify a provider and make recommendation to the Board of Directors for their appointment.

- 4.4.2 To review and approve the annual counter fraud plan, ensuring there is consistency with the potential risks and needs of the organisation.
- 4.4.3 To receive reports to every meeting on the work of the counter fraud service in the delivery of the annual plan.
- 4.4.4 To receive reports on referrals to and the outcome of investigation conducted by the counter fraud service, including assurance on the actions taken against perpetrators and additional controls recommended to avoid recurrence.
- 4.4.5 To undertake an annual review of the effectiveness of the counter fraud service.
- 4.5.6 To scrutinise the policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority.

4.5 Financial Reporting and Financial Stewardship

- 4.5.1 To review all internal financial controls and all internal control and risk management systems, examples may include procurement cards, single tender waivers, losses and special payments.
- 4.5.2 To scrutinise and review compliance with accounting policies, practices and estimation techniques.
- 4.5.3 To scrutinise and review unadjusted misstatements in the financial statements.
- 4.5.4 To scrutinise and review major judgemental areas.
- 4.5.5 To scrutinise and review significant adjustments (both adjusted and unadjusted misstatements & their explanations) resulting from audit scrutiny.
- 4.5.6 To ensure the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided to the Board of Directors. Including those of significant external financial systems.
- 4.5.7 To receive specific Board delegation annually for agreement on the annual accounts, via the existing governance arrangements.

4.6 Management and Risk Assurance Process

- 4.6.1 To request, receive and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 4.6.2 To scrutinise and review the effectiveness of the Board Assurance Framework and compliance with the risk management framework and policy, including an annual report on risk management.

4.7 Emergency Preparedness Resilience and Response (EPRR)

- 4.7.1 To receive and review reports and assurances on the statutory arrangements for process, risk management and internal control for the Trusts EPRR.
- 4.7.2 To receive an annual report on the effectiveness of the Trusts EPRR.

4.8 Information Governance and Cybersecurity

- 4.8.1 To receive and review reports and assurances on the arrangements for process, risk management and internal control for the Trusts cybersecurity and data protection arrangements.
- 4.8.2 Review and take assurance on the Trust's annual data security and protection toolkit process, noting when this has been submitted and any issues identified as part of the audit process.

5. MEMBERSHIP

- 5.1 The membership of the Committee will be four named non-executive directors, each being a Chair of the 3 other standing committees of the Board of Directors, not including the Chair of the Trust and one of whom will be the Committee Chair.
- 5.2 At least one of the members of the Committee will have recent and relevant financial experience.
- 5.3 The Board of Directors will appoint the Chair of the Committee, in their absence, they can nominate another non-executive director to chair the meeting.

6. ATTENDANCE

- 6.1 The Chief Executive Officer and the Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.
- 6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.
- 6.3 The Board of Directors has delegated authority to Deputy Directors to act as a nominated deputy in the absence of an Executive Director where applicable.
- 6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.
- 6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

- 6.6 The following roles will be regular attendees and will be recorded as being 'in attendance' and not as being 'present'.
- Internal Audit representative(s)
 - External Audit representative(s)
 - Counter Fraud representative(s)
 - Chief Finance Officer
 - Deputy Director of Finance
 - Deputy Chief Executive
 - Company Secretary / Deputy Company Secretary
- 6.7 Other executive director / officers should be invited to attend, particularly when the Committee is discussing areas of risk, internal audit limited assurance reports or operation that are the responsibility of that director.
- 6.8 The Trust Board has delegated authority to any non-executive director of the Trust, excluding the Chair, to act as nominated deputy in the absence of any non-executive member and this attendance will count towards the quorum.

7. FREQUENCY OF MEETINGS

- 7.1 The Committee will meet a minimum of four times per year with additional ad hoc meetings as required.
- 7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.
- 7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.
- 7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.
- 7.5 At least once per year, the Committee members only should meet with the external and internal auditors, to discuss matters relating to its responsibilities and issues arising from the audit. The External Auditor and Head of Internal Audit may request a private meeting if they consider that one is necessary. They will also have direct access to the Chair of the Committee as required.

8. QUORUM

A quorum shall be not less than three non-executive director members, this can include deputies as specified in point 6.8 above.

9. REPORTING

- 9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

- 9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.
- 9.3 The Committee will report to the Board of Directors annually on its work.
- 9.4 The Committee will receive effectiveness annual reports from each of the standing assurance committees.

10. REVIEW

- 10.1 The Committee will review its work plan at each meeting.
- 10.2 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved
(Chair of the Board of Directors)

Date of approval

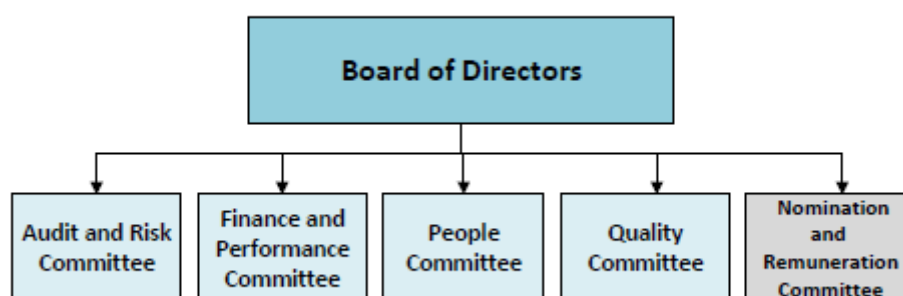
Annex 1 (Aide Memoire on policy documents)

The Committee is responsible for the oversight of the following policies:

1. Anti-fraud corruption and Bribery Policy (4.5.6)
2. Standards of business conduct policy (4.1.3)
3. Governance documents Standing Finance Instructions, Standing Orders, Scheme of Reservation and Delegation. (4.1.4)
- Risk Management Policy (4.6.2)

Finance and Performance Committee

Terms of Reference 2026 FINAL



2. Constitution

The Finance and Performance Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

- 2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.
- 2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.
- 2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.
- 2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.
- 2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.
- 2.6 Committee members and attendees will be expected to conduct business in line with the Trust values, objectives, constitution and supporting governance policies and demonstrably consider the equality and diversity implications of decisions they make.

3. Purpose

The committee is established to:

- 3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of all aspects of the Trusts financial and activity plans and performance against constitutional and contractual standards, including identification of risks and mitigating actions.
- 3.2 Ensure there are robust processes and controls in place for the effective development, implementation and management of Trust assets, including, but not limited to: finances, physical, digital and information.
- 3.3 Provide assurance to the Board that the Trust has in place processes and controls for effective delivery of its Green Plan.
- 3.4 Give consideration to the wider impacts of Trust decisions-making as part of the Integrated Care System, Provider Alliances, Partners, and the wider NHS.
- 3.5 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of the Productivity and Financial reset, Access and Flow pillars of the DBTH 2026 medium-term plan.
- 3.6 Oversight of the delivery of the Productivity and Financial reset, Access and Flow pillars of the Medium-term plan to be reported to each committee via an agreed reporting matrix as defined by each programme.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to give detailed consideration on those activities listed within the section 4 of these Terms of Reference. To provide the Board of Directors with assurance, recommendations and information on key issues and clear decision points.

The Committee shall scrutinise and recommend to the Board of Directors the risks and actions identified in the relevant sections of the Board Assurance Framework which the Board has delegated to it.

4.1 Finance and Business

- 4.1.1 All aspects of the financial arrangements of the Trusts Medium-term plan, ensuring these are being appropriately addressed including in year financial performance, productivity plans and corrective actions required and review of the Draft Accounts ahead of Audit and Risk Committee.
- 4.1.2 All aspects of the Trusts capital program (digital, estates and equipment), including work with system partners, providing the Board of Directors with assurance these are fit for purpose and planned to meet future need.
- 4.1.3 The Trust's Procurement and Contracting plans incorporating the Board Lead for Procurement annually.
- 4.1.4 Oversight of and gain assurance on the Productivity and Financial Reset Pillar and local schemes.
- 4.1.5 Oversight of and gain assurance on the Shape of DBTH (Sites and Services) Reset Pillar of Infrastructure enablers.
- 4.1.6 All aspects of the Trust's Annual Financial plan, plus any in-year financial submissions to NHS England, providing final recommendation to the Board of Directors in accordance with prescribed guidance and timescales and receive in year financial performance reporting of revenue, capital, working capital, linked to the Financial Plan with any corrective actions required.
- 4.1.7 Provide oversight and scrutiny of significant business cases for new business or capital investment in order to ensure affordability and alignment with strategic aims.
- 4.1.8 To keep under review, consider and recommend to the Board of Directors subject to the Standing Financial Instructions, all financially related policies and enabling strategies plans, for example: Treasury Management Policy, Procurement, Estates and Digital etc.
- 4.1.9 Provide assurance to the Board of Directors that the Trust is financially viable as a foundation trust, including current and forecast compliance with financial covenants,

4.2 Digital and Data Quality

- 4.2.1 Oversight and assurance on the Shape of DBTH (Sites and Services) Reset Programme under the Infrastructure Enabling programmes elements; the EPR development and implementation programme.

4.3 Performance Management

- 4.3.1 Monitor and scrutinise the Trust's performance reporting and Performance Assurance Framework (annually)
- 4.3.2 Oversight and assurance on the Access and Flow Reset Pillar.

4.4 Infrastructure Estates and Net Zero

- 4.4.1 Oversight and assurance on the Shape of DBTH (Sites and Services) Reset Programme under the Infrastructure Enabling programmes elements; the Estates and Facility non-pay schemes.
- 4.4.2 To scrutinise, and recommend for approval to the Board of Directors, the net-zero Management Development Plan (Green plan).

4.5 Trust Health Safety and Fire

- 4.5.1 Oversight and assurance on the arrangements for process, risk management and internal control for the Trusts Health and Safety, fire and security duties.

5. MEMBERSHIP

- 5.1 The membership of the Committee will comprise of executives and non-executive directors only:
 - Three Non-executive Directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
 - Chief Finance Officer
 - Chief Operating Officer
- 5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-executive Director to chair the meeting.

6. ATTENDANCE

- 6.1 The Chief Executive Officer and The Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.
- 6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.
- 6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an Executive Director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.
- 6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.
- 6.5 Committee Members will be required to attend a minimum of eight meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

- 6.6 Others who may be invited to attend the meeting include:
- Company Secretary / Deputy Company Secretary
 - Chief Medical Officer
 - Deputy Director of Finance
 - Deputy Chief Operating Officer

7. FREQUENCY OF MEETING

- 7.1 The Committee will meet monthly with additional ad hoc meetings as required.
- 7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.
- 7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the Committee Chair.
- 7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two Executive Directors (one of whom may be a Deputy Director) and two Non-executive Directors

9. REPORTING

- 9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.
- 9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible Executive Director, any issues that require disclosure to the Board of Directors or require Executive action.
- 9.3 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

- 10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

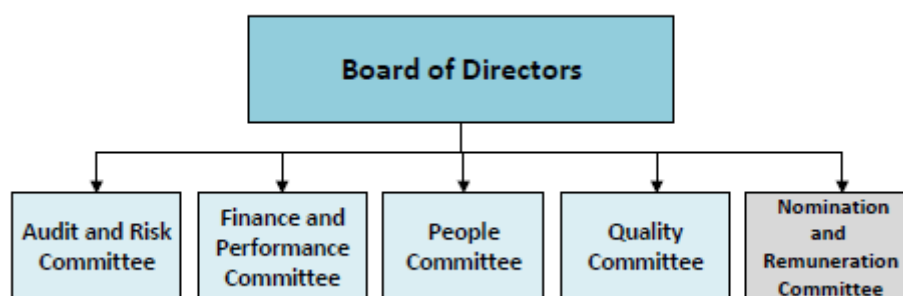
Signed as approved

(Interim Chair)

Date of approval:

People Committee

Terms of Reference 2026 FINAL



3. Constitution

The People Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

- 2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- 2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.
- 2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.
- 2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.
- 2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.
- 2.6 Committee members and attendees will be expected to conduct business in line with the Trust values, objectives, constitution and supporting governance policies and demonstrably consider the equality and diversity implications of decisions they make.

3. Purpose

The committee is established to:

- 3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of the people aspects of the Trust's People Enabling Plan.

- 3.2 Provide assurance to the Board of Directors that the Trust has in place a system of internal control to identify and mitigate the risks affecting delivery of the Trust's People Enabling Plan.
- 3.3 Provide assurance to the Board that appropriate and effective governance mechanisms are in place for all aspects of people legislation, regulation, and best practice in order to comply with national, regional and local requirements.
- 3.4 Shape the culture, organisational development, learning and leadership of people within the Trust and contribute to shaping the culture of how organisations work together, across the Integrated Care System, Provider Alliances, and the wider NHS.
- 3.5 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of the Culture, Leadership, Workforce and Organisational Design Pillars of the DBTH 2026 medium-term plan.
- 3.6 Delivery of the Culture, Leadership, Workforce and Organisational design pillars of the Medium-term plan to be reported to each committee via an agreed reporting matrix as defined by each programme.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to ensure that there are robust processes in place for the effective management of people and culture and these operate effectively so that action is taken to address any areas of concern.

The Committee will provide assurance to the Board of Directors on the implementation and delivery of the People Enabling Plan, the medium-term plan and compliance with the Trusts statutory requirements.

The Committee shall scrutinise and recommend to the Board of Directors the risks and actions identified in the relevant sections of the Board Assurance Framework which the Board has delegated to it.

The Committee will provide the Board of Directors with assurance, information on key issues and clear decision points, by scrutinising triangulated, analysed information in order to gain assurance on the effectiveness and delivery of:

4.1 Looking after our people

- 4.1.1 All health and wellbeing programmes across the Trust, via evidence in line with the national framework, local priorities, flexible working and reward schemes and input from the NED Wellbeing Guardian role.
- 4.1.2 The Trust's delivery of its educational commitment to colleagues, including meeting regulatory requirements plus library and information standards, at least biannually with action plans in areas where required.
- 4.1.3 The Trust's performance against key people metrics at each meeting, including, but not limited to: sickness absence rates, employee turnover, statutory and essential training, and appraisals.

- 4.1.4 Oversight of and gain assurance on the Culture and Leadership Reset pillar for zero tolerance, including bullying and harassment deep dive and an annual report on Violence and Preventions standards.
- 4.1.5 The results of the national staff survey, plus regional or local surveys presented with links to key areas of learning, strategic priorities and actions as required.
- 4.1.6 Oversight of and gain assurance on the Culture and Leadership Reset pillar for colleague recognition, storytelling, Just and learning culture initiatives, 'line in the sand'. To include the board oversight as the NED lead role on doctors disciplinary and its case work.
- 4.1.7 To scrutinise and gain assurance that the Trust has in place systems and controls to deliver on the Trust's compliance with the requirements set out in the NHSE Safe Staffing guidance.
- 4.1.8 To scrutinise and recommend for the Board of Directors the Safe Staffing Annual review and declaration in line with the NHSE Safe Staff guidance.

4.2 Belonging in #Team DBTH

- 4.2.1 The Trust's Equality Diversity and Inclusion approach, ensuring this is embedded within all aspects of the Trust, including colleague networks. With evidence presented via annual reporting plus deep dives of improvements and action plans in areas where required.
- 4.2.2 The Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) progress presented annually together with deep dives and evidence of improvements and action plans in areas where required. Gender Pay Gap analysis to be included within the annual report.
- 4.2.3 Oversight of and gain assurance on the Culture and Leadership Reset Pillar for Leadership Development and management capability, senior leadership visibility and for colleague engagement and shared decision-making forums.
- 4.2.4 The Trust's approach to 'Speaking up' including progress on how this is embedded into Trust culture. Evidence presented to Committee biannually including an annual impact report presented to the Board of Directors.

4.3 Growing for the future

- 4.3.1 The Trust's delivery of its research commitment through the Research and Innovation Enabling Plan, from evidence presented annually.
- 4.3.2 Oversight of and gain assurance on the Workforce and Organisational Design Reset Pillar for each enabling service function area, including recruitment, retention and workforce planning, development and temporary staffing as relevant.
- 4.3.3 The trusts compliance to Year 8 reporting for the integrated perinatal workforce report bi-annually

4.4 New Ways of Working

- 4.4.1 The Trust's progress against delivery to digitise its people systems.

- 4.4.2 The Trust's progress of its plans to attain University Teaching Hospital Status as part of the Research and Innovation Enabling Plan from evidence presented annually.
- 4.4.3 To gain assurance on the implementation of internal audit recommendations that relate specifically to People actions, via progress and monitoring reports to each committee on outstanding internal audit actions
- 4.4.4 Oversight of and gain assurance on the Workforce and Organisational Design Reset Pillar for Medical workforce, including job planning and appraisal rates
- 4.4.5 To review the medical revalidation process and compliance for the Trust from evidence presented annually.

5. MEMBERSHIP

- 5.1 The membership of the Committee will comprise of executives and non-executive directors only:
- Three non-executive directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
 - Chief People Officer
 - Chief Nurse
 - Chief Medical Officer
- 5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another non-executive director to chair the meeting.

6. ATTENDANCE

- 6.1 The Chief Executive Officer and the Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.
- 6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.
- 6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an executive director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.
- 6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.
- 6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.
- 6.6 Others who may be invited to attend the meeting include:
- Company Secretary / Deputy Company Secretary
 - Deputy Director of People & Organisational Development
 - Director of Education and Research
 - Head of OD, EDI and Wellbeing

7. FREQUENCY OF MEETING

- 7.1 The Committee will meet at least 5 times a year with additional ad hoc meetings as required.
- 7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.
- 7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.
- 7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two non-executive directors

9. REPORTING

- 9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.
- 9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.
- 9.3 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

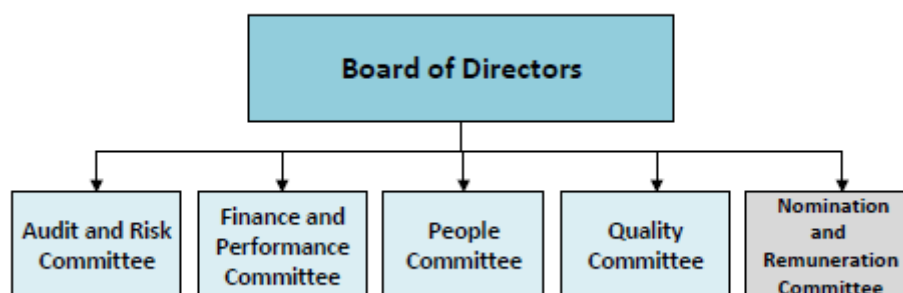
- 10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved
(Chair of the Board of Directors)

Date of approval:

Quality Committee

Terms of Reference 2026 FINAL



4. Constitution

The Quality Committee (the Committee) is appointed by the Board of Directors and has no executive powers other than those set out explicitly within these terms of reference.

2. Authority

- 2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.
- 2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.
- 2.3 The Committee is authorised by the Board of Directors to create sub-committee or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.
- 2.4 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board Committees to understand their processes or assurance and links with the work of this committee.
- 2.5 Any committee member will refer to or receive from other committees, pieces of work or information, in order to fulfil its terms of reference.
- 2.6 Committee members and attendees will be expected to conduct business in line with the Trust values, objectives, constitution and supporting governance policies and demonstrably consider the equality and diversity implications of decisions they make.

3. Purpose

The committee is established to:

- 3.1 Provide assurance to the Board of Directors that the Trust has in place structures, processes, and controls to ensure that the legislative requirements within these terms of reference that ensure the safety, rights and quality of service delivery is maintained to all service users, carers, staff, and the public.
- 3.2 Provide assurance to the Board of Directors that appropriate and effective governance systems are in place for all aspects of quality including patient experience, health outcomes and compliance with national, regional and local requirements, where these are provided directly or commissioned by DBTH.
- 3.3 Give consideration to the wider impacts of Trust decision making as part of the Integrated Care System.
- 3.4 Provide assurance to the Board of Directors that the Trust has in place structures, processes and controls for the effective delivery of the Shape of DBTH (Sites and Services) Pillar of the DBTH 2026 medium-term plan.
- 3.5 Oversight of the delivery of the Shape of DBTH (Sites and Services) Reset Pillar of the Medium-term plan to be reported to each committee via an agreed reporting matrix as defined by each programme.

4. ROLES AND RESPONSIBILITIES

The Committee is authorised by the Board of Directors to set annual objectives and a forward plan that enables it to delivery its responsibilities and to review and update any strategic risks and mitigating actions in line with the Board Assurance Framework. To provide the Board of Directors with assurance, recommendations and information on key issues and clear decision points in respect to those activities outlined in section 4 of these Terms of Reference.

The Committee shall scrutinise and recommend to the Board of Directors the risks and actions identified in the relevant sections of the Board Assurance Framework which the Board has delegated to it.

4.1 Annual Quality Strategy, Plan and Reports

- 4.1.1 To scrutinise the strategic content and direction of any Annual Quality Report, Priorities and Plan, the Trust determines locally, engaging with the Council of Governors, on behalf of the Board of Directors prior to publishing.
- 4.1.2 To scrutinise Quality Performance Impact Assessments and Equality Impact Assessment of any Cost Improvement Plans or transformational change programme, that may impact the quality-of-service delivery in accordance with the Trust's QPIA Policy CORP/COMM 28.
- 4.1.3 To scrutinise the review of any identified Integrated Care System or national developments that may impact on the Trust in respect of service quality and patient risk.
- 4.1.4 To review progress on the Maternity and Neonatal plans in accordance with national directions.
- 4.1.5 Oversight of and gain assurance on the Shape of DBTH (Sites and Services) of the Reset pillar. .

4.2 Legislative and Statutory Compliance

- 4.2.1 To gain assurance on Mental Health Act (MHA) via an annual report, and by exception reporting, that demonstrate the Mental Health Act is appropriately applied and compliant with legislative requirements, plus any actions to improve compliance where identified.
- 4.2.2 To have oversight and report to the Board of Directors as the Non-Executive Director (NED) lead role for safeguarding and gain assurance from all evidence presented to the committee that the Trust is compliant with all its regulatory duties. Evidencing associated actions to improve compliance including Mental Capacity Act and Deprivation of Liberty.

4.3 Regulatory Assurance

- 4.3.1 To scrutinise and enable a discursive forum to review Care Quality Commission (CQC) compliance reports, notices or licence requirements and ensure actions are taken to address identified issues in CQC compliance reports.
- 4.3.2 To gain assurance from triangulation of information, including internal audit as appropriate, that progress on the actions identified in CQC compliance reports are embedded into clinical practice. This will be received through existing reports that will reference relevant regulatory requirements.
- 4.3.3 To carry out the assurance duties of the Board champion requirements, via triangulated data, receiving reports across all areas and specifically where required in respect to:
 - Maternity Neonatal Safety and Quality
 - Hip Fracture, Falls and Dementia
 - Learning from Deaths
 - Children and Young People
 - Resuscitation
 - Safeguarding
 - Palliative and End of Life Care

For the avoidance of doubt these are **not** all individual named leads.

- 4.3.4 To scrutinise and recommend to the Board of Directors the Clinical Negligence Scheme for Trusts, (CNST) Maternity Incentive Scheme declaration and compliance against the standards.

4.4 Patient Safety, Experience and outcomes

- 4.4.1 To gain assurance via reports to each committee, and where necessary deep dive reports, that the Trust has in place legislatively compliant systems and controls that ensure patient incidents, complaints, duty of candour, compliments and claims are effectively monitored to ensure high quality care is delivered and to enable lessons learnt and ensure actions are progressed.
- 4.4.2 To review the annual clinical audit programme and monitor its delivery at least biannually with action plans in areas where required.
- 4.4.3 To review any overdue outstanding Internal Audit actions where recommendations directly affect clinical standards and quality of services.

- 4.4.4 Oversight of and gain assurance on the Patient Led Assessments of the Care Environment (PLACE).
- 4.4.5 To receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.
- 4.4.6 Oversight of and gain assurance from the learning of the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of external feedback.
- 4.4.7 To gain assurance via six-monthly plus exception reports, as required, that the Trust is legislatively compliant and is implementing guidance and best practice in respect of its mortality surveillance systems and learning-from-deaths processes.

4.5 Medicines Optimisation and Medical Devices

- 4.5.1 To gain annual assurance the Trust has in place processes and controls that ensure medicines are effectively managed and compliant with legislative requirements.
- 4.5.2 To gain annual assurance the Trust has in place processes and controls that ensure medical devices are effectively managed and compliant with legislative requirements.

4.6 Infection Prevention and Control

- 4.6.1 To gain annual assurance that the Trust has in place Infection Prevention and Control systems and controls to ensure this is effectively managed and compliant with all legislative requirements.
- 4.6.2 To approve the annual Infection Prevention and Control plan.
- 4.6.3 To scrutinise and recommend to the Board of the Directors the Annual Infection Control Statement.

5. MEMBERSHIP

- 5.1 The membership of the Committee will comprise of executives and non-executive directors only:
 - Three Non-executive Directors including the Committee Chair (The Chair shall not be the Chair of the Trust)
 - Chief Nurse
 - Chief Medical Officer
- 5.2 The Board of Directors will appoint the Chair of the Committee, in their absence, the Committee Chair can nominate another Non-Executive Director to chair the meeting.

6. ATTENDANCE

- 6.1 The Chief Executive Officer and The Trust Chair may attend the meetings of the Committee; however, they will be recorded as being 'in attendance' and not as being 'present'. No other party may attend without the specific invitation of the Committee Chair.
- 6.2 The Committee has the powers to invite or co-opt any individual that it deems appropriate to assist in the conduct of its purpose.

- 6.3 The Board of Directors has delegated authority to Deputy Directors to act as nominated deputy in the absence of an Executive Director of the Committee and where applicable, only one Deputy Director will count towards a meetings quoracy.
- 6.4 The Secretariat within the Office of the Chief Executive will be in attendance to provide administrative support.
- 6.5 Committee Members will be required to attend a minimum of four meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.
- 6.6 Others who may be invited to attend the meeting include:
- Company Secretary / Deputy Company Secretary
 - Director of Midwifery
 - Associate Medical Director, Clinical Safety
 - Clinical Governance and Professional Standards Co-Ordinator

7. FREQUENCY OF MEETING

- 7.1 The Committee will meet bi-monthly and a minimum of five times per year with additional ad hoc meetings as required.
- 7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.
- 7.3 Papers received after the deadline date (7 calendar days prior to the meeting) will not be accepted for presentation at the meeting, other than with the express agreement of the committee chair.
- 7.4 Reports to the Committee must be completed on the agreed template, with coversheet fully completed and following the expected Committee report writing protocols. The Chair has the authority not to accept reports that do not meet this standard.

8. QUORUM

A quorum shall be not less than four members of the Committee with a minimum of two executive directors (one of whom may be a Deputy Director) and two Non-Executive Directors

9. REPORTING

- 9.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.
- 9.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.
- 9.3 The Committee will report to the Board of Directors annually on its work through the Audit and Risk Committee.

10. REVIEW

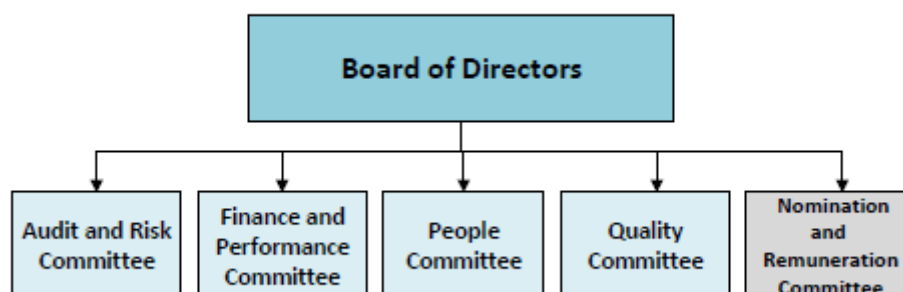
- 10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved
(Interim Chair of the Board of Directors)

Date of approval:

Nominations and Remunerations Committee

Terms of Reference 2026 FINAL



5. Constitution

The Nominations and Remunerations Committee (the Committee) is a standing committee, appointed by the Board of Directors ("The Board").

2. Authority

- 2.1 The Board of Directors authorises the Committee to fulfil its terms of reference. In doing so, the Committee is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- 2.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of people with the relevant expertise and experience if it considers this necessary.
- 2.3 The Committee is authorised by the Board of Directors to create sub-groups or Task and Finish Groups as it deems necessary in the fulfilment of these terms of reference.
- 2.4 Committee members and attendees will be expected to conduct business in line with the Trust values, objectives, constitution and supporting governance policies and demonstrably consider the equality and diversity implications of decisions they make.

3. Purpose

The committee is established to:

To review the structure, size, and executive composition of the Board of Directors, including nominations, succession planning, plus remuneration packages for executive directors and those not employed on Agenda for Change or medical contracts.

To approve arrangements for any redundancies, or special schemes (i.e. Mutually Agreed Resignations Scheme (MARS)). Authorise MARS payments over £80,000 or those payments where the Executive Team need further advice.

4. ROLES AND RESPONSIBILITIES

4.1 Nominations

- 4.1.1 Review the structure, size, and composition (including the skills, knowledge, and experience) of the Board and make recommendations to the Board about any changes.

- 4.1.2 Consider and make plans for succession planning for the Chief Executive and other executive directors.
- 4.1.3 Following appropriate recruitment processes and protocols, support the identification of candidates to fill executive director positions when they arise.
- 4.1.4 To Identify and nominate a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
- 4.1.5 Before an appointment is made evaluate the balance of skills, knowledge, and experience on the Board, and, in the light of this evaluation, support the preparation of a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the committee shall use open advertising or the services of external advisers to facilitate the search and consider candidates on merit against objective criteria. As part of this process ensure that the appointment process for the Chief Executive and executive directors meets the requirements of the Fit & Proper Person Test Framework.
- 4.1.6 Consider any matter relating to the continuation in office of the Chief Executive or any executive director at any time, including the suspension or termination of service of an individual as an employee of the Trust. For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.
- 4.1.7 Consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.
- 4.1.8 To make recommendation to the board on the appointment or removal of the Company Secretary.

4.2 Remuneration

- 4.2.1 Decide and review the terms and conditions of office of the Foundation Trust's executive directors, considering national guidance and policy, including.
 - 4.2.1(i) Salary, including any performance related pay or bonus.
 - 4.2.1(ii) Provisions for other benefits, including pensions and cars; and
 - 4.2.1(iii) Allowances
- 4.2.2 To monitor and evaluate the performance of individual executive directors.
- 4.2.3 To adhere to all relevant laws, regulations, and company policies, including, but not limited to, determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.
- 4.2.4 To Advise upon and oversee contractual arrangements for executive directors, including, but not limited to, termination payments.

5. MEMBERSHIP

- 5.1 The membership of the Committee will be only non-executive directors including the Chair of the Trust.

5.2 The Chair of the Board will chair the Committee (the Committee Chair). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

5.3 Where the Committee is reviewing the role of the Trust Chair or where there is a perceived conflict of interest, the Committee will be chaired by the Senior Independent Director. (see 6.2)

6. ATTENDANCE

6.1 Other people may attend the committee, as appropriate and with the specific invitation of the Committee Chair, however, they will be recorded as being 'in attendance' and not as being 'present'. These will include:

- (i) Chief Executive or the Deputy Chief Executive in their absence.
- (ii) Chief People Officer.
- (iii) Company Secretary, to provide administrative support as required.

6.2 Individuals shall not be present in the meeting when matters relating to their own terms and conditions of employment or remuneration are being discussed.

7. FREQUENCY OF MEETING

7.1 The Committee will meet at least annually.

7.2 Agenda and papers will be circulated seven calendar days prior to each meeting.

8. QUORUM

A quorum shall be not less than four non-executive directors including the Committee Chair or their deputy.

9. REPORTING

9.1 The minutes of all meetings of the committee shall be formally recorded by the Company Secretary. These will be retained by the Chief People Officer and Company Secretary for auditable purposes.

9.2 Following each Committee meeting, an update will be taken to the next confidential board meeting, an extra-ordinary confidential Board meeting can be called if the matter requires urgent attention.

9.3 The Committee will ensure that Directors' emoluments are accurately reported in the required format in the Trust's annual report.

10. REVIEW

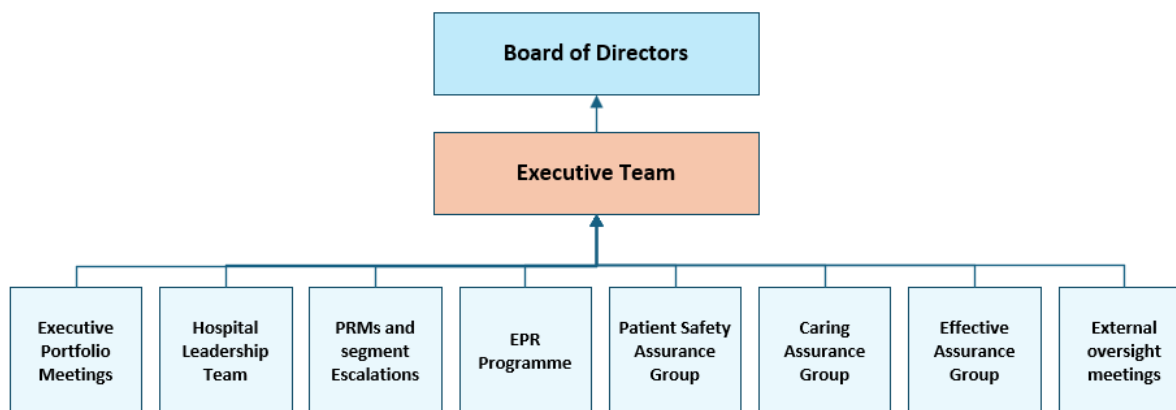
10.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors, at least annually and more frequently where required.

Signed as approved
(Interim Chair of the Board of Directors)

Date of approval:

Executive Team Meeting

Terms of Reference



1. Constitution

The Board of Directors delegates decision-making for the operational running of the Trust to the Trusts Executive Team in accordance with the Standing Orders of the Board of Directors, Reservation of Powers and Scheme of Delegation and Standing Financial Instructions

2. Authority

- 2.1 The Board of Directors authorises the executive team to fulfil its terms of reference. In doing so, the executive team is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by them.
- 2.2 In carrying out its role the executive team is authorised to seek reports and assurance from other executive directors and managers as required.

3. Purpose

The executive team is responsible for overseeing the day-to-day management of an effective system of integrated governance, risk management, and internal control across the whole organisation's activities (both clinical and non-clinical), which will deliver the Trusts strategic objectives.

The executive team will promote and embed the Trust's WE CARE values and reinforce a culture of quality improvement and innovation. The executive team will actively seek opportunities to collaborate via system and place-based partnerships for the benefit of local stakeholders and the wider community to promote Equality, Diversity and Inclusion and address health inequalities.

4. ROLES AND RESPONSIBILITIES

The executive team should ensure that governance and assurance systems operate effectively and underpin effective delivery of quality, person centred care. To achieve this the executive team will need to develop, agree, and implement strategies, policies and plans, procedures, and budgets, to ensure that the Trust has a proper system of controls in place to deliver high quality services to patients.

By exception and where required for decision the executive team should monitor decide and report:

- 4.1 Prioritising programmes of work and ensuring appropriate allocation of resources as required and in line with the Trusts medium term plan and strategic objectives.
- 4.2 Quality, contractual, financial and outcome performance where these are below national or internal standards.
- 4.3 Assessment, control, and management of trust risks, including oversight of risk treatment plans where these have been specifically escalated or are giving cause for concern.
- 4.4 Ensuring the delivery of board decisions are disseminated across the trust and enacted within in any stated time frames.
- 4.5 Supporting and informing board discussion on any agenda items required.
- 4.6 To have oversight in relation to significant internal or external incidents via the Emergency Accountable Officer.
- 4.7 To ensure compliance to trust policies as an executive team and within individual portfolios.

5. MEMBERSHIP

- 5.1 The membership of the executive team shall be all executive directors that are a voting member of the board:

Chief Executive Officer (Chair)
Deputy Chief Executive Officer (Deputy Chair)
Chief Finance Officer
Chief Medical Officer
Chief Nurse
Chief Operating Officer
Chief People Officer

- 5.2 In the Chairs and Deputy Chairs absence, another executive director can be nominated to chair the meeting.

6. ATTENDANCE

- 6.1 The Company Secretary will attend the formal executive team meeting for advice and guidance but will not have a vote on matters.
- 6.2 If an executive director is absent, they can nominate a deputy to attend, however, they **are not** included in the membership for that meeting or included in the quoracy and will be marked as attending.
- 6.3 Executive directors will be required to attend a minimum of 70% of meetings per year. A register of attendance will be maintained and reviewed by the chair annually.

7. FREQUENCY OF MEETING

- 7.1 The executive team will meet weekly on a Wednesday morning, attendance is expected in person, but hybrid options will be available if required, except the first Wednesday of each month which will be replaced by the Hospital Leadership Team The Chair can step down the meeting where required, and items will be deferred to the next meeting.

- 7.2 Agenda and papers will be circulated by the Monday prior to each meeting no later than 14:00 and stored on the Executive Teams Channel for access.

8. QUORUM

A quorum shall be not less than three executive directors. No deputy will count towards the quoracy.

9. REPORTING

- 9.1 The Chief Executive shall draw to the attention of the Board any issues that require disclosure, or escalation from the executive team meeting via the Chief Executive's Report

10. REVIEW

- 10.1 The executive team will review its effectiveness and, where appropriate, revise the groups terms of reference, at least annually and more frequently where required.

Signed as approved.
(Interim Trust Chair)

Date of approval

2607 - I1 BOARD ASSURANCE FRAMEWORK INCLUDING TRUST RISK

REGISTER

● Decision Item

👤 Rebecca Allen, Associate Director Strategy, Partnerships & Governance

Executive Directors

10 minutes

REFERENCES

Only PDFs are attached



I1 - Board Assurance Framework & and Risk Regsiter.pdf

Report						
Meeting Title:	Board of Directors			Meeting Date:	07 July 2026	
Report Title/ Ref:	Board Assurance Framework Compliance and Risk Register					
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	Approval/decision		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.					
Is this in line with Current risk appetite YES	Avoid	Minimal	Cautious	Open	Seek	Mature
			Regulatory Quality	Finance	People	
Executive Summary – Key messages and Issues						
This report presents the Board Assurance Framework (BAF) up to and including reviews to 23 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. Following the board development session in April, the board meeting in May and a further development session in June, which had focussed discussions on strategic risks and assurance, the decision was made to integrate the partnership risk within the other existing BAF risk framework, identifying clearly where partnerships were an enabler or potential barrier to Trust delivery of its strategic objectives. 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.

This includes a summary of the BAF over the preceding 12months and a summary of Trust risk register.

Recommendations

The Board of Directors are 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

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 committee's 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 suggested overall target risk scores that reflect the risk appetite. These changes also reflect the closure of some actions and the integration of partnership risks into the appropriate BAF risks
- 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 08 June 2026

Author: Tracy Evans-Phillips, Trust Risk Manager.

Introduction

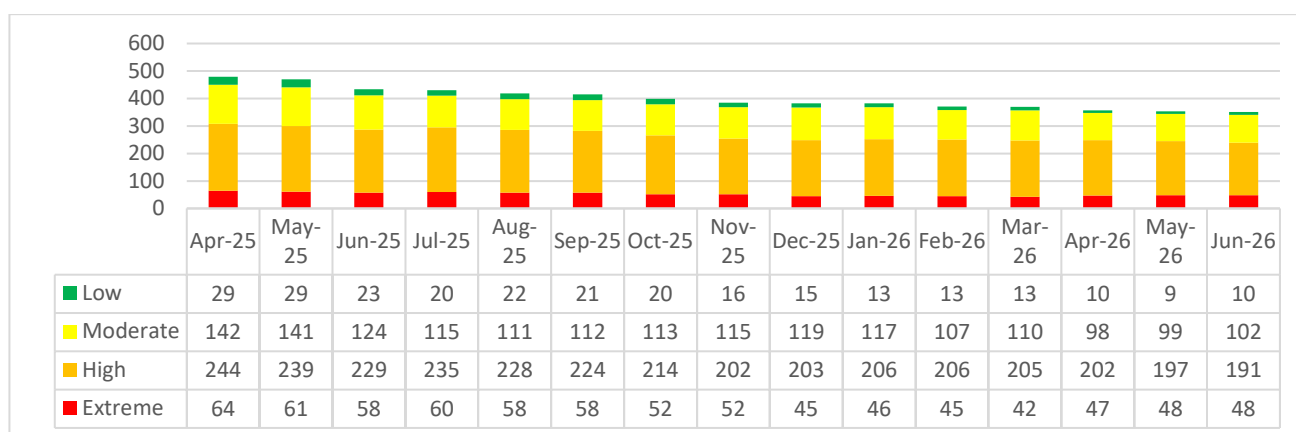
This report presents an update to the Board of Directors as part of the ongoing comprehensive review of all risks within the Trust. It outlines recent changes to the risk profile and details the work of the Risk Management Group to assess and moderate risks, including escalations and any new developments 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 April 2026 to June 2026

From April 2026 to June 2026, the risk register declined from 357 to 351 entries due to resolved issues, updated controls, and completed action plans. The number of open risks continues to reduce showing the effects of ongoing mitigation, register maintenance, and risk review including archiving, amalgamating or the reduction in scores of risks that had met their target threshold.

Over the last financial year (2025/26) there has been a 22.7% reduction in the number of recorded risks with the number of Extreme risks falling by 34.4%. 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. April 2026 saw an increase in the number of Extreme risks reflecting the financial challenges of the coming year.



Overview of Risk Numbers and Changes

- Risks archived: 39
- New risks added: 20
- Risks escalated (risk rating increased): 2
- Risks downgraded (risk rating decreased): 29
- Risks with no change in rating: 329

From April 2026 to June 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. The new risks identified fall within the themes of capacity, workforce and equipment.

Archived Risks

Risk Rating	Number Archived	Notable Detail
Low	8	
Moderate	16	
High	14	Resolution of digital improvement works
Extreme	1	Completion of electric works in Substation 4
Total	39	

Risk Management Group (RMG) Update

RMG oversight and assurance

The Risk Management Group continued to provide robust oversight of the Trust's risk profile, with particular focus on:

- risk quality and scoring consistency;
- delivery of agreed actions;
- strength of assurance; and
- appropriate escalation or de-escalation where supported by evidence.

In May 2026, risk management performance continued to improve, with overall risk numbers reducing and overdue reviews remaining below the breach target. In June 2026, risk themes remained broadly stable and governance maturity continued to progress. However, compliance with risk reviews deteriorated slightly as reported through the risk management group and will require continued focus in the coming months with direct interventions through the performance review meetings at divisional level.

Performance highlights

Strengthened assurance challenge

RMG continued to challenge risks through an assurance lens, focusing on whether controls were demonstrably effective and whether target ratings were realistic and achievable. This forum continues to effectively enable clinical and operational dialogue on risks and their mitigations with any escalations reported through to the hospital leadership team and executive team. In June there was one escalation to the hospital leadership team concerning lifts at Montagu Hospital. This was discussed from a clinical risk perspective with additional mitigations and actions put in place to manage the risk effectively.

Enhanced deep dive process

The enhanced deep dive process at the risk management group, covered the Surgery division in May 2026 and Executive Offices in June 2026. The discussions tested whether risks were understood, controls were effective, assurance was sufficient, and target ratings were realistic. This supported more informed scrutiny and decision-making. The evidence and challenge from the deep-dive process includes:

- structured consideration of whether controls are working and can be evidenced;
- explicit assessment of assurance strength, rather than reliance on risk scores alone;
- identification of gaps and the changes needed before risks can be reduced further;
- greater challenge on risk appetite, target ratings and residual risk; and
- improved visibility of strategic barriers, including workforce resilience, training capacity and capital constraints.

This provides clear line of sight from risk to controls, to assurance and Board oversight, which was evidenced through the RMG deep dive discussions and subsequent escalation to HLT.

Further review was requested for two risks:

- Deep Clean/Infection Prevention; and
- paper-based surgical records.

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	Managing medicine supply challenges to support timely patient care	30/09/2026	✓	15	6	No	23 Months	Deep Dive ✓	0	✓
BAF 1	3209	Chief Operating Officer	Improving patient pathway tracking and coordination	30/11/2026	✓	8	6	No	11 Months	No	0	✓
BAF 1	3246	Deputy Chief Nurse	Mental Capacity and Deprivation of Liberty Safeguards Compliance	30/09/2026	✓	12	9	No	3 Month	Deep Dive ✓	0	✓
BAF 1	3290	Chief Nurse	Ensuring appropriate workforce deployment and skill mix across inpatient services	01/12/2026	✓	10	6	No	35 Months	Deep Dive ✓	0	✓
BAF 6	3507	Director of Education and Research	Maintaining compliance with research governance standards	29/06/2026	✓	12	4	No	21 Months	Deep Dive ✓	0	✓
BAF 1	3454	Chief Medical Officer	Enhancing governance arrangements and service resilience	30/06/2026	✓	16	8	No	26 Months	Deep Dive ✓	4	✓
BAF 1	3883	Chief Operating Officer	Further developing emergency preparedness and response planning	31/10/2026	✓	12	3	No	2 Months	No	0	✓
BAF 1	3884	Chief Operating Officer	Enhancing on-call preparedness and incident management capability	30/09/2026	✓	12	3	No	2 Months	No	0	✓
BAF 1	3885	Chief Operating Officer	Strengthening emergency preparedness training and testing arrangements	30/09/2026	✓	12	3	No	2 Months	No	0	✓
BAF 1	3887	Chief Operating Officer	Developing specialist emergency response capabilities	30/09/2026	✓	12	3	No	2 Months	No	0	✓
BAF 2	16	Chief People Officer	Maintaining workforce capacity and capability	31/08/2026	✓	9	6	No	9 Months	No	1	✓
BAF 2	19	Chief People Officer	Improving colleague engagement and involvement	30/10/2026	✓	9	6	No	4 Months	Deep Dive ✓	0	✓
BAF 3	3890	Deputy Chief Operating Officer	Improving access to diagnostic services	31/07/2026	✓	12	12	RMG	2 Months	No	2	✓
BAF 3	3891	Deputy Chief Operating Officer	Improving access to elective care	31/07/2026	✓	12	12	RMG	2 Months	No	0	✓
BAF 3	3892	Head of Cancer Nursing	Improving access to cancer services	31/07/2026	✓	12	12	RMG	2 Months	No	1	✓

BAF 3	3893	Deputy Chief Operating Officer	Improving access to urgent and emergency care	31/07/2026	✓	16	12	RMG	2 Months	No	1	✓
BAF 4	12	Director of Infrastructure	Maintaining estate infrastructure to required standards	30/11/2026	✓	25	10	No	14 Months	Deep Dive ✓	9	✓
BAF 4	1083	Operational Director of Estates & Facilities	Modernising electrical infrastructure and resilience	02/11/2026	✓	15	10	No	94 Months	Deep Dive ✓	1	✓
BAF 4	1412	Deputy Director of Estates & Facilities	Maintaining fire safety compliance across the estate	31/12/2026	✓	15	10	No	62 Months	Deep Dive ✓	7	✓
BAF 4	1807	Operational Director of Estates & Facilities	Sustaining lift infrastructure and operational reliability	31/12/2026	✓	16	8	No	14 Months	Deep Dive ✓	2	✓
BAF 4	3348	Chief Medical Officer	Managing ageing equipment and asset replacement	01/10/2026	✓	12	8	No	19 Months	Yes Jun 26	1	✓
BAF 5	3895	Chief Finance Officer	Developing sustainable efficiency programmes	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3896	Chief Finance Officer	Advancing service redesign and productivity improvement	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3897	Chief Finance Officer	Strengthening workforce planning and productivity	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3898	Chief Finance Officer	Maximising income opportunities and service delivery	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3899	Chief Finance Officer	Managing workforce expenditure within planned resources	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3900	Chief Finance Officer	Managing non-pay expenditure effectively	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3901	Chief Finance Officer	Strengthening clinical engagement in efficiency programmes	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3902	Chief Finance Officer	Supporting delivery of the capital investment programme	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3903	Chief Finance Officer	Achieving planned cash and savings performance	15/06/2026	✓	16	6	RMG	2 Months	No	0	In progress
BAF 5	3880	Chief Finance Officer	Strengthening financial controls and payment verification	01/07/2026	✓	9	9	No	2 Months	Deep Dive ✓	0	✓
BAF 5	3920	Chief Finance Officer	Enhancing recruitment assurance and fraud prevention	01/09/2026	✓	9	9	No	1 Month	Deep Dive ✓	0	✓
BAF 7	1410	Head of Digital Operations & Cyber Security	Strengthening cyber security and digital resilience	31/10/2026	✓	10	10	No	10 Months	Deep Dive ✓	0	✓
BAF 7	1663	Chief Information Officer	Maintaining reliable connectivity and communications services	31/07/2026	✓	8	4	No	17 Months	No	0	✓
BAF 7	2727	Digital Infrastructure Manager	Enhancing server room infrastructure and environmental controls	30/06/2026	✓	9	3	No	24 Months	Deep Dive ✓	0	✓
BAF 7	2736	Head of Digital Operations & Cyber Security	Improving technical documentation and business continuity arrangements	31/07/2026	✓	9	6	No	49 Months	Deep Dive ✓	0	✗
BAF 7	3184	Chief Information Officer	Maintaining network infrastructure performance	30/09/2026	✓	8	4	No	17 Months	Deep Dive ✓	0	✓
BAF 7	3384	Chief Information Officer	Managing software and hardware lifecycle replacement	17/09/2026	✓	12	4	No	2 Months	No	0	✓
BAF 7	2638	UEC – Divisional Nurse Manager	Improving medicines management during patient transfers and admission pathways	17/07/2026	✓	15	3	No	28 Months	Deep Dive ✓	0	✓

BAF Linked operational risks

BAF No.	Risk Title		Rating
Patients	Quality Committee Oversight		
BAF 1	Strengthening the use of organisational learning and insight to support high-quality patient care		16
RISK 1517	Managing medicine supply challenges to support timely patient care		15
RISK 3209	Improving patient pathway tracking and coordination		8
RISK 3246	Strengthening compliance with Mental Capacity Act and Deprivation of Liberty Safeguards requirements		12
RISK 3290	Ensuring appropriate workforce deployment and skill mix across inpatient services		10
RISK 3454	Enhancing governance arrangements and service resilience		16
RISK 3507	Maintaining compliance with research governance standards		12
RISK 3883	Further developing emergency preparedness and response planning		12
RISK 3884	Enhancing on-call preparedness and incident management capability		12
RISK 3885	Strengthening emergency preparedness training and testing arrangements		12
RISK 3887	Developing specialist emergency response capabilities		12
People	People Committee Oversight		
BAF 2	Supporting an engaged, inclusive and sustainable workforce		16
RISK 16	Maintaining workforce capacity and capability		9
RISK 19	Improving colleague engagement and involvement		9
Patients	Finance and Performance Committee Oversight		
BAF 3	Balancing demand and capacity to improve access to care		16
RISK 3890	Improving access to diagnostic services		12
RISK 3891	Improving access to elective care		12
RISK 3892	Improving access to cancer services		12
RISK 3893	Improving access to urgent and emergency care		16
Patients & People	Finance and Performance Committee Oversight		
BAF 4	Maintaining a safe, compliant and effective care environment		20
RISK 12	Maintaining estate infrastructure to required standards		25
RISK 1083	Modernising electrical infrastructure and resilience		15
RISK 1412	Maintaining fire safety compliance across the estate		15
RISK 1807	Sustaining lift infrastructure and operational reliability		16
RISK 3348	Managing ageing equipment and asset replacement		12
Pounds	Finance and Performance Committee Oversight		
BAF 5	Delivering long-term financial sustainability		16
RISK 3895	Developing sustainable efficiency programmes		16
RISK 3896	Advancing service redesign and productivity improvement		16
RISK 3897	Strengthening workforce planning and productivity		16
RISK 3898	Maximising income opportunities and service delivery		16
RISK 3899	Managing workforce expenditure within planned resources		16
RISK 3900	Managing non-pay expenditure effectively		16
RISK 3901	Strengthening clinical engagement in efficiency programmes		16
RISK 3902	Supporting delivery of the capital investment programme		16
RISK 3903	Achieving planned cash and savings performance		16
RISK 3880	Strengthening financial controls and payment verification		9
RISK 3920	Enhancing recruitment assurance and fraud prevention		9
Patients & People	Finance and Performance Committee Oversight		
BAF 7	Developing resilient digital, data and technology services		15
RISK 1410	Strengthening cyber security and digital resilience		10
RISK 1663	Maintaining reliable connectivity and communications services		8
RISK 2727	Enhancing server room infrastructure and environmental controls		9
RISK 2736	Improving technical documentation and business continuity arrangements		9
RISK 3184	Maintaining network infrastructure performance		8
RISK 3384	Managing software and hardware lifecycle replacement		12
RISK 2638	Improving medicines management during patient transfers and admission pathways		15

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 Summary

BAF ref	Strategic Priority	Oversight	Description	Target Score March 28	Target Score March 26	Current Score (L x I)	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	March 26	April 26	May 26	June 26
BAF 1	Patients	Quality	Learning and listening to support delivery of excellent patient care		12	4 x 4	16	16	16	16	16	16	16	16	16	16	16	16
BAF 2	People	People	An open, inclusive culture that supports a skilled workforce	12	12	4 x 4	12	12	12	12	12	16	16	16	16	16	16	16
BAF 3	Patients	F&P	Timely access to care		12	4 x 4	16	16	16	16	16	16	16	16	16	16	16	16
BAF 4	Patients/People	F&P	A safe and welcoming Care Environment for all		20	4 x 5	20	20	20	20	20	20	20	20	20	20	20	20
BAF 5	Pounds	F&P	Delivery of financial plans and address the underlying deficit		12	4 x 4	16	16	16	16	16	16	16	16	16	16	16	16
BAF 6	Partnership	Board	Partnerships and Collaboration to transform and enhance services	6	6	2 x 4	8	8	8	8	8	8	8	8	8	8	Closed Integrated with remaining Risks	
BAF 7	Patients/People	F&P	Digital and Cyber resilience	12	15	3 x 5	15	15	15	15	15	15	15	15	15	15	15	15

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		
Trust Assurance Level	What this means for Board	Descriptions that are supported by the evidence presented
Substantial	High levels of confidence in Objectives being met	Controls and actions are designed, embedded and operating consistently across the Trust as intended. Evidence is clear, independent and triangulated across sources and demonstrates consistent performance over time
Significant	Good confidence with minor gaps that do not threaten delivery	Controls are largely effective with isolated weaknesses, which are known. There are targeted actions in place to close gaps with clear timelines and accountability for delivery.
Moderate	Some confidence, although there is a risk that objectives may not be fully met	Controls exist but are not consistently applied or embedded across the Trust. Action plans do not fully address identified gaps, there is some evidence to demonstrate progress in delivery, but this is not consistent, and or actions plans are not fully developed and/or there is only some evidence available to demonstrate the required impact/outcomes/performance.
Limited	Low confidence that risks are adequately controlled	Controls are underdeveloped, are reactive or are inconsistently applied across the Trust. Low or inconclusive evidence of remedial action plans that will deliver or evidence of outcomes being achieved, and a small number of priority areas require urgent action.
Weak	Little or no confidence that objectives will be achieved	Controls are ineffective, absent or failing. Several fundamental operational weaknesses have been recognised. Existing performance is below required standard with no evidence of immediate improvements. 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.	

BAF 1

Strategic Risk 1	If learning from incidents, patient experience, clinical outcomes and workforce insight is not effectively triangulated and translated into sustainable quality care, patients could experience avoidable harm, leading to deteriorating outcomes and potential 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 Regulatory: Cautious	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)	June 2026	Risk Rating	16		12	Risk Target Score	10	
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
Learning Opportunities			
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)	
Mortality Overview	GC4 Insufficient structured judgement reviews (SJRs) in line with best practice guidelines completed to contribute to Learning from Deaths and overview of mortality rates at DBTH 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) Structured Judgement Review (1) Mortality Report presented to Quality committee (2) Perinatal Mortality Review Tool (1) Maternity Outcomes Signal System (1) The National Maternity and Newborn Safety Investigations (1) <i>Planned Internal Audit Plan 2026-27 Q3/4 - Learning from deaths</i> <i>Planned Internal Audit Plan 2026-27 Q1/2 - Mortality data quality assurance</i>	GA1: SHMI data remains within confidence levels although at the upper limits within this, despite the ongoing projects to reduce this.
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)	

GC5) Recruitment to Learning from Deaths Manager	September 2026	CMO	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	Reviewed at the May 2026 Hospital Leadership Team meeting. Actions agreed: *to review to ensure documents are required as a policy and not SOP or guidance, *to review highest priority clinical policies and provide dates for completion to the July Hospital Leadership Team Meeting.
GC10) Action plan to address the CQC 29A Notice.	May 2026	CN	CQC action plan monitored through PRMs, HLT and executive with assurance oversight via the Quality Committee

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 / Partnerships	We are supportive, positive, and welcoming We work together to enhance our services with clear goals for our communities
Lead Committee	People Committee	Risk Rating	Current Exposure		Target (March 28)	Risk Type	Strategic	Links to Significant Risks on Risk Register
Executive Lead	Chief People Officer	Likelihood	4		4	Risk Appetite	People: Seek (4)	16;19, 3507
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Manage	
Risks Last reviewed (by on behalf of Lead Director)	May 2026	Risk Rating	16		15	Target risk Score	15	
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) Oversight of the People metrics Partnership working across place/ICS to align and share best practice on multiple areas including inclusion, education and Freedom to Speak Up (e.g., joint learning and benchmarking) Culture and Leadership Reset Programme Pillar Workforce and Organisational Design Reset Programme Pillar	GC5: National initiative 10-point plan for improving working lives of Resident Doctors’ GC6) System-wide workforce pipeline and learning pipeline, are not yet consistently developed and delivering	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) Data triangulation group (1) Education partners quality reviews and placement / learner feedback surveys (3) Progress reporting to People Committee (2) Reset Board (1) Board of Directors (2) NHSE meetings (3) RESET Delivery plans (2) Feedback to executive team on the ‘line in the sand’ (1) TLT workshop on ‘Line in the sand’ impact (1)	

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 Partnership arrangements with universities/education providers	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) (Significant Assurance)	GA2: the Trust wide Culture and Leadership programme to include the recommendations and actions following external cultural review of DBTH Way in Action.
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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	July 2026	Chief People Officer	The latest version of the draft policy has been to Policy Formulation Group and Staff Side meetings in May, further feedback has been received about the wellbeing passport. This will be presented to PFG in June. Once approved it will then be launched with supporting training and guidance. This information will form part of the people metrics data and the work of the data triangulation Group, which are aware of the impact of key Trust programmes which may negatively impact some people metrics initially.
GC4: Design of holistic leadership development modules into an overarching leadership programme	March 27	Chief People Officer	The Leadership conference was well attended and its evaluation and attendee feedback will be forming part of the learning for the next event. Under the leadership development and management capability scheme development is ongoing to progress to launch date.
GC5: Implementation of the 10-point plan for the national initiative of 'improving working lives of resident doctors	July 2026	Chief Medical Officer	Update included on the April 2026 People Committee agenda. – received Significant assurance and is on the June 26 agenda, with the reporting frequency for People committee agreed.
GA2: Development of Trust Wide Culture and Leadership Programme	March 2027	Chief People Officer	Culture and leadership pillar established as part of the reset programme with detailed underpinning delivery plans, articulating the 4 schemes. Reporting to the Rest Board, people committee from June meeting and Board updates (June).
GC6: System-wide workforce pipeline and learning pipeline plans are not yet consistently developed and delivered	March 2027	Chief People Officer	There is a SYB education group established, with plans to develop further with the acute trusts

BAF 3

Strategic Risk 3 (Cause – Event-impact)	If demand for clinical services exceeds the capacity available including where discharge capacity is dependent on partners, 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)	June 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

[illegible]

Patient initiated Follow-up (PIFU) policy Advice and Guidance policy Diagnostic improvement programme Virtual ward System partnership demand and capacity planning (ICB/place/provider collaborative), including agreed mutual aid triggers for elective, diagnostics and UEC	GC10) Implement frailty and surgical SDEC GC11) Formal mutual aid / capacity-sharing agreements and escalation triggers with system partners are not yet consistently in place across key pathways	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
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
GC11) Develop and implement formal mutual aid and escalation arrangements with system partners for elective, diagnostics and UEC pathways (with agreed KPIs and triggers)	March 2027	COO	Mutal Aid options being explored for a number of pathways to support with the access and waiting time standards. Initial clinical conversations held at Hospital Leadership Team
GA7) Limited assurance on partner-delivered elements of access recovery plans	March 2027	COO	Commence review of enabling partnership arrangements and plans to address key aspects of these on DBTH access plans.
GA8) Internal Audit of Patient Flow: Focus on Discharge (limited assurance)	March 2027	COO	Review of Internal Audit recommendations and commence implementation plan

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)	May 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 25 th 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 13 th 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 3 rd 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) 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 remain on track to deliver the medium term financial plans then the Trust may face 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	3895; 3896; 3897; 3898; 3899; 3900; 3901; 3902; 3903; 3880; 3920
Initial Date of Risk Assessment	July 2023	Impact	4		3	Risk Treatment Strategy	Treat	
Risk Last reviewed (by / on behalf of Lead Director)	May 2026	Risk Rating	16		12	Risk Score	10	
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 Alignment to ICB/system financial plan, including governance of partner assumptions, risk share and cross-system recovery actions Productivity and Financial Rest Programme Pillar	GC1: Medium Term Finance Plan requires review and updating GC9: Strengthen governance and assurance over system/partner assumptions within the Medium Term Finance Plan and any joint recovery schemes (activity, income, risk share)	Annual Plan reviewed by the F&P Committee (2) Trust Board Approve the Annual Plan (2) Progress reporting to F&P Committee (2) Reset Board (1) Board of Directors (2)	
Cost Improvement Plans system efficiency schemes (e.g., collaborative procurement, shared pathways and demand management) with named SROs and delivery governance	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) Reset Board (2) Board of Directors (2) NHSE IQIG Meeting (3)	
BAU Financial Operating policies, procedures HFMA checklist processes Estates Contract management Commissioner and partner contract management, including contract variation governance and assurance over partner-delivered savings/income assumptions	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) ICB/system finance meetings and system plan sign-off (3) Provider collaborative finance recovery reporting and peer benchmarking (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)	
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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
GC9: Implement a structured review of system/partner assumptions in the Medium Term Finance Plan (including sensitivity testing and escalation routes)	September 2026	CFO	commencing

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 and interoperability dependencies with system partners and third-party suppliers, we increase the risk of key system failure, disruption to services and negatively impacting patient care.						Strategic Objective: Patients People Partnerships	*We deliver safe, exceptional, person-centred care. *We are supportive, positive and welcoming *We work together to enhance our services with clear goals for our communities
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)	June 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) ICS/Place digital and interoperability strategy (including shared care record integration) and associated delivery roadmap with partners		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 Partnership Agreement in Place Interoperability and interface governance with partner organisations (including data sharing agreements and clinical safety assurance for integrations)	GC1: Development of Partnership relationships to support effective EPR implementation and ongoing Trust requirements	DSPT Audit reports, external cyber security assessments such as penetration testing, ad testing of information sharing agreements. (3) ICB/ICS Digital Board reporting on interoperability and cyber readiness (3)	GA1: Potential gap in board assurance and strategic oversight of the digital programme delivery GA2: Limited independent assurance over third-party and partner cyber resilience and EPR interoperability risks, including clinical safety of interfaces
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 GC9: Consistent assurance over third-party supplier and system partner cyber resilience and integration dependencies (including EPR interfaces) is not yet fully in place	Digital Maturity Assessment (3)	

Cyber security monitoring (monitoring, penetration testing, awareness campaigns, software/hardware)		NHS Cyber Assurance Framework results (3) Results of business continuity / EPRR testing (1) Reporting into DDaT (1) Report to Audit and Risk Committee (2) Data Security and Protection Toolkit (3) Audit plan (internal audit) (3) Counter Fraud arrangements (3)	
Cyber Assurance Framework actions implemented (IA Significant Assurance)			
Third-party/supplier cyber assurance (contractual requirements and compliance reviews) and joint cyber incident response exercises with system partners		Supplier assurance reports (e.g., ISO27001/SOC reports where available) and contract compliance reviews (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
GA1: Potential gap in board assurance and strategic oversight of the digital programme delivery	April 2026	CIO/CMO	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.
GA2: Limited independent assurance over third-party and partner cyber resilience and EPR interoperability risks, including clinical safety of interfaces	September 2026	CIO/CMO	Review and check against the DSPT and build into the EPR programme
GC1: Development of Partnership relationships to support confidence based on evidence of effective EPR implementation	Dec 2026	CMO	commencing
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.
GC8: IT Service management Report Recommendations	October 2026	CIO	Implementation of the recommendations from the report. Currently drafting action plan and owners.
GC9: Establish and implement a third-party/supplier and partner assurance framework for cyber resilience and interoperability (incl. EPR interfaces)	December 2026	CIO	commencing

2607 - I2 TRIANGULATION OF INFORMATION TO IDENTIFY AGENDA ITEM

THEMES

● Discussion Item

● Mark Bailey, Interim Chair

● 12:25

5 minutes

● Discussion Item

● Mark Bailey, Interim Chair

● 12:30

- 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

2607 - J CLOSING ITEMS

🕒 12:35

2607 - J1 MINUTES OF THE MEETING HELD ON 5 MAY 2026

● Decision Item

👤 Mark Bailey, Interim Chair

🕒 12:35

5 minutes

REFERENCES

Only PDFs are attached

📄 J1 - Board of Directors Draft Minutes - 5 May 2026.pdf

BOARD OF DIRECTORS – PUBLIC MEETING

**Minutes of the Board of Directors held in public on
Tuesday 5 May 2026 at 10:15am
in the Boardroom at Doncaster Royal Infirmary**

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 Dr Nick Mallaband - Chief Medical 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 Angela O'Mara - Deputy Company Secretary (minutes) Kelly Mackenzie - Consultant in Public Health (agenda item D3) Lois Mellor - Director of Midwifery (agenda item E1) Daniel Ratchford - Senior Director & General Manager, IQVIA (agenda C1) Emma Shaheen - Director of Communications & Engagement
Public in attendance:	Tanweer Ahmed - Board Development Programme Delegate Luke Appleton - IQVIA Hannah Beardmore - Staff Side Bo Escritt - Board Development Programme Delegate Gina Holmes - Staff Side Molly Houghton - Graduate Management Trainee Michael Taylor - Cinapsis
Apologies:	Richard Parker OBE - Chief Executive

ACTION

P26/05/A1 Welcome, apologies for absence and declarations of interest

The Chair welcomed everyone to the Board of Directors meeting, the above apology for absence was noted, and no conflicts of interest were declared.

World Hand Hygiene Day and the International Day of the Midwife were formally acknowledged by the Board. Members would visit midwifery colleagues during the day to express their appreciation and recognise colleagues' valuable contribution.

Actions from Previous Meetings (Enclosure A2)

Action 1 - Action Plan - DBTH in Action - an update was provided on the action log, the findings of the health and safety culture review had been considered alongside the wider culture and leadership programme of work. The report at agenda item C2 identified the themes, mapped to individual recommendations of the DBTH Way in Action and Well-led review and the specific actions required to address these. Action closed.

Action 2 - Mortality Review Update - the report was included at agenda item D3. Action closed.

Action 3 - Mental Capacity Assessments - Mental Capacity Act compliance was included as a quality priority for 2026/27, approved by the Quality Committee on 23 April 2026. Quarterly progress reports would be received by the Quality Committee. Action closed.

Action 4 - Sepsis Management - the report would be received by the Board's Quality Committee on 4 June 2026. Action closed.

Action 5 - Speaking Up Reports - a discussion paper would be considered by the Board's People Committee on 16 June 2026, and a subsequent update would be provided to the Board.

Action 6 – Guardian of Safe Working - the Chief People Officer and Chief Medical Officer 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 were opportunities to consider other routes to recruit to 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. Action closed.

Patient Story - Elisabeth's Story

The Chief Nurse introduced the short digital recording, which shared the journey of Elisabeth and her parents following her birth at Doncaster Royal Infirmary in 2024; their subsequent contact with the Trust and wider healthcare teams including primary, urgent and emergency care and the private sector.

The story highlights the concerns of Elisabeth's parents which began shortly after her birth and how they continued to seek medical advice related to Elisabeth's symptoms and developmental concerns over a seven-month period, which ultimately led to a diagnosis of spinal muscular atrophy.

The Matron in the digital story referenced the learning, education and changes to guidance, alongside the planned roll out of Martha's Rule which would support families to seek a second opinion. Recent media coverage had also raised public awareness of the condition.

The Chief Nurse recognised the importance of listening and acting upon families' concerns, which was also a key theme from Children & Young People surveys. An extended version of the story, which included Elisabeth's parents, had also been produced to support with learning across the division. Each division had been asked to produce two patient stories and a central repository of these would be available on the Trust's intranet. The Board's Quality Committee would receive a digital patient story on a quarterly basis.

In response to a question from Non-executive Director, Stephen Radford, the Chief Nurse confirmed that the Trust was implementing Marthas Rule in accordance with national guidance. Phase one, which included the introduction of Patient Wellness Questionnaires, was complete. There was a need to consider the Trust's approach to the provision of an independent second opinion due to 24/7 critical care outreach not being available.

The Board:

- ***Noted Elisabeth's Story***

P26/05/C1 2025 National Staff Survey Results (Enclosure C1)

The Chair welcomed Daniel Ratchford of IQVIA, the Trust's Staff Survey provider, to the meeting.

Before Daniel reflected on the findings of the 2025 survey, the Chief People Officer confirmed that the staff survey results had been considered alongside the feedback from the DBTH Way in Action, Well-Led, and Speaking Up Peer Review which informed the Culture and Leadership Programme. This rich source of information, including narrative provided as part of the feedback process, was triangulated with patient and people metrics to inform the development of colleague led local improvement plans.

Whilst the response rate of 54% was a reduction to that of 2024, it was not unexpected given the local and national context the Trust and wider NHS operated in. The Trust's 2025 response rate compared favourably to the sector average of 47%, which had also seen a decline from 49% in the previous year.

The year-round cycle of engagement had commenced with local leaders engaged with colleagues in action improvement planning, with support available from the People Business Partner team and oversight of action planning as part of the Performance Review Meetings.

A consistent methodology had been used since the launch of the survey, which supported the tracking of opinion over time, although it was acknowledged that the method of data collection and the associated delay in reporting was now outdated and more responsive means of seeking real time feedback was used in other non-NHS organisations.

Daniel highlighted the importance of colleague engagement, noting the positive impact of an engaged workforce on patient experience and outcomes and in attracting and retaining colleagues.

The presentation provided an at a glance summary of 2024 and 2025 scores across the themes of staff engagement and morale and the seven People Promises. 2025's results showed no significant change in the majority of areas, with a significant improvement seen in People Promise 6 "We work flexibly" and a significant decline in People Promise 3 "We each have a voice that counts". When compared to the sector score, the Trust scored significantly better on colleague morale, People Promise 4 "We are safe and healthy", People Promise 5 "We are always learning" and People Promise 6 "We work

flexibly". The key themes and suggested areas to celebrate and focus for 2026 were shared.

In respect of the advocacy sub section in colleague engagement, it was noted all three questions regarding the care of patients and service users being a top priority, recommending the Trust as a place to work and to receive care/treatment had significantly declined from 2024 and were significantly worse than the sector average.

The Chief People Officer confirmed that as part of action planning all teams would be asked to consider three areas for improvement which included colleagues advocacy in recommending the Trust as a place to work and to receive care/treatment.

The Board:

- ***Noted and took assurance from the 2025 National Staff Survey Results***

P26/05/C2

DBTH Way in Action & Well-led Review Progress Report (Enclosure C2)

Since the report findings were shared at January's Board meeting work had been ongoing to map themed recommendations to actions, with identified governance routes, clearly articulated success measures, responsible executive leads, target completion dates and a RAG rated tracker. This cohesive action plan had taken into consideration the findings of the 2025 staff survey, triangulated with broader evidence sources, including the Speaking Up peer review.

The Acting Chief Executive recognised the significance of this work and encouraged members to review, and sense check the plan and impact of the actions. This would remain a live piece of work to support ongoing delivery.

Executive colleagues recognised the all-encompassing nature of the plan and the need to embed the change arising from the actions would be fundamental to its success.

Non-executive Director, Stephen Radford, welcomed the comprehensive action plan and enquired how the actions would positively impact on patient care and experience. The Chief Nurse noted the various sources of evidence where the impact could be seen, including patient surveys, complaint themes, patient metrics, Speaking Up and social media feedback. The Chief People Officer reiterated the strong evidence base that indicated a correlation between engaged colleagues and a positive patient experience.

The Acting Chief Executive reflected on the impact of the audiology improvement work, informed by colleague, patient and partner feedback and engagement, which had included informal and formal service visits. Work continued to drive further improvements across the service.

Non-executive Director, Lucy Nickson, acknowledged that the decline in staff survey response rate from the previous year to 54% was not unexpected and was assured by IQVIA that this reduction had been seen in other trusts, with a reduction seen across the sector.

Non-executive Director, Kath Smart, highlighted the perception, of some colleagues, of a lack of anonymity in the survey. Daniel recognised this view and confirmed the

processes in place to allay that fear with survey providers providing anonymised aggregated data. He also noted that the likely outcome of such a belief would be seen in the response rate, which did not appear to be an issue for the trust when comparing to sector response rates.

Non-executive Director, Kath Smart, enquired of the impact of action planning and in particular if there were areas where feedback had resulted in a positive change, or perhaps the desired outcome had not been achieved. The Chief People Officer cited the positive impact on People Promise six (we work flexibly), with benefits realised by individuals and the organisation. Despite significant efforts to support colleagues in Speaking Up, the benefits were not seen in the staff survey results, further work was ongoing to seek improvements by understanding colleagues views across the organisation and by professional groups.

In response to a question from Non-executive Director, Jo Gander, regarding how learning would be captured from the DBTH Way in Action and Well-led reviews, the Chief People Officer confirmed that the recommendations tracker would be considered by executive led groups and Board committees. The Board of Directors would review progress against the summary action plan at alternate meetings.

The Chief Finance Officer encouraged curiosity around the decline seen in colleague advocacy in respect of recommending the trust as a place to work and receive treatment which should be explored as part of local engagement.

Non-executive Director, Lucy Nickson, recognised the need for communications to address any misconceptions that the focus was on delivery of financial plans and to articulate that quality was equally important.

Daniel Ratchford welcomed the opportunity to present the findings of the staff survey, which he felt was a positive reflection on the importance placed on the survey outcomes by the organisation.

The Chair welcomed the extensive discussion and shared his appreciation of this programme of work.

The Board:

- ***Noted and took significant assurance that the Trust had responded to the independent reviews, with partial assurance in respect of longer term cultural and behavioural change which will demonstrate impact over time***

P26/05/D1

Chair's Report including Partnership Update (Enclosure D1)

The Board received the Chair's report which confirmed the Trust would move into the delivery phase of its three-year medium-term plan, which would see a more consistent and sustainable way of delivering services. Working alongside our system partners to ensure mutual benefit.

Later this month, governor elections would commence and nominations would be sought for public and colleague governors to contribute to the Trust's future direction of travel.

The Board:

- ***Noted the Chair's Report***

P26/05/D2

Chief Executive's Report (Enclosure D2)

The Acting Chief Executive brought the Board's attention to the following key highlights from the report.

Delivery of a breakeven financial plan had been supported by receipt of £4.2m of additional funding in the final quarter of 2025/26 and progress was noted in the delivery of urgent and emergency care operational standards, supported by the adoption of national improvement initiatives. There was a need for consistency in delivery, with a balanced approach to finance and quality and for more rapid improvements to be seen in the number of patients waiting over 52 weeks.

The Acting Chief Executive shared her appreciation of colleagues efforts in delivering these improvements and recognised the ongoing support required across the Trust to drive and embed change to create a sustainable organisation.

The positive work to improve audiology patient experience and service improvements by the Trust and in the community was recognised. The Montagu Elective Orthopaedic Centre of Excellence had secured national accreditation and an automation upgrade to the inpatient pharmacy had improved dispensing efficiency and released colleague time for direct patient care.

Additional car parking provision had been made available on the Doncaster Royal Infirmary site, with further expansions planned.

Initial feedback from the Care Quality Commission's inspection of paediatric services was being considered and responded to.

To close, the Acting Chief Executive confirmed that the Chief Medical Officer's recruitment process concluded last week, with the appointment of Dr Nick Mallaband. Dr Mallaband had joined the Trust as a Consultant in Acute Medicine in 2011 and had held senior roles, including the Acting Executive Medical Director role for the previous two years. Along with significant experience and organisational knowledge the appointment provided continuity and congratulations were shared.

The Board:

- ***Noted the Chief Executive's Report***

P26/05/D3

Integrated Quality & Performance Report (Enclosure D3)

The Integrated Quality and Performance Report (IQPR) provided key performance and safety measures relating to cancer standards for February and remaining access, quality, and workforce standards for March 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 significant improvements had been seen in four hour waits due to the national Spring reset initiative, in month performance was 0.5% below target. 12-hour performance and ambulance handovers were both above plan. A variation in the provision of emergency care was seen at Doncaster Royal Infirmary, whilst organisational grip and control had improved there remained challenges with extended waits out of hours. With a more noticeable increase in demand seen at Bassetlaw Hospital.

The standard for patients waiting less than 18 weeks from referral to treatment had not been met, the underperformance was largely driven by the high volume waits in Trauma and Orthopaedics.

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, with challenges seen in specific tumour sites, with 26% of prostate waits in excess of 62 days. Internal radiology and external histopathology delays had been seen, and targeted actions were being progressed.

The Chief Nurse reported a combined total of five hospital and community onset healthcare associated C. difficile cases, against a target of four. The 2025/26 national threshold, set upon historical performance, had been breached. The assurance report highlighted strengthened antimicrobial stewardship arrangements, and the Chief Nurse confirmed plans for a Trust C. difficile roundtable.

The Chief Finance Officer confirmed delivery of the 2025/26 financial plan. A record £31.4m of efficiencies had been delivered in year, £22.3m of which were recurrent. This addressed £9.6m of the Trust's underlying deficit, which would need to be resolved during the course of the three-year plan.

The latest published data (month eight) showed implied productivity had improved by 8% when compared to the same period in the previous year and placed the Trust in the best quartile nationally.

2025/26 capital investment programme had been delivered and the cash balance at year end was £53.4m, £37.6m favourable to plan.

The Chief People Officer confirmed that sickness absence stood at 5.6% as at March 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 (SET) compliance was 84.1% against a local target of 90% and feedback from the commissioned audit would be welcomed as part of the audit closure meeting.

Non-executive Director, Jo Gander, enquired of plans to address the prostate wait time, which the Chief Operating Officer confirmed related to a bottleneck at the beginning of the pathway. Discussions with primary care colleagues in respect of referrals had taken place.

Non-executive Director, Stephen Radford, recognised the increasing demand on urgent and emergency care and enquired how improvements could be sustained, the Chief

Operating Officer confirmed that early performance data for April indicated 74% of patients waited no more than four hours, with the main challenge being flow out of the Emergency Department.

The Board

- ***Noted & took assurance from the Integrated Quality & Performance Report***

P26/05/D3i Mortality Review Update (Enclosure D3i)

The Chief Medical Officer clarified the purpose of the Summary Hospital-level Mortality Indicator (SHMI), as a statistical tool to identify variance between the actual and predicted number of deaths. Since 2025 the Trust's SHMI performance had remained stable. Whilst performance was within the national statistical control limits it was at the upper limit and there remained a desire to reduce this towards the baseline of 1.0. It was recognised that the level of deprivation in the local population negatively impacted the Trust's performance.

Robust mortality governance arrangements were in place and the Board's attention was drawn to an improved level of completion of Structured Judgement Reviews (SJRs). The majority of SJRs identified good or excellent care, including the timely recognition and escalation of sepsis, a reflection of the ongoing sepsis improvement work. The timely administration of antibiotics on diagnosis remained challenging and performance was lower than hoped and below that of our peers. A deep dive review of sepsis management would be presented to the Board's Quality Committee in June 2026.

A dashboard was in development, using a range of quality metrics to act as an early alert and warning system; this would be subject to ongoing refinement.

The Chief Medical Officer confirmed that the most recent national published SHMI data spanned the period, December 2024 to November 2025, whilst the data at section five of the report was provided by an internal monitoring tool up to February 2026. Should this performance translate into the national data a positive impact on SHMI was expected.

In response to a question from Non-executive Director, Lucy Nickson, regarding the challenges in the timely administration of antibiotics, the Chief Medical Officer confirmed this was a key action of the Sepsis Action Group. A series of quality improvement initiatives, including prescribing arrangements and antimicrobial ward rounds, were underway across the organisation. A recent update to NICE guidance was noted, which had seen a focus on the identification and escalation of high-risk sepsis.

Non-executive Director, Kath Smart, welcomed the provision of additional data. In response to how mortality was scrutinised at the Performance Review Meetings, the Chief Medical Officer confirmed that this extended beyond divisional and into speciality level data.

Non-executive Director, Kath Smart, acknowledged the increased SJR completion rate and enquired if there was sufficient capacity to deliver an improved position. The Chief Medical Officer confirmed capacity had improved, however, the completion rate in Q3

2025/26 had been impacted by a national software issue and reported that in Q4 a total of 57 SJRs had been completed.

The 2026/27 internal audit plan included an assessment of the systems and processes in place to support learning from deaths, via SJRs. The Chief Medical Officer confirmed that since the previous audit there would be additional areas of focus resulting in a different sample.

The Chief Finance Officer enquired how the Trust's capacity to complete SJRs compared to that of other organisations. The Chief Medical Officer confirmed that whilst progress had not progressed as quickly as hoped, 100% of SJRs requested by the Medical Examiner's team were completed and the remaining reviews were part of a targeted approach. Neighbouring District General Hospitals had a different approach to the completion of SJRs and whilst their capacity was greater, it was not significantly different to that of the Trust.

In response to a question from Non-executive Director, Stephen Radford, the Chief Medical Officer confirmed that co-morbidities and age were factors taken into consideration in SHMI, however, deprivation was not and this had a negative impact on the Trust's performance. The Chief Medical Officer clarified that SHMI primarily focused on acute hospital care whereas healthy life expectancy considered broader population health and living conditions.

The Board:

- ***Noted and took assurance from the Mortality Review Update***

P26/05/D3ii Health Inequalities Bi-annual Report (enclosure D3ii)

The Chair welcomed Dr Kelly Mackenzie, Consultant in Public Health to the meeting. The Board's attention was drawn to the areas of focus to address health inequalities in 2026/27, which included education, evidence-based interventions, research and developing a culture where addressing health inequalities became business as usual.

Collaborative programmes of work would focus on the elective care pathway, reducing non-attendance and improving access to Women and Children's services. With funded research projects to understand the prevalence and impact of period poverty and exploring the barriers to accessing perinatal mental health care.

To improve health inequalities data, and with the support of data analyst colleagues, an equity index tool and did not attend (DNA) health inequalities dashboard had been developed, which would be helpful in prioritising efforts and tracking progress.

Board member volunteers were sought to complete the health inequalities self-assessment tool, to benchmark to data collected in April 2025.

The Chief People Officer recognised the positive evaluation of the Change Initiator training and enquired what the expectation was of colleagues upon completion. It was suggested that a follow up questionnaire to understand the application and impact of learning would be beneficial and would enable colleagues to understand how their role made a difference to patients and service users as explored in the Staff Survey.

The Chief Nurse enquired how the shift from training and education into business as usual was best achieved and in terms of the inclusion of health inequalities data, suggested an approach to identify a chosen metric and weave inequalities data into existing reporting. The Chief Operating Officer confirmed that this has been explored with the Associate Director of Planning, Performance and Improvement in regard to access standards and focusing efforts on areas requiring improvement, such as DNA rates.

The Consultant in Public Health welcomed this approach and as the index was now embedded into the trust's data systems, information including ethnicity and deprivation would be accessible.

The Chair encouraged colleagues to explore ways to explore how health inequalities could be incorporated into routine reporting.

The Board:

- ***Noted the Health Inequalities Bi-annual Report***

P26/05/D4 Delivery of 2025/26 Strategic Success Measures (Enclosure D4)

The paper highlighted strong delivery against the Trust's strategic ambitions, with clear and triangulated evidence of progress. Where residual risks were identified, forward plans for resolution had been identified.

Going forwards, delivery would be considered as part of the governance arrangements for the medium-term plan.

Non-executive Director, Kath Smart, noted the reference to variable NICE compliance and enquired how improvements would be secured. The Chief Medical Officer confirmed compliance was actively monitored by the Effective Assurance Group, with areas of non-completion subject to scrutiny and approval. Where compliance levels were below required levels, improvement trajectories were agreed. The Board's Quality Committee maintained oversight of clinical effectiveness through routine reporting.

The Chair acknowledged the achievements, welcomed the inclusion of data and clarity of next steps. Communication of the achievements should be shared across the organisation, which would feature as part of a review of 2025/26 and as part of the Trust's Annual Report and Accounts.

The Board:

- ***Noted and took significant assurance from the Delivery of 2025/26 Strategic Success Measures***

P26/05/D5 Medium Term Plan (Enclosure D5)

The Chief Finance Officer confirmed that a compliant (with conditions) medium term plan had been agreed by NHSE, which featured financial support during 2026/27 linked to Trust performance.

NHSE's requirements were summarised in the paper, and the Chief Operating Officer confirmed the first draft performance recovery plans were expected by the end of this week.

The Acting Chief Executive confirmed the need to deliver actions at pace to improve patient outcomes and strengthen the sustainability of the organisation. Delivery of the plans would be reported at the Board and its assurance committees.

The Board:

- ***Noted the Medium-Term Plan***

P26/05/E1 Maternity & Neonatal Safety Report (Enclosure E1)

The interim report confirmed that perinatal mortality remained within the expected range, with no Maternity Outcomes Signal System (MOSS) alerts.

The Trust quality metrics and MOSS charts were reviewed and noted by the Board, the quality metrics had remained largely static, except for the postpartum haemorrhage (PPH) and neonatal death rate per 1000. The Board's Quality Committee had considered maternity and neonatal safety reporting in more detail at its April 2026 meeting, as captured in the Chair's assurance log.

The information team were working with maternity colleagues to support the presentation of data in line with technical guidance around the use of statistical process control charts.

The Board:

- ***Noted and took assurance from the Maternity and Neonatal Safety Report***
- ***Reviewed and noted the Trust's Quality Metrics***
- ***Reviewed and noted the Maternity Outcomes Signal System (MOSS) update***

P26/05/E2 Provider Licence Compliance & Self Certification (Enclosure E2)

The Board received the draft self-certification in respect of the Continuity of Services (Condition 7) of the Provider Licence. This had been reviewed and recommended for sign off by the Audit & Risk Committee at its meeting of 17 April 2026.

The Board approved the declaration and post meeting the Acting Chief Executive and Chair's signatures were applied to allow the declaration to be published on the Trust website.

The Board:

- ***Approved the Provider Licence Compliance & Self Certification***

P26/05/E3 Unannounced Care Quality Commission Inspection of Children & Young Persons' Service (verbal)

The Chief Nurse confirmed that written correspondence had been received from the Care Quality Commission which confirmed the initial feedback provided at the time of the unannounced inspection of Children and Young Persons' Services at the Trust on 22 and 23 April 2026.

The feedback was largely positive, with the service demonstrating positive learning and innovation, reflecting a commitment to improve the quality and responsiveness of care. The multidisciplinary team had spoken positively of recent service change, and senior leaders were visible and accessible.

The feedback acknowledged the ongoing review of staffing in line with the Safer Nursing Care Tool and discussions in respect of the operational policy for the assessment area on the Bassetlaw site.

In excess of 130 data submissions were to be verified for submission and in due course factual accuracy would be required when the draft inspection report was received.

The Board:

- ***Noted the verbal update on the Care Quality Commission Inspection of Children & Young Persons' Service***

P26/05/F1 2025/26 Going Concern Assumption & Delegation of Authority to Approve the Annual Report & Accounts (Enclosure F1)

Following consideration by the Finance & Performance Committee in March 2026, a recommendation was made to the Board, that the Trust's 2025/26 accounts be prepared on a going concern basis.

The Chief Finance Officer confirmed that the assumption was further strengthened by NHSE's acceptance, with conditions, of the Trust's medium-term plan which included deficit support funding during 2026/27.

As the submission of the annual report and accounts was required ahead of July's Board meeting, the Trust Board delegated authority to the Audit & Risk Committee to approve the audited report and accounts on its behalf.

The Board:

- ***Approved the 2025/26 Going Concern Assumption & delegated authority for approval of the annual report & accounts***

P26/05/G1 Doncaster & Bassetlaw Healthcare Services Update (Enclosure G1)

The Chief Finance Officer brought the Board's attention to the key highlights of the report, noting the strong financial performance and delivery of pharmacy key performance indicators.

In response to a question from the Chief People Officer, the Chief Medical Officer confirmed that despite applicants no longer being accepted to the Medical Training Initiative, Doncaster & Bassetlaw Healthcare Services would continue to work in partnership with QiMET International. Internal discussions within the Trust were at an early stage, with more advanced external discussions.

The Chair highlighted his conflict of interest as Chair of Doncaster & Bassetlaw Healthcare Services and welcomed their contribution.

The Board:

- ***Noted and took assurance from the Doncaster & Bassetlaw Healthcare Services Update***

P26/05/G2 Chair's Assurance Log – Finance & Performance Committee (Enclosure G2)

The Board received the Finance & Performance Committee Chair's assurance log from April 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

Non-executive Director, Stephen Radford, brought the Board's attention to the split assurance taken in respect of the Local Security Management biannual report, which recognised that although effective controls were in place the compliance rating assigned to the Violence Prevention and Reduction Standard was amber due to external limiting factors.

The committee supported the proposed governance model for the Getting it Right First Time Programme and approved the updates to its terms of reference which would be subject to a further review to ensure oversight and assurance on delivery of the Medium-Term Plan.

The Board:

- ***Noted the Chair's Assurance Log***

P26/05/G3 Chair's Assurance Log – Quality Committee (Enclosure G3)

The Board received the Quality Committee Chair's assurance log from April 2026's meeting, which summarised the assurance taken, areas of ongoing work, matters of concern and decisions taken.

Non-executive Director, Jo Gander, confirmed the committee had taken partial assurance in respect of the national clinical audit of early inflammatory arthritis and emergency laparotomy, where the Trust had been identified as an outlier. Robust governance and escalation arrangements were in place, however, an improvement in outcomes had not yet been delivered and the committee would retain oversight.

The Board:

- ***Noted the Chair's Assurance Log***

P26/05/G4 **Chair's Assurance Log – People Committee (Enclosure G4)**

The Board received the People Committee Chair's assurance log from April 2026's meeting which summarised the significant assurance taken by the committee, with no matters of concern or escalation to be shared.

The Board:

- ***Noted the Chair's Assurance Log***

P26/05/G5 **Chair's Assurance Log – Audit & Risk Committee (Enclosure G5)**

The Board received the Audit & Risk Committee Chair's assurance log from April 2026's meeting, which summarised the assurance taken, areas of ongoing work, and decisions taken, including the approval of 2026/27 audit plans.

As part of the annual review of committee effectiveness and incorporating recommendations from a recent Board development session, a number of recommendations would be incorporated into future Board committees to enhance assurance, triangulation of evidence and further improve reporting in Board and committee papers.

The Board:

- ***Noted the Chair's Assurance Log***

P26/05/H1 **Board Assurance Framework Compliance & Trust Risk Register (Enclosure H1)**

The Board Assurance Framework (BAF) was received and the content approved, 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.

The Associate Director of Strategy, Partnerships & Governance confirmed that further to the review of the Trust's risk appetite statements at April's Board development session, a paper would be brought to July's Board meeting for approval. This would propose no change to the appetite scores, with updated supporting statements

RA

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.***

P26/05/H2 **Triangulation of Information to Identify Agenda Item Themes (verbal)**

The following examples of triangulated discussions were noted from the meeting:

- Elisabeth's Story and the findings of the Children and Young Persons' Inspection

- Findings of the 2025 Staff Survey, alongside the DBTH Way in Action and Speaking Up peer review
- Summary Hospital-level Mortality Indicator (SHMI) linked to health inequalities actions
- Findings of the Staff Survey, the reporting and compliance with the Violence Prevention and Reduction Standards as part of the Local Security Management report - considered alongside the impact on colleagues as part of the work of the People Committee

P26/05/H3 Board Effectiveness and Demonstrating the DBTH Way (verbal)

The Board reflected on today's meeting and shared the following observations:

- The time taken was appropriate for individual discussion items.
- Papers were of a good standard.
- The importance of the Director of Midwifery's contribution at Board was recognised.
- An acknowledgement that there was more to do on the presentation of data, and the use of trajectories.
- Our people were the focus of many discussions.
- Some conversation around the table were difficult to hear, colleagues to be mindful of their volume and revisions to room layout to be explored.
- Challenge was appropriate and courteous.

P26/05/I1 Minutes of the meeting held on 24 March 2026 (Enclosure I1)

The Board:

- ***Approved the minutes of the meeting held on 24 March 2026, subject to the amendments shared by the Chief Nurse to agenda item P26/03/D2***

P26/05/I2 Pre-submitted Governor or Public Questions (verbal)

The following question was submitted in writing by a member of the public:

Access to Services

1 - what is the Trust standard for answering telephones, does the Board allow for answerphones to be used and if so, what is the expectation on replying to left messages? What response timescales does the Board believe are acceptable.

2 - does the Board or Board sub committees receive performance information on incoming calls that are unanswered and or abandoned? If so, which services perform the worst.

3 - does the Board expect equal access to services no matter the communication type e.g. face to face/ phone calls / email / letter

I should be grateful if I could be provided with a copy of the minutes or correspondence that demonstrates these questions were raised and answered in public.

The Chief Finance Officer confirmed that the Trust's switchboard handled an average of 65,000 calls per month, a response standard of 30 seconds was largely met, with c.7% of calls abandoned before being answered. Performance was available for the switchboard and appointment centre, monitored via the Digital Performance Group, with an agreed escalation route, as required.

Ansaphones were in use across some clinical and corporate areas, however, response times were dependent upon the type of service and its criticality and were commensurate with clinical needs. Work to measure wider call handling performance was underway.

It was recognised that response times differed between verbal and written communication, due to the nature of contact. Parity of access was supported through services such as Relay UK.

Service standards across corporate and divisional teams were reviewed as part of the executive led Performance Review Meetings, with executive and non-executive board member service visits providing a valuable opportunity to engage directly with colleagues, hearing first hand their experiences and using this to triangulate with other sources of evidence.

P26/05/13 Any other business (to be agreed with the Chair prior to the meeting)

No items of other business were raised.

P26/05/14 Board of Directors Work Plan (Enclosure 14)

The Board

- ***Received the Board of Directors Work Plan for information***

P26/05/15 Date and time of next meeting (verbal):

Date: 7 July 2026

Time: 9:30am

Venue: Boardroom, Bassetlaw Hospital

P26/05/16 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.***

P26/05/17 Close of meeting (Verbal)

The meeting closed at 14.17

2607 - J2 PRE-SUBMITTED QUESTIONS

● Discussion Item

● Mark Bailey, Interim Chair

● 12:40

10 minutes

2607 - J3 BOARD OF DIRECTORS WORK PLAN

 Rebecca Allen, Associate Director of Strategy, Partnerships & Governance

 12:50

REFERENCES

Only PDFs are attached

 J3 - 4Ps Board Work Plan Update 2026.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									COMMENTS
				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									IPC/AMS presentation to BoD Q1 2026. By April 2026 3 priority areas for AMR improvement (progress reports quarterly, annually to BoD
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-27			x						
Maternity Workforce-	Director of Midwifery	Bi-annual										
Research & Innovation Case Study	Chief People Officer	Annual	Jul-26				x					Report changed from Quality to People Committee in June 2026 - next due December 2026
DBTH Way in Action & Well-led Review Progress Update	Acting Chief Executive	Alternate	September			x		x		x	x	
PARTNERSHIP												
Doncaster & Bassetlaw Healthcare Services Update	Chief Financial Officer	Quarterly	May-26			x	x	x		x		
Wider Partnership updates	CEO	As required	As Req'd									
POUNDS												
Financial Plan	Chief Financial Officer	Annual	TBC		x							
Going Concern	Chief Financial Officer	Annual	May-27			x						
Delegation for the Approval of Annual Accounts and Annual report	Chief Financial Officer	Annual	May-27			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 Janary 2026)	COO/CN/EMD/CPO	Every Meeting	Jul-26	x	x	x	x	x	x	x	x	
Board Assurance Framework & Trust Risk Register	Executive Directors	Every Meeting	Jul-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- Medium Term Plan	Deputy Chief Executive	Annual	May-27			x						
Delivery Update 2025/26 Strategic Priorities Success Measures Medium Term Plan / Reset Programme	Deputy Chief Executive	Every meeting	May-26			x	x	x	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	Jul-26	x	x	x	x	x	x	x	x	
Chair's Assurance Log - Quality & Effective Committee	QEC Chair	Post Committee	Jul-26	x	x	x	x	x	x	x	x	
Chair's Assurance Log - People Committee	Chair of People Chair	Post Committee	Jul-26	x	x	x	x	x	x	x	x	
Chair's Assurance Log - Audit & Risk Committee	ARC Chair	Post Committee	Jul-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 & C	Annually	Nov-26	x					x			
Trust Seal	AD of Strategy, Partnerships & C	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)			HI - health inequalities six monthly reporting
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									Read across to BoD Standing Orders contained in CORP/FIN 1 E annually as part of review of CORP/FIN 1 B & C
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	

2607 - J4 ANY OTHER BUSINESS - TO BE AGREED WITH THE CHAIR PRIOR
TO THE MEETING

● Discussion Item

● Mark Bailey, Interim Chair

● 12:50

10 minutes

2607 - J5 DATE AND TIME OF THE NEXT MEETING

● Information Item

👤 Mark Bailey, Interim Chair

🕒 13:00

Date: Tuesday 1 September 2026

Time: 09:30am

Venue: Boardroom, Doncaster Royal Infirmary

2607- J6 WITHDRAWAL OF PRESS AND PUBLIC

● Information Item

● Mark Bailey, Interim Chair

● 13:00

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.